Appendix C. Glossary of Key Terms

ACAPT Teaching & Learning Institute
Task Force Develop a Systems Approach to
Social Determinants of Health in Physical Therapy Curriculum
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Terminology related to social determinants of health and structural drivers of health is expansive and continues to evolve. This glossary was compiled from existing resources and literature published by experts in justice, equity, diversity, and inclusion (JEDI) principles, health equity, and educational best practices. Because terminology and its application vary across academic, clinical, and community contexts, this glossary may not fully reflect the dynamics of all settings. For example, the term driver of health is increasingly preferred over determinant of health, as determinant may imply finality rather than a modifiable factor.[1]

This glossary is not intended to be a comprehensive list of terms that must be included in all physical therapy education programs. Nor does it define these terms for any legal purpose, or provide legal guidance to any person or entity regarding the interpretation of these terms for the purpose of complying with federal, state, or local law. Rather, it is intended to be informational and educational, providing a collection of terminology commonly found in contemporary literature and resources related to social and structural drivers of health, health inequities, and social justice. Some jurisdictions may present legislative or institutional barriers to using certain terminology, and we recognize that these restrictions may present challenges for educators, clinicians, and scientists engaging with this material. We offer this glossary to ACAPT programs as an optional resource to help educators prepare future physical therapists to provide patient-centered care and to understand the contextual factors affecting the patients and populations they will encounter in practice. The materials are not intended as requirements or prescriptive guidance from ACAPT to member institutions. Each institution should determine the suitability of these materials for their own institution, and ensure compliance with applicable legal requirements.

Drawing on guidance from colleagues across the health professions, we identified key terms that physical therapy educators may encounter when preparing to teach about social drivers of health. We also provide resources to support continued learning and engagement with this content across a variety of settings. Recognizing the limitations of offering a definitive or exhaustive set of terms, we encourage educators to seek current evidence and best practices as language and scholarship continue to evolve. These terms and resources are intended as a starting point for building deeper understanding and supporting the preparation of future physical therapists to better serve students, patients, and communities.

This glossary is divided into three sections:

1. Terms specific to social and structural drivers of health, including terms related to justice, equity, diversity, and inclusion (pg. 4)
2. Pedagogical terms and frameworks (pg. 27)
3. Additional web resources and reference list (pg. 29)

This glossary supplements additional resources provided by the ACAPT Social Determinants of Health Task Force.

This glossary is for informational and educational purposes only , and does not constitute legal advice. If you have anyquestions about compliance with federal, state, or local law that may apply to your program or practice, you should consult experienced legal counsel.

Master List of Terms

I. Social and Structural Determinant of Health Terms

able-bodied
ableism
affirmative action
ally
anti-racism
asset-based (or strength-based) approach
assimilationist
belonging
biomedical model
biphobia
built environment
centering
cis/cisgender
cisgenderism
cissexism
class
class conflict
class consciousness
class structure
coded racial appeals (dog whistles)
“colorblind” racism
colorism
community needs assessment
critical consciousness
Critical Race Theory
culture
culture of poverty
cultural appropriation
cultural competence
cultural humility
cultural responsiveness
cultural safety
cultural taxation
disability
discrimination
diversity
“Discovery” of the Americas
dominant public narrative
downstream/upstream
embodiment
environmental justice
Equity
ethnicity
exploitation
gender
gender binary
gender dysphoria
gender expansive
gender expression
gender fluid
gender identity
genderqueer
gender neutral/inclusive pronouns
gender nonbinary
gender nonconforming
gender-inclusive
gender transition or gender confirmation
hate crime
health care inequities
health disparities
health equity
health literacy
health inequity
historical trauma
holistic care
homophobia
implicit bias
inclusion
indigenous
individualism
intersectionality
justice
Latinx
LGBTQ
marginalization
medical mistrust
medical model of disability
microaggression
minority
misogyny
narrative change
non-white
oppression
outing
patriarchy
people of color
person-first language/people-first language
political determinants of health
political power
population health
post-racial society
power
prevention/preventive medicine
privilege
public health
public narrative
questioning
race
racialization
racial capitalism
racial domination
racial justice
racism
racial essentialism
racial exploitation
root causes
Section 503 and 508
sex assigned at birth
sexism
sexual orientation
social determinants of health
social drivers (of health)
social epidemiology
social exclusion
social gradient of health
social justice

social model of disability
social needs
stereotype
stigma
stigmatizing language
structural competency
structural determinants of health
structural determinants of health equity
structural violence
structural vulnerability
WCAG (Web Content Accessibility Guidelines)
weathering
white fragility
white privilege
white supremacy
whiteness

II. Pedagogical Terms and Frameworks

community -based education
community -engaged learning
competencies
competency-based education
Entrustable Professional Activities (EPAs)
experiential learning
interprofessional education
lifelong learner
master adaptive learner
problem-based learning
service learning
social accountability
systems thinking
transformative learning

Glossary of Terms:

I. Social and Structural Determinants of Health Terms

Able-bodied[2]: A term used to "describe someone who does not identify as having a disability. Some members of the disability community oppose its use because it implies that all people with disabilities lack "able bodies" or the ability to use their bodies well. They may prefer "non-disabled" or "enabled" as being more accurate." Some disability rights groups use the term "temporarily able bodied" with the acknowledgment that many people who today are able-bodied will remain so throughout their lives.

Ableism[2]: Discrimination of people with disabilities based on the belief that typical abilities are superior. Like racism and sexism, ableism classifies entire groups of people as "less than," and structures opportunity to advantage some and disadvantage others.

Affirmative action [2]: A term describing policies adopted since the 1960s that require "affirmative" (or positive) actions be to taken to ensure people of color and women have opportunities equal to those of white men in the areas of promotions, salary increases, school admissions, financial aid, scholarships and representation among vendors in government contracts. Although they have been effective in redressing injustice and discrimination that persisted in spite of civil rights laws and constitutional guarantees, the policies have been criticized because of perceived "reverse discrimination."

Ally[2]: Someone who makes the commitment and effort to recognize their privilege (based on gender, class, race, sexual identity, etc.) and work in solidarity with oppressed groups in the struggle for justice. Allies understand that it is in their own interest to end all forms of oppression, even those from which they may benefit in concrete ways.

Anti-racism[2]: The active process of naming and confronting racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably. Per Ibram X. Kendi: "The opposite of racist isn't 'not racist.' It is 'antiracist.' What's the difference? One endorses either the idea of racial hierarchy as a racist, or racial equality as an antiracist. One either believes problems are rooted in groups of people, as a racist, or locates the roots of problems in power and policies, as an antiracist. One either allows racial inequities to persevere, as a racist, or confronts racial inequities, as an antiracist. There is no in-between safe space of 'not racist.'" Anti-racism is a strategy to achieve racial justice. An anti-racist is someone who supports an antiracist policy through their actions or expressing antiracist ideas.

Asset-based (or strength-based, agency-focused) approach[2]: Focuses on the assets of communities rather than their needs, deficits or problems; focuses on what is working well to support the health and well-being of individuals, populations and communities. This perspective recognizes the competencies and resources people possess to exert their own

empowerment. It asserts that people are capable of solving problems and learning new skills; they are part of the process, not just dependent on professional resources.

Assimilationist [2]: One who is expressing the racist idea that a racial group is culturally or behaviorally inferior and is supporting cultural or behavioral enrichment programs to develop that racial group with the goal that the group would then be better able to blend wit hin the dominant group.

Belonging[3]**:** "the extent to which individuals feel they can be authentic selves and can fully participate in all aspects of their lives." Belonging encompasses an individual feeling "valued for their authenticity and intersectionality….and able to express themselves wi thout a fear of retribution, feel validated for multiple identities, and feel valued for their unique contributions."

Biomedical model[2]: Model of health employed since the mid-19th century that emphasizes biological factors in the understanding and treatment of diseases, excluding environmental and social influences. It provides the foundational assumptions that shape the context for health professionals to diagnose and treat diseases in most Western countries. This individualized, reductionist approach neglects other critical components, generally blaming individuals for their condition instead of acknowledging long term, intersecting str uctural influences associated with social injustice.

Biphobia[2]: The fear and hatred of, or discomfort with, people who love and are sexually attracted to more than one gender. Related to bisexual erasure, the tendency to ignore or deny the existence of bisexuality.

Built Environment [4,5]**:** Long viewed as a structural determinant of health by social epidemiologists. A substantial body of research has documented the association of built environment characteristics, such as: accessibility, physical disorder, access to public transit and recreational spaces, and greenery with health-related behaviors, health outcomes, and health care expenditures. Features of the built environment may influence health -related behaviors and outcomes through several pathways, including encouraging (or discouraging) exercise and recreational activities, determining whether residents have easy access to healthy foods and preventive health resources, and affecting stress and other psychosocial facto rs. The built environment includes the physical makeup of where we live, learn, work, and play. It involves homes, schools, businesses, streets and sidewalks, open spaces, and transportation options.

Centering (voices)[2]: Uplifting, trusting, and valuing the lived experiences of the people most impacted by the issue(s) and inequity(ies) you want to address; the process of centering the voices of those who have been historically marginalized.

Cis/Cisgender[2]: Gender identity in which a person's experiences of their gender matches the gender and sex they were assigned at birth (i.e., a cisgender man or cis man).

Cisgenderism[2]: Socially constructed assumption that everyone's gender matches their biological sex, and that this assumption is the norm from which all other gender identities deviate.

Cissexism[2]: A discriminatory system that oppresses and marginalizes people whose gender identity and/or gender expression (e.g., transgender, non -binary, etc.) fall outside the normative social constructions of gender (i.e., the gender binary). This system confers advantages to those aligned with normative gender norms, roles, expressions, and identity by privileging the binary social structure through representation, policies, practices, and structures that reflect and accommodate their rights, needs and lived exper ience. An example of cissexism is refusing to recognize the rights of transgender people to use the bathrooms appropriate for their gender identity while structuring bathrooms to accommodate cisgender people.

Class[2]: Relations of power among networked/ organized social groups that direct society's major institutions (such as corporations and government authorities), material resources and investments. Classism is the systematic oppression of subordinated class groups , held in place by attitudes that rank people according to economic status, family lineage, job status, level of education and other divisions.

Class conflict[2]: A permanent division and antagonism between those who own and control capital and the resources and mechanisms of production, as well as the structures of power in society, and those who do not.

Class consciousness[2]: The recognition by workers of their unity as a social class in opposition to capitalists and to capitalism itself.

Class structure[2]: In health research, the concept of class is often reduced to social status (usually measured by household income or educational attainment). This can be very useful in documenting social gradients in health and quantifying the relationships between socia l status and health outcomes. Yet describing class in this way hampers efforts to understand and confront root causes —because class is not simply an attribute of an individual or their household, but a system of social relations.

Coded racial appeals (dog whistles)[2]: The use of coded or suggestive language in political messaging to gain support from a particular group without provoking opposition. Dog whistles incorporate language which may appear normal to a general audience, but which communicates specific meanings to intended audiences . They can take the form of symbols that have previously been considered benign (and may still be used in benign ways in certain contexts). Coded racial appeals suggest deep-seated stereotypes without emphasizing race — "welfare queen" is an example of this . More generally, dog whistles are "used against a group or idea that threatens traditional power structures, which in America are predominantly white, male, heterosexual, cisgender."

“Colorblind” racism [2]: Term used to argue that we live in a world where racial privilege and racial discrimination no longer exists. The concept of colorblindness is often promoted by those who dismiss the importance of race in order to proclaim the end of racism. As an example, the statement: “I don’t see color” denies acknowledgment or acceptance of structural arrangements that harm some people and privilege others. According to Eduardo Bonilla-Silva, colorblind racism operates as an ideology, with four underlying “frames” or guides for interpreting information. These are: (1) abstract liberalism (using ideas associated with political liberalism, like “equal opportunity,” and economic liberalism, like “choice,” and “individualism,” to explain racial matters); (2) naturalization (explaining racial phenomena by suggesting they are natural occurrences); (3) cultural racism (relying on culturally-based arguments to explain the standing of minorities in society); and (4) minimization (suggesting that discrimination is no longer a central force affecting minorities’ life opportunities today.)

Colorism[2]: Discrimination based on skin color, which often privileges lighter-skinned people within a racial group, positioning people with darker complexions at the bottom of the racial hierarchy.

Community needs assessment[3]**:** “A community needs assessment provides community leaders with a snapshot of local policy, systems, and environmental change strategies currently in place and helps to identify areas for improvement. With this data, communities can map out a course for health improvement by creating strategies to make positive and sustainable changes in their communities.”

Critical Consciousness[3]**:** An educational and social concept developed by Paulo Freire, critical consciousness captures an in-depth understanding of the world, exposure to and perception of social and political contradictions and taking action against oppressive elements.

Critical Race Theory[2]: Born out of both legal studies and education scholarship, this is a framework that centers experiential knowledge, challenges dominant ideology, and mobilizes interdisciplinary action and research in order to uncover inequalities related to race and racism and other intersectional identities and/or experiences.

Culture[2]: Set of shared attitudes, values, goals and practices that characterize an institution, organization or group. Culture is transmitted and reinforced through tradition, art, language and ritual, among other practices. It has also been defined more broadly as a social system of meaning and custom by a group of people to assure its adaptation and survival.

Culture of poverty[2]: Commonly used phrase that blames people for their own poverty and assumes that some groups have a destructive element in their culture that leads them into poverty. The assumption ignores patterns of policy and discrimination that create poverty.

Cultural appropriation [2]: Adoption of elements of a culture that has been subordinated in social, political or economic status by a different cultural group. It may rely on offensive stereotypes

and is insensitive to how the culture of a group has been exploited by the culture in power, often for profit.

Cultural competence[2]: A component of medical education for the past 30 years. The cultural competence framework seeks to promote "culturally sensitive" practice and describes the trained ability of a clinician to identify cross-cultural expressions of illness and health. However, this umbrella term has been criticized on several grounds: it presents overly reductionist, simplistic and static depictions of culture, often reduced to race/ethnicity, and frames culture and race/ethnicity as residing only in the "Other," normalizing dominant white culture. Perhaps most negatively, cultural competence "is understood as something that can be attained, individualizing failure to do so. This misconstrues structured power relations which cannot be altered individually. Worse yet, competence is measured in terms of learner confidence and/or comfort, which may have little to do with working effectively across differences."

Cultural Humility[6]: Tervalon and Murray-Garcia (1998) advocate that cultural humility training is necessary within the patient/provider dynamic, which is frequently compromised by the "sociocultural mismatches between patients and providers, including providers' lack of knowledge regarding patients' health beliefs and life experiences." Whereas competence refers to a measurable endpoint or a finite outcome, humility requires continuous engagement, self-critique, and reflection. Clinicians have an obligation to evaluate their own beliefs and consider the impact of their position as they navigate the client-practitioner relationship. This ongoing reflective process mitigates the potential to stereotype a client based on a superficial perception of identity or culture. Humility demands empathy for the current and past lived experiences of others and acknowledgement of the limited perspective of one's own experience.

Cultural responsiveness[3]**:** "the ability to accommodate the cultural needs of the service user rather than being able to function without error in their culture. Thus, culturally responsive communication can be defined as communicating with awareness and knowledge of cultural differences and attempting to accommodate those differences. This involves respect and an understanding that socio-cultural issues such as race, gender, sexual orientation, disability, social class and status can affect health beliefs and behaviors. Therefore providing person-centered healthcare requires culturally responsive communication."

Cultural safety[2]: Developed in the 1980s in response to discontent with medical care in New Zealand. Cultural safety goes beyond the basic notion of cultural sensitivity that characterizes cultural competence to focus on analyzing power imbalances, institutional discrimination, and colonial relationships as they manifest in health care. Cultural safety calls on medical professionals and health care institutions to create spaces for patients to receive care that is responsive to their social, political, linguistic, economic and spiritual realities. Culturally unsafe practices, in contrast, are actions that diminish, demean, or disempower the cultural identity and well-being of patients.

Cultural taxation [3]**:** the idea that certain individuals, often people of color and people with ethnically diverse backgrounds, are expected to provide uncompensated professional services relevant to culture above and beyond the responsibilities of other people in a learning or workplace community. These disproportionate expectations and obligations may include mentorship, facilitating professional development, and DEI service efforts.

Disability [2]: Any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). Under the traditional medic al model, disability was viewed as a problem that exists in a person's body. This has been criticized on several fronts, including for pathologizing and disempowering people with disabilities. In contrast, the social model of disability focuses on systemic barriers, derogatory at titudes, and social exclusion which require structural solutions, including universal design to meet the needs of all people. "The concept of disability has been used to justify discrimination against other groups by attributing disability to them."

Discrimination [2]: Treatment of an individual or group based on their actual or perceived membership in a social category, usually used to describe unjust or prejudicial treatment on the grounds of race, age, sex, gender, ability, socioeconomic class, immigration status, n ational origin or religion. Discrimination by default positions some groups to have more advantages, opportunities, resources, and protections than others based on a given social characteristic or combination of social characteristics that are differentially valued.

Diversity[2]: Refers to the identities we carry. There are many kinds of diversity, based on race, gender, sexual orientation, class, age, country of origin, education, religion, geography, physical or cognitive abilities, or other characteristics. Valuing diversity m eans recognizing differences between people, acknowledging that these differences are a valued asset, and striving for diverse representation as a critical step towards equity.

"Discovery" of the Americas [2]: The land known as the Americas was not discovered; it was conquered and appropriated. This violent acquisition and genocide perpetuated by European settlers followed by centuries of ill -informed and harmful federal policy (e.g., boarding schools, urban relocation) by the U.S caused the destruction of many Indigenous peoples' culture and way of life.

Dominant public narrative [2]: Explanations or stories that support and reflect a dominant social group's interests and ideologies. They can be used to describe the dominant culture's explanation for societal events, guiding perceived reality.

Downstream/upstream [2]: Upstream refers to acknowledging and addressing the structural, societal, community and individual -level factors that influence health. Whereas downstream refers to the dominant approach of treating individual -level factors and/or contributors without wh olly addressing structural, societal and community factors. "Moving upstream"

involves continuously seeking to address the root causes of health inequities and improving the structural and social drivers of health for all people.

Embodiment [2]: A core concept in ecosocialtheory, used to describe the idea that we literally incorporate the world in which we live biologically. Nancy Krieger notes that it is a "… deliberate corrective to dominant disembodied and decontextualized accounts of 'genes' 'behaviors,' and mechanisms of disease causation, offering in their place an integrated approach to analyzing the multilevel processes, from societal and ecological to subcellular, that co -produce population distributions of health, disease, and wellbeing."

Environmental justice [2]: Fair treatment and meaningful involvement of all people regardless of race, color, national origin or income, with respect to the development, implementation and enforcement of environmental laws, regulations and policies.

Equity[2]: Refers to fairness and justice and is distinguished from equality. While equality means providing the same to all, equity requires recognizing that we do not all start from the same place because power is unevenly distributed. The process is ongoing, requiring us to identify and overcome uneven distribution of power as well as intentional and unintentional barriers arising from bias or structural root causes.

Ethnicity [2]: Social construct and category based on shared geography, language, ancestry, traditions or history. The boundaries of authenticity (that is, who or what "counts" in recognizing members of an ethnic group) are often changeable and dependent on generationa l, social, political and historical situations.

Exploitation [2]: Systematic transfer of the power of some persons or groups to others. With respect to the working class, it occurs through the social division of labor, specifically "the transfer of the labor of one social group to benefit another … Exploitation enacts a structural relation between social groups. Socia l rules about what work is, who does what for whom, how work is compensated, and the social process by which the results of work are appropriated operate to enact relations of power and inequity."

Gender[2]: Conventionally, refers to the "social, psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society's expectations, that classify someone as man, woman, both, or neither." A term associated primarily with social and cu ltural differences that more broadly denotes a range of identities that do not correspond to established ideas of the cisgender male and female. Self-determination of gender identities has significant implications for health outcomes. According to the WHO, "gender has implications for health across the course of a person's life in terms of norms, roles and relations. It influences a person's risk-taking and health -seeking behaviors, exposure to health risks and vulnerability to diseases. Gender shapes everyone's experience of health care, in terms of affordability, access and use of services and products, and interaction with healthcare providers."

Gender binary[2]: Classification of gender into two distinct, opposite, and separate forms of masculine and feminine, whether through social system or cultural belief. This is a widely used but oppressive model that erases the identities of people who fall outside of it.

Gender dysphoria[2]: Psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity.

Gender-expansive[2]: A person with a wider, more flexible range of gender identity and/or expression than typically associated with the binary gender system. Often used as an umbrella term when referring to young people still exploring the possibilities of their gender expre ssion and/or gender identity.

Gender expression[2]: "The way in which someone expresses their gender, either consciously or unconsciously. This can encompass everything that communicates our gender to others, including clothing, hairstyle , body language, manner of speaking, social interactions, and gender roles. Most people have some blend of masculine and feminine qualities that comprise their gender expression, and this expression can also vary depending on the social context. There is not always a direct translation between gender identity and gender expression. A person's gender expression may or may not align with the way people attribute gender to that person."

Gender fluid[2]: Term to describe individuals whose gender identity is not fixed, but may change over space, time, context, etc. People who identify as gender fluid may identify outside of the gender binary, e.g., as both male and female or as neither male nor female.

Gender identity[2]: How people conceptualize themselves as gendered beings, including one's innate and personal experience of gender. This may or may not align with one's gender expression or biological sex.

Genderqueer[2]: An umbrella term within the LGBTQ+ community referring to anyone who doesn't prescribe to societal views of gender and sexuality; implies elasticity and a resistance to the notion of a predetermined gender and sexual identity based on biology.

Gender neutral/inclusive pronouns[2]: Pronoun which does not associate a specific binary gender with an individual (e.g., they, them, their, theirs, themself, sie, hir, hirs, hirself, zie, zir, zirs, zirself).

Gender nonbinary[2]: An adjective describing a person who does not identify exclusively or at all as a man or a woman. Nonbinary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all nonbinary people do. Nonbinary can also be used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender -fluid.

Gender nonconforming [2]: People who do not follow conventional ideas or stereotypes about gender roles, how they should look or act based on their female or male sex assigned at birth. Can also refer to people who do not identify with their sex assigned at birth.

Gender-inclusive[2]: Term to describe places, spaces, policies, language, procedures, etc., that validate, accommodate and honor the existence, experience, and rights of all gender identities and expressions.

Gender transition or gender confirmation [2]: A process some transgender people undergo to match their gender identity more closely with their outward appearance. This can include changing clothes, names or pronouns to fit their gender identity. It may also include health care needs such as hormonesor surgeries. Gender confirmation is the more appropriate term in medical contexts.

Hate crime[2]: Criminal acts, motivated by bias, that target victims based on their perceived membership in a certain social group.

Health care inequities [2]: A measurable, systemic, avoidable and unjust difference in health care access, utilization, quality and outcomes between groups, stemming from differences in levels of social advantage and disadvantage.

Health disparities [2]: Refer to a higher burden of illness, injury, disability or mortality experienced by one group relative to another. In some uses, including in Healthy People 2030, the term is explicitly linked to economic, social or environmental disadvantage but in many cases the term is used to refer to simple mathematical differences (and as such, has fallen out of use in contemporary health equity discourse). Health "inequities," in contrast, are explicitly defined as health differences that are avoidable, unnecessary , unfair and unjust. As used in public health and medicine, the term health disparities often ignores the historical context, political processes and unjust nature of some health outcomes, thereby preventing a structural analysis of root causes.

Health equity [2]: Defined by the WHO as "the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. 'Health equity ' or 'equity in health' implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."

- Other valuable definitions include that of Paula Braveman: "Health equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions. …Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/ socially disadvantaged)."

- Another is from Camara Jones: "Health equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally recognizing and rectifying historical injustice, and providing resources according to need."

Health literacy [2]: Used to describe the ability of individuals to locate, understand, interpret, and apply health information to guide their decisions and behavior. For the past three decades, the term has been used as an individual-level characteristic, an attribute of a person—someone who has low/high levels of health literacy. A variety of research instruments are available to measure health literacy in this way. This term has received substantial criticism in recent years for its undue and harmful focus on individuals, neglecting the complex system of communication that occurs in all aspects of health care.

- The U.S. Department of Health and Human Services has proposed to refine health literacy as a systems level characteristic: "Health literacy occurs when a society provides accurate health information and services that people can easily find, understand, and use to inform their decisions and actions." This new definition acknowledges that literacy is not a skill that a person has or does not have, but rather, is the outcome of an effective system.
- Additionally, Ivelyse Andino has developed an updated term, "healthcare fluency," which offers an equity -focused alternative to health literacy. Health care fluency includes literacy, but also acknowledges the importance of scientific knowledge (i.e., capacity to give true inf ormed consent), cultural perception (i.e., community -level trust in medical system), and confidence (i.e., personal trust in medical system and ability to advocate for self in the medical encounter).

Health inequity [2]: Differences in health outcomes that are systematic, avoidable, unnecessary, unfair and unjust. These differences are a product of the "structures and systems [that] date back to the founding of this nation and its economy on principles of racial, class, and gender hierarchy."

Historical trauma [2]: Collective and complex trauma inflicted on a group who share a specific identity or affiliation. It reflects past treatment of certain racial and ethnic groups, especially Native Peoples, including their consignment to reservations with limited resources , and the cumulative harm caused by traumatic experiences and policies. This is another form of structural (i.e., systemic) racism that continues to shape the opportunities, risks and health outcomes of these populations today. While thinking tends to focu s on past treatment, there are modern occurrences that are experienced as collective traumas. The compounding of the old and new traumatic experiences impacts health status and social position today and in the future.

Holistic care[3]**:** healthcare that takes a "systems -based view of the individual (as an environmentally -influenced, complex biological system)"; sometimes referred to as systems medicine that may include "the study of both structure and dynamics of interacting nodes, forming networks at multiple levels of a multidimensional matrix, including molecular, cellular, organ, person, family, community, society, and environment." "Holistic healthcare is complete

or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person, his or her response to illness and the effect of the illness on the ability to meet self-care needs."

Homophobia[2]: The fear and hatred of or discomfort with people who are attracted to members of the same sex.

Implicit bias[2]: Unconscious mental process that stimulates negative attitudes about people outside one's own "in group" and positive attitude or beliefs about people recognized inside one's own "in group." Implicit racial bias leads to discrimination against people not of one's own group.

Inclusion[2]: Refers to how our defining identities are accepted in the circles that we navigate. Belonging evolves from inclusion; it refers to the extent to which individuals feel they can be authentic selves and can fully participate in all aspects of their lives. Inclusion is a state of being valued, respected and supported. At the same time, inclusion is the process of creating a working culture and environment that recognizes, appreciates, and effectively utilizes the talents, skills and perspectives of every employee; uses employee skills to achieve the agency's objectives and mission; connects each employee to the organization; and encourages collaboration, flexibility and fairness. In total, inclusion is a set of behaviors (culture) that encourages employees to feel valued for their unique qualities and experience a sense of belonging.

Indigenous[2]**:** a generic term describing a diverse group of peoples with historical continuity with pre-colonial and/or pre-settler societies; a modern understanding of this term includes a "strong link to territories and surrounding natural resources, distinct social, economic or political systems, and distinct language, culture and beliefs. In some countries, there may be preference for other terms including tribes, first peoples/nations, aboriginals, ethnic groups, adivasi, janajati."

Individualism[2]: Philosophy and group of ideas, expressed in symbols, practices, and stories that support the belief that self-sufficient individuals are rational beings who freely make consumer-like choices, independent of political influences, living conditions or historical context. As a philosophy, it problematically obscures the dynamics of group domination.

Intersectionality[2]: Leading feminist and social justice theories and practices acknowledge that intersectionality, first coined by Kimberlé Crenshaw, as legal terminology to recognize the unique experiences and legal challenges of Black women, who as a group experienced both racism and sexism. It is the ongoing examination of the overlapping systems of oppression and discrimination that communities face based on race, gender, ethnicity, ability, etc. It is our role to continuously examine the multiple forms and kinds of intersectional exclusions. The call for an anti-racist health care system—one which recognizes and addresses the intersectionality of systems of oppression—amplifies every day.

Justice[2]: Describes a future state where the root causes (e.g., racism, sexism, class oppression) of inequity have been dismantled and barriers have been removed. It is an achievable goal that requires the sustained focus, investment, and energy of leaders and com munities working together holding each other accountable to redesign our structures, policies, and practices to deliver the high quality and safest possible conditions that allows for everyone to reach their highest potential.

Latinx[2]: A relatively new term that to describe people who are of or relate to Latin American origin or descent. It is a gender neutral and nonbinary alternative to Latina/Latino. While awareness and acceptance of Latinx is thought to be low, there is growing acc eptance of the term Latinx in the U.S., due to its inclusivity. Of note, many Hispanic, Latina/Latino/Latinx members prefer to identify using other terms including national or ethnic origin (i.e., Argentinian, Mexican, Puerto Rican). Furthermore, other ter ms like Chicano or Chicana are used historically and politically to signal social justice and advocacy inclusion and people still identify with this term. Finally, the term Spanish is used regionally to identify descendants of Spain who also have other eth nic and national origins. Preferred terms vary regionally. Best practice is to consult the specific communities involved in discussion to ask their preference.

LGBTQ[3]: An acronym for "lesbian, gay, bisexual, transgender and queer." Other forms of the term include LGBTQIA "lesbian, gay, transgender, queer or questioning, intersex, and asexual," LGBTQ+ to recognize the growing understanding of sex and gender and to include allies, and LGBTQQIP2SAA, for "lesbian, gay, bisexual, transgender, questioning, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual." It is a developing term, shifting regularly.

- **Lesbian**[2]**:** A woman who is emotionally, romantically or sexually attracted to other women. People of many different gender identities may use this term to describe themselves.
- **Gay**[2]: A person who is emotionally, romantically or sexually attracted to members of the same gender. Men, women and nonbinary people may use this term to describe themselves.
- **Bisexual/ Pansexual**[2]: Describes someone who has the potential for emotional, romantic or sexual attraction to people of any gender though not necessarily simultaneously, in the same way or to the same degree.
- **Queer**[2]: A term people often use to express a spectrum of identities and orientations that are counter to the mainstream. Queer is often used as a catch-all to include many people, including those who do not identify as exclusively straight and/or folks who have non-binary or gender-expansive identities. This term was previously used as a slur (and is still considered a slur by some) but has been reclaimed by many parts of the LGBTQ+ movement.
- **Transgender/transsexual/trans** [2]: Denotes a person whose sense of personal identity and gender expression does not correspond with their assigned sex at birth. Some people who request medical and/or surgical assistance to transition from one sex to another identify themselves as transsexual. Many transgender people experience

extensive forms of discrimination by the medical profession in accessing care and treatment. A growing body of research continues to elucidate health inequities experienced by transgender individuals and further underscores the need for medical providers to be appropriately trained to deliver care to this population. Research has shown that transgender populations experience significant health disparities such as a disproportionately higher burden of mental health illness, including increased rates of depression, anxiety and suicide.

- **Intersex**[2]: Term to describe a subset of individuals whose reproductive organs and anatomy (e.g., primary sex characteristics, hormones, chromosomes, etc.) do not align with medically defined and socially expected notions of male and female. It is seen as both an identity and a "condition" and can vary by person. Viewing intersex as a condition can be problematic as is often "treated" medically in infancy (i.e., the infant's sex is assigned, and they are socialized to embody the corresponding gender identity as expected). Some argue intersex infants should not undergo medically unnecessary surgical procedures to "correct" the condition, thereby mitigating further stigmatization, reinforcement of the binary system, and medicalizing normative human variation. The terms "differences of sexual development" or "disorders of sexual development" may sometimes also be used especially in the medical setting. Intersex is formally known as hermaphrodite or hermaphroditic—terms now largely out of use and considered offensive.

- **Asexual**[2]: Someone who does not experience sexual attraction (asexual), or rarely experiences sexual attraction (asexual spectrum). The term does not necessarily refer to actions, medical conditions, or romantic inclinations. Asexually identified individuals can experience marginalization in society.

- **Two-spirit** [2]: Direct translation of the Ojibwe term, Niizh manidoowag. "Two-Spirited" or "Two Spirit" is usually used to indicate a person whose body simultaneously houses a masculine spirit and a feminine spirit. This pan-Indigenous term can also be used more abstractly, to indicate the presence of two contrasting human spirits (such as Warrior and Clan Mother), challenging the colonial gender binary. Two-Spirit People (also Two Spirit or Twospirit), an English term that emerged in 1990 out of the third annual inter-tribal Native American/First Nations gay/lesbian American conference in Winnipeg, describes Indigenous North Americans who fulfill mixed gender roles in their respective community. The mixed gender roles encompassed by the term, historically included wearing the clothing and performing work associated with both men and women. It's important to know that the traditional term for Two Spirit identity varies between Indigenous groups. It is also not a term that can be used by a non-Indigenous person.

Marginalization [2]: Process experienced by those under- or unemployed or in poverty, unable to participate economically or socially in society, including the labor market, who thereby suffer material as well as social deprivation.

Medical Mistrust [7]: "a tendency to distrust medical systems and personnel believed to represent the dominant culture in a given society". Medical mistrust is "not the same as "no trust"; rather MM implies that a trustor's negative beliefs are that the trustee will go agains t the person's best interest. For instance, a person may trust a specific clinician, but may hold suspicious attitudes towards the broader healthcare system and its providers.

Medical model of disability [2]: Based on a functional analysis of the body as a machine to be fixed in order to conform with normative values. The medical model of disability views disability as a "problem" that belongs to the person with the disability. It stands in contrast to the social model of disability, which focuses on systemic barriers, derogatory attitudes, and social exclusion (intentional or inadvertent), which make it difficult or impossible for individuals with impairments to attain their valued functionings.

Microaggression [2]: Everyday verbal, nonverbal and environmental slights, snubs or insults, whether intentional or unintentional, which communicate hostile, derogatory or negative messages to persons targeted solely for their membership in historically marginalized groups.

Minority [2]: Term to define the status of a population by what they are not and the lack of some characteristic held by those in the dominant category. Defining people of color as "minorities" is not recommended because of changing demographics and the ways in which it reinforces ideas of inferiority and marginalization of a grou p of people.

Misogyny [2]: The dictionary definition of misogyny is hatred, contempt for or prejudice against women. However, Kate Manne contends that "it's an ideology founded on controlling and punishing women who challenge patriarchal norms." In her view, misogyny consists of " social systems or environments where women face hostility and hatred because they're women in a man's world—a historical patriarchy."

Narrative change [2]: A long-term strategy towards an end; a tool for restructuring the way people feel, think and respond to the world. Narrative change is concerned with changing perspectives or consciousness, transforming how we communicate. The purpose is to create profou nd shifts in the narratives, values, beliefs and behaviors of people.

Non-white [2]: Term previously used in the U.S. Census and still heard today to describe people of color. It centers race on whiteness as a norm and implies that those not white are "other." "The moment you say nonwhite, you have made white people the norm and everyone else a deviation, mutation, or variation of white people and the characteristics associated with whiteness."

Oppression [2]: Unjust or cruel exercise of power or authority; the product of injustice. But also, as Iris Marion Young explains, "… the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well -meaning people in ordinary interactions, media, and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms—in short the normal processes of everyday life."

Outing[2]: Exposing someone's lesbian, gay, bisexual transgender or gender non-binary identity to others without their permission. Outing someone can have serious repercussions on employment, economic stability, personal safety or religious or family situations.

Patriarchy[2]: Systematic domination by men. A system of society or government in which men hold the power and women are largely excluded from it. Male power typically includes political leadership, moral authority, social privilege and control of property. Generates a nd is supported by hegemonic masculinity.

People of color[2]: Term used mostly, but not exclusively, in the U.S. to describe people not considered "white." The term emphasizes shared experiences of structural racism, and opposes reference to people as "non white " or "minority." In recent years, the related term BIPOC (Black, Indigenous, and People of Color) has also been used. Not to be confused with the pejorative "colored people". Per Race Forward: "While 'people of color' can be a politically useful term, and describes people with their own attributes (as opposed to what they are not, e.g.: "non-White"), it is also important whenever possible to identify people through their own racial/ethnic group, as each has its own distinct experience and meaning and may be more appropriate."

Person-first language/ people -first language [2]: Emphasizes the individual over the person's condition, e.g., "woman with diabetes," rather than "diabetic woman." In general, public health entities are encouraged to use person -first language whenever possible. However, they should keep in mind that not all individuals prefer person -first language; some, such as the deaf community, prefer to emphasize their shared group identity as "people who are deaf." It is important to acknowledge that different communities and individuals have different standards and preferences.

Political determinants of health [3]**:** "the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities." "The political determinants of health create the social drivers - including poor environmental conditions, inadequate transportation, unsafe neighborhoods, and lack of healthy food options - that affect all other dynamics of health."

Political power [2]: Organized ability to control, exercise, or direct the behavior of people or institutions over time, and influence the outcome of events, as well as the rules that govern the use of power. Sources of power include force, influence, narrative or ideology, and authority, as well as control over resources and wealth. In a society like the United States, it is based on unequal power relations which, whether corporate or governmental, are socially constructed over time and are thus subject to change. Often poli tical power is accepted as legitimate and normal even when the source of power and its processes remain obscure.

Population health [2]: The health outcomes of a group of individuals, including the distribution of such outcomes within the group. The field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link them.

Post-racial society[2]: Term used to describe a time in which racial prejudice and discrimination no longer exist. The term is based on the assumption , says Ta-Nehisi Coates, "that the long struggle that commenced when the first enslaved African arrived on American soil centuries ago could somehow be resolved in an instant." He adds: "America's struggle is to become not post-racial, but post-racist. Put differently, we should seek not a world where the black race and the white race live in harmony, but a world in which the terms black and white have no real political meaning."

Power[3]**:** "in political science and sociology, the capacity to influence, lead, dominate, or otherwise have an impact on the life and actions of others in society. The concept of power encompasses, but is not limited to, the notion of authority. Unlike authority, wh ich implies legitimacy, power can be exercised illegitimately." Power sustains racism; prejudice backed by power transforms "psychological processes into asymmetric societal processes."

Prevention/preventive medicine [2]: Traditionally, in public health, measures to prevent the occurrence of disease and illness that are focused on changing individual (risky) behavior through health promotion policies or marketing activities, primarily associated with making choices. Also refers to broad types of regulation (of environments, housing, medications, support for vaccinations) to ensure the public is adequately protected. Although prophylactic in nature, these forms of prevention do not attempt to end the generation of inequitie s in the distribution of disease and illness by focusing on the structures of power that create economic and social conditions. Those conditions are generally not under control of the individual. Similarly, preventive medicine involves medical practices designed to avert and avoid disease, disability and death. For example, screening for hypertension and treating it before it causes disease. It emphasizes a proactive approach to patient care and focuses on the health of individuals and communities. Problems arise, however, with relying on either approach for eliminating health inequities.

Privilege[2]: A set of advantages systemically conferred on a particular person or group of people.

Public health[2]: is "concerned with the social, economic, cultural, and political conditions that shape the health of populations." Per the American Public Health Association, public health promotes and protects the health of people and the communities where they live, l earn, work and play. The classic definition, still accepted today, was developed by CEA Winslow in 1920: "The science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organi zations, public and private communities, and individuals." Public health "is fundamentally about community and about shared values of life, health and security." The primary goal of public health is to prevent disease and promote health at the population l evel. As a social enterprise, public health exists simultaneously as an area of knowledge and a field of practice. The practice includes a variety

of organized institutions and professionals, governmental and non-governmental. The non-governmental organizations can include communities and facilities run by non-profit organizations. In some ways public health includes an interdisciplinary range of activities since all realms of economic and social life play a role in affecting health outcomes, particularly health inequities.

Public narrative[2]: Collection of stories or explanations that reflect a shared interpretation of how the world works. According to the Narrative Initiative, "Narratives are often described as a collection or system of related stories that are articulated and refined over time to represent a central idea or belief. Unlike individual stories, narratives have no standard form or structure; they have no beginning or end. What tiles are to mosaics, stories are to narratives. The relationship is symbiotic; stories bring narratives to life by making them relatable and accessible, while narratives infuse stories with deeper meaning."

Questioning[2]: A term used to describe people who are in the process of exploring their sexual orientation or gender identity.

Race[2]: System of categorizing people that arises to differentiate groups of people in hierarchies to advantage some and disadvantage others. Stated another way, race is a social construct or "a symbolic category [actively created and recreated, rather than pre-given], based on phenotype or ancestry and constructed to specific racial and historical contexts, that is misrecognized as a natural category." While often assumed to be a biological classification, based on physical and genetic variation, racial categories do not have a scientific basis.

- Camara Jones explains: "the variable race is only a rough proxy for socioeconomic status, culture, and genes, but it precisely captures the social classification of people in a race-conscious society such as the United States. The race noted on a health form is the same race noted by a sales clerk, a police officer, or a judge, and this racial classification has a profound impact on daily life experience in this country. That is, the variable 'race' is not a biological construct that reflects innate differences, but a social construct that precisely captures the impacts of racism."
- Race is a concept 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). Race, more perniciously, is a political construction created to concentrate power with white people and legitimize dominance over non-white people.

Racialization[2]: The imposition, over time, of racial differences onto a population. This process or set of processes may or may not be animated by conscious forces, rather than a static event that constructs races as real and unequal that negatively affects social, economic and political life. It underscores the fluid and dynamic nature of race. Racialization can also be described as a form of judgmental racial classification characterizing a population group which is used, publicly, to justify stigmatization, exploitation and paternalism.

Racial capitalism[2]: Idea that racialized exploitation and capital accumulation are mutually reinforcing. The concept is attributed to Cedric Robinson, who argued that "the development, organization and expansion of capitalist society pursued essentially racial directions."

Racial domination[2]: "A type of power that encompasses the symbolic power to classify one group of people as 'normal' and other groups of people as 'abnormal'; the political power to withhold basic rights from people of color and marshal the full power of the state to enforce segregation and inequality; the social power to deny people of color full inclusion or membership in associational life; and the economic power that privileges Whites in terms of job placement, advancement, wealth, and property accumulation."

Racial justice[2]: The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice —or racial equity—goes beyond "anti-racism." It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures.

Racism[2]: As defined by Camara Jones, "racism is a system of structuring opportunity and assigning value based on phenotype ("race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources" Racism can operate at different levels: structural, institutional, interpersonal and internalized.

- **Structural**[2]: As defined by Zinzi Bailey et al, structural racism "refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources." Structural racism results in systemic variation in opportunity according to race or ethnic background—including differentials in access to health care based on race. It is a deep-seated and core form of social injustice and oppression seen across society, perpetuating cumulative advantage for whites throughout life.
- **Institutional**[2]: Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race. Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.
- **Interpersonal**[2]: The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs or racial jokes. It may also take more subtle forms of unequal treatment, including micro aggressions.
- **Internalized**[2]: Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.

Racial essentialism[2]: A belief in a genetic or biological basis for categorization that defines membership of a racial category. Underpinning the belief are notions of naturalness (e.g.,

“race” is a natural/objective category rather than a social construction), cross-cultural stability (e.g., racial categories hold the same meaning across the world), and inductive potential (e.g., knowledge of a person’s race can inform your actions and decisions pertaining to that person).

Racial exploitation [2]: Racial exploitation has been a common form of discrimination in not only the undemocratic workplace itself through lower wage rates, but also in excluding or segregating African Americans in access to labor markets in sectors of the economy through constricting worker rights. The consequences included exacerbating economic insecurity and stability in employment which has had negative effects on health outcomes.

Root causes[2]: Underlying systems and structures of social injustice that generate health inequity over time, including white supremacy, patriarchy, and class oppression. They interact with each other to produce social exclusion, marginalization and exploitation.

Section 503 and 508[2]: Section 503 of the Rehabilitation Act of 1973 is a law that prohibits federal contractors and subcontractors from discriminating in employment against individuals with disabilities and requires employers to take affirmative action to recruit, hire, promote and retain these individuals. Section 508 requires that the federal government procure, create, use, and maintain information and communications technology that is accessible to people with disabilities, regardless of whether or not they work for the federal government.

Sex assigned at birth[2]: A concept used to describe a person’s sex assigned at birth, typically based on a subjective evaluation of external anatomic structure(s) and its comparison to various sex categories. This may or may not align with how they identify themselves.

Sexism[2]: Discrimination based on sex, typically the belief that cisgender males are inherently superior to all other genders.

Sexual orientation [2]: An inherent or immutable enduring emotional, romantic or sexual attraction to other people. Note: an individual’s sexual orientation is independent of their gender identity.

Social determinants of health [2]: Refer to the underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age. They affect a wide range of health, functioning, and quality-of-life outcomes and risks. These determinants and their unequal distribution according to social position, result in differences in health status between population groups that are avoidable and unfair. Social determinants of health inequities refer to the connection between social determinants of health (SDoH) and place specific levels of health inequities. This acknowledges that while underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age affect individual level health they also influence patterns of health inequities within and between communities.

Social drivers (of health)[1]: An updated clarification of social determinants of health. The National Association of Community Health Centers (NACHC)advocates for using “drivers” of

health to better reflect the accuracy of factors that contribute to health and health inequities. The NACHC states, “When using the term “determinants” it can have a sense of finality, stripping individuals of their agency to manage their own health and well-being, and minimizing accountability amongst policymakers and those in power for the social and political decisions that create these inequities —as though struggles to access food or housing are predetermined and thus cannot be changed.”

Social epidemiology[2]: The branch of epidemiology that focuses on the effects of social-structural drivers of health.

Social exclusion[2]: Relational process of denying groups of people access to economic, social, political, and cultural resources, based on unequal power relations. Experienced most vividly in housing and employment as well as school segregation, for example, social exclusion limits full participation in community and social life for particular groups of people.

Social gradient of health [2]: Describes the correlation between socioeconomic status and health; a person of lower-socioeconomic status will generally have poorer health than an otherwise similar person of higher socio economic status.

Social justice[2]: The state of social, economic and political equality and realizing “the institutional conditions necessary for the development and exercise of individual capacities and collective communication and cooperation.” It is a standard concerned primarily with outcomes not process. The structure of power relations in a society determines the opportunities to achieve social justice.

Social model of disability [2]: Focuses on systemic barriers, derogatory attitudes, and social exclusion (intentional or inadvertent), which make it difficult or impossible for individuals with impairments to attain their valued functionings. The social model of disability stands in contrast to the dominant medical model of disability, which is a functional analysis of the body as a machine to be fixed in order to conform with normative values. The social model distinguishes impairment (used to refer to the actual attributes, or lack of attributes, that affect a person) from disability (used to refer to the restrictions caused by society when it does not give equivalent attention and accommodation to the needs of individuals with impairments). Honoring the principle of “Nothing about us, without us,” the social model of disability also calls for all education promoting the health of persons with disability to be guided and informed by persons with disabilities.

Social needs[2]: The individual-level material resources and psychosocial circumstances required for the well being of one’s physical and mental health. These also include social risk factors, or specific adverse social conditions that are associated with poor health, including social isolation, food insecurity or housing instability.

Stereotype [2]: Assignment of assumed characteristics or attributes to the members of a given group (e.g., by ethnicity, nationality, class, or other status/identities). It occurs in a variety of

historical representations or expressions that can cause trauma and racial injury by “othering” groups and denying people their individuality, culture and humanity.

Stigma[2]: Elements of labeling, stereotyping, separating, status loss and discrimination co -occurring in a power situation that allows these processes to unfold.

Stigmatizing language[2]: According to Mona Shattell, “Language is a method of communication that transmits intended and unintended meanings. Unintended stigmatizing meanings, which are probably more insidious and dangerous (than language that clearly communicates intended meanin gs) can perpetuate socially constructed power dynamics and become so ‘commonplace’ that they are invisible. Persons must be aware of these unintended stigmatizing meanings. ... Stigmatizing language with unintended meanings can perpetuate power and control and further marginalize persons … [or communities].” Stigmatizing language places an illness before the person, giving primacy of the illness (e.g., “mental illness”) over the human being.

Structural competency[2]: According to Jonathan Metzl and Helena Hansen, “the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication “non -compliance,” trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health . … [It] consists of training in five core competencies: (1) recognizing the structures that shape clinical interactions; (2) developing an extra -clinical language of structure; (3) rearticulating ‘cultural’ formulations in structural terms; (4) observing and imagining structural interventions; and (5) developing structural humility.”

Structural Determinants of Health[8]**:** “cultural norms, policies, institutions, and practices that define the distribution (or maldistribution) of SDOH”

Structural determinants of health equity[2]: Described by social epidemiologist Nancy Krieger as directly connected to social injustice; “political -economic systems, whereby health inequities result from the promotion of the political and economic interests of those with power and privilege (within and across countries) against the rest, and whose wealth and better health is gained at the expense of those whom they subject to adverse living and working conditions.”

Structural violence[2]: A term first developed by Johan Galtung to describe violence (harm) generated by a society’s system of stratification. According to Galtung: “If a person died from tuberculosis in the eighteenth century, it would be hard to conceive of this as violence s ince it might have been quite unavoidable, but if he dies from it today, despite all the medical resources in the world, then violence is present.” For Galtung, structural violence is synonymous with social injustice. The term has been popularized in healt h equity work by Paul Famer et al., who define structural violence as “social arrangements that put individuals and populations in harm’s way. The arrangements are structural because they are embedded in the

political and economic organization of our social world; they are violent because they cause injury to people." The concept's power lies in its focus on the deep structural roots of health inequities; in contrast to the more passive term "social determinan ts of health," structural violence explicitly identifies social, economic and political systems as the causes of the causes of poor health.

Structural vulnerability [2]: Term developed by Philippe Bourgois, Seth Holmes, and others to describe an individual's or a group's condition of being at risk for poor health outcomes through their interface with socioeconomic, political, and cultural/normative hierarchies. Patients are structurally vulnerable when their location in their society's multiple overlapping and mutually reinforcing power hierarchies and institutional and policy -level statuses constrain their ability to access health care and make healthy choices.

WCAG (Web Content Accessibility Guidelines)[2]: Formalized standards by law as of 2017, with requirements starting January 2018 for all government contractors to make their electronic and information technology (EIT) compliant to be considered accessible.

Weathering [2]: A hypothesis first proposed by Arlene Geronimus positing that Blacks experience early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization. The hypothesis has been explored with other groups, including American Indian and Alaska Native elders, documenting the structural roots of weath ering.

White fragility [2]: According to Robin DiAngelo, "White fragility is a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear and guilt, and behaviors such as argumentation, silence and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium. Racial stress results from an interruption to what is racially familiar." For Katy Waldman, it is "t he disbelieving defensiveness that white people exhibit when their ideas about race and racism are challenged—and particularly when they feel implicated in white supremacy."

White privilege [2]: Unquestioned and unearned sets of advantages, entitlements, benefits and options that people have solely because they are white. Generally, white people who experience such privilege do so without being conscious of it.

White supremacy [2]: Historically based, institutionally perpetuated system of exploitation and oppression of continents, nations, and people of color by white people and nations of European descent for the purpose of maintaining and defending a system of wealth, power and privilege. "White supremacy is not only…associated with…extreme political movements [but] is seen to relate to the operation of forces that saturate the everyday, mundane actions and policies that shape the world in the interests of white people." White sup remacy, constantly adapting to legal and cultural changes, persists in part by the way many whites ignore their whiteness to the point of invisibility, their role in a racial hierarchy, and the

privilege it gives them. A myth of innocence, an assumption of objectivity and other rationalizing devices, supports an unwillingness to recognize or reckon with racial injustice. It furthers a refusal to recognize their complicity in affirming and normali zing the structure of racist domination. Social codes, “othering” people who are not white, and the threat of violence or its anticipation play a role in supporting white supremacy.

Whiteness[2]: It is important to differentiate “white” (a category of racial classification with no scientific basis) and “whiteness” (reflecting the power and privileges that people who are defined as white receive). Whiteness, in this way, is both cultural and socio economic power and privilege. Whiteness, according to sociologist Ruth Frankenberg, is “dominant cultural space with enormous political significance, with the purpose to keep others on the margin. ... white people are not required to explain to others how ‘white’ culture works, because ‘white’ culture is the dominant culture that sets the norms. Everybody else is then compared to that norm.” It is a complex and debated term, full of paradox, as exemplified in Jonathan Metzl’s Dying of Whiteness.

II. Pedagogical Terms and Frameworks

Community-based education[9]: consists of learning activities that use the community extensively as a learning environment.

Community-engaged learning[9]: an educational process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them; in making decisions about factors that affect their lives; in formulating and implementing policies; in planning, developing and delivering services; and in taking action to active change.

Competencies[10]: the characteristics of the learner that demonstrate knowledge, skills, abilities, and professional behaviors specific to a profession.

- See SDH Task Force Bibliography for examples

Competency-based education[11]: "an outcomes-based approach rooted in behaviorism and constructivism. It seeks to emphasize necessary learner abilities, de-emphasize time-based training, promote greater learner-centeredness, and ensure that the public's needs are met."

Entrustable Professional Activities (EPAs)[12]: "the core tasks health professionals must be competent performing prior to promotion and/or moving into unsupervised practice."

Experiential learning[9]: involves concrete experiences, reflective observation, abstract conceptualization, and application of knowledge.

Interprofessional education[9]: occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.

Lifelong learning[9]: a continuum of learning throughout the life course aimed at "improving knowledge, skills, and competences within a personal, civic, social, and/or employment-related perspective".

Master adaptive learner[13]: The Master Adaptive Learner (MAL) theoretical framework describes an integrated approach to learning that combines features of educational theory on self-regulated learning and aspects of quality improvement. Learners travel through phases similar to Plan-Do-Study-Act (PDSA) cycles, which include learning, identifying gaps, adjusting and putting this new knowledge into practice.

Problem-based learning[9]: a way of delivering a curriculum in order to develop problem solving skills as well as assisting learners with the acquisition of necessary knowledge and skills. Students work cooperatively in groups to seek solutions to real-world problems, set to engage students' curiosity and initiate learning the subject matter.

Service learning[14]: a structured learning experience that combines community service with explicit learning objectives, preparation, and reflection (IOM). Learning experiences that

“provide a transition between didactic academic training and clinical practice with early hands-on realistic and context-based experience and provide valuable community services.”

Social accountability [15]: “Differing from social responsibility, social accountability requires educational institutions to not simply act in the interest of society, but to determine the impact of their activities on society. Social accountability is the measure of an institution’s response to societal needs. Both social accountability and responsibility maintain serving disadvantaged populations as a high priority” (Hartman et al., 2022, p. 1369).

Systems thinking [16]: an approach to problem-solving that views problems as part of a wider dynamic system. It recognizes and prioritizes the understanding of linkages, relationships, interactions and interdependencies among the components of a system that give rise to the system’s observed behavior. Systems thinking is a philosophical frame, and it can also be considered a method with its own tools.

Transformative learning [9]: education that emphasizes searching, analysis, and synthesis of information for decision making; achieving core competencies for effective teamwork in health systems; and creative adaptation of global resources to address local priorities.

III. Additional Web Resources:

i. BARHII Framework

- https://barhii.org/framework

ii. Carnegie Classification of Institutions of Higher Education

- Carnegie Classifications

iii. Master Adaptive Learner Framework:

- https://bei.brighamandwomens.org/master-adaptive-learner-framework

iv. Moving Health Care Upstream

- About - Moving Health Care Upstream

v. Theory of Informed Clinical Practice: How Physical Therapists Can Use Fundamental Interventions to Address Social Determinants of Health

- Theory of Informed Clinical Practice,McCarty 2021

vi. WHO: A Conceptual Framework for Actions on Social Determinants of Health

- WHO2010.pdf

Glossary References:

1. National Association of Community Health Centers. https://www.nachc.org/social-drivers-vs-social-determinants-using-clear-terms/. Accessed March 9, 2026.

2. AMA: American Medical Association and Association of American Medical Colleges. (2021) Advancing Health Equity: Guide on Language, Narrative and Concepts.

   Available: https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf

3. Sutkowi-Hemstreet, A., Covington, J. K., & Adams, T. N. (2024). Justice, Equity, Diversity, and Inclusion-Related Curricular Elements in Entry-Level Physical Therapist Education: A Delphi Study. *Journal, physical therapy education*, 10.1097/JTE.0000000000000361. Advance online publication. https://doi.org/10.1097/JTE.0000000000000361

4. Keralis JM, et al. Health and the built environment in United States cities: measuring associations using Google Street View-derived indicators of the built environment. BMC Public Health. 2020 Feb 12;20(1):215.

5. Goodman KJ, et al. DCH Built Environment Assessment Tool (BE Tool) and MAPS.(2015). ICF International & CDC, Division of Community Health.

6. Tervalon, M. & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2), 117–125. https://melanietervalon.com/wp-content/uploads/2013/08/CulturalHumility_Tervalon-and-Murray-Garcia-Article.pdf

7. Benkert, R., Cuevas, A., Thompson, H.S., Dove-Medows, E., & Knuckles, D. (2019). Ubiquitous yet unclear: A systematic review of medical mistrust. *Behavioral Medicine*, 45(2), 1–17. DOI: 10.1080/08964289.2019.1588220.

8. Crear-Perry, J., Correa-de-Araujo, R., Johnson, T. L., McLemore, M.R., Neilson, E., & Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. Journal of Women's Health, 30(2), 230–235. DOI: 10.1089/jwh.2020.8882.

9. National Academies of Sciences, Engineering, and Medicine. (2016). *A Framework for Educating Health Professionals to Address the Social Determinants of Health*. The National Academies Press. http://nap.nationalacademies.org/21923

10. Timmerberg, J. F., Dole, R., Silberman, N., Goffar, S. L., Mathur, D., Miller, A., Murray, L., Pelletier, D., Simpson, M. S., Stolfi, A., Thompson, A., & Utzman, R. (2019). Physical Therapist Student Readiness for Entrance Into the First Full-Time Clinical Experience: A Delphi Study. *Physical Therapy*, 99(2), 131–146. DOI: 10.1093/ptj/pzy134.

11. Van Melle, E., Hall, A. K., Schumacher, D. J., Kinnear, B., Gruppen, L., Thoma, B., Caretta-Weyer, H., Cooke, L. J., Frank, J. R., & ICBME Collaborators (2021). Capturing outcomes of competency-based medical education: The call and the challenge. *Medical teacher*, *43*(7), 794–800. https://doi.org/10.1080/0142159X.2021.1925640

12. Taylor, D., Park, Y. S., Smith, C., ten Cate, O., & Tekian, A. (2021). Constructing approaches to entrustable professional activity development that deliver valid descriptions of professional practice. *Teaching and Learning in Medicine*, 33(1), 89–97. DOI: 10.1080/10401334.2020.1784740.

13. Auerbach, L., Santen, S. A., Cutrer, W. B., Daniel, M., Wilson-Delfosse, A. L., & Roberts, N. K. (2020). The educators' experience: Learning environments that support the master adaptive learner. *Medical Teacher*, *42*(11), 1270–1274. https://doi.org/10.1080/0142159X.2020.1801998

14. Gilles, J., Bishop, M., McGehee, W., MacPherson, K., & Dunleavy, K. (2018). Impact on Clinical Performance of Required Participation in a Student-Run Pro Bono Clinic. Journal of Physical Therapy Education. 33. 1. 10.1097/JTE.0000000000000083.

15. Hartman, J., Sharp, A., Van de Winckel, A., Tetreault, K., & Pechak, C. (2022). Exploring the Characteristics of Doctor of Physical Therapy Students Intending to Work in Medically Underserved Areas. *Journal of health care for the poor and underserved*, *33*(3), 1368–1382. https://doi.org/10.1353/hpu.2022.0118

16. Don de Savigny and Taghreed Adam (Eds). Systems thinking for health systems strengthening. Alliance for Health Policy and Systems Research, WHO, 2009.