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ДЕРЖАВНИЙ ВИЩИЙ НАВЧАЛЬНИЙ ЗАКЛАД
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ФАКУЛЬТЕТ СУСПІЛЬНИХ НАУК
КАФЕДРА СОЦІОЛОГІЇ ТА СОЦІАЛЬНОЇ РОБОТИ

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МЕДИЧНА СОЦІОЛОГІЯ

MEDICAL SOCIOLOGY

Навчально-методичні рекомендації для іноземних студентів

Рівень вищої освіти	**Другий (магістерський)**
Галузь знань	**22 Охорона здоров'я**
Спеціальність	**222 Медицина**
Освітня програма	**Лікувальна справа**
Статус дисципліни	**Вибіркова**
Мова навчання	**Англійська**

Ужгород – 2022

УДК 316.334(076):61

Навчально-методичні рекомендації з навчальної дисципліни «Медична соціологія» для студентів галузі знань 22 «Охорона здоров'я», спеціальності 222 «Медицина», освітньо-професійна програма «Лікувальна справа», другого (магістерського) рівня вищої освіти: / Укладачі: Н.І. Варга, М.М. Ляшко. Ужгород, ДВНЗ УжНУ. 2022, 32 с.

Укладачі:
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Розглянуто та рекомендовано до друку і використання у навчальному процесі на засіданні кафедри кафедри соціології та соціальної роботи ДВНЗ «УжНУ» 10. 04. 2022 року, № 6

Схвалено і рекомендовано до друку і використання у навчальному процесі науково-методичною радою факультету суспільних наук ДВНЗ «УжНУ»,19.04.2022 року, №7

Навчально-методичне видання розроблене з метою забезпечення здобувачів вищої освіти методичними рекомендаціями щодо самостійного вивчення дисципліни «Медична соціологія». Методичні рекомендації розраховані на студентів денного відділення медичного факультету № 2 ДВНЗ «Ужгородський національний університет», що навчаються за галуззю знань: 22 «Охорона здоров'я», спеціальності 222 «Медицина», освітньо-професійна програма «Лікувальна справа», другого (магістерського) рівня вищої освіти. Методичні рекомендації включають типову програму, рекомендацій щодо вивчення окремих тем, виконання практичних занять, тематику самостійної роботи, порядок поточного та підсумкового оцінювання, перелік рекомендованої літератури, який може бути використаний при самостійному вивчені дисципліни в умовах кредитно-модульної організації навчального процесу студентами медичних спеціальностей вищих навчальних закладів.

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1. DESCRIPTION OF THE COURSE

<table>
<tr><th rowspan="2">Name of indicators</th><th colspan="2">Distribution of hours according to the curriculum</th></tr>
<tr><th>Full-time teaching</th><th>External form of teaching</th></tr>
<tr><td>Credits ECTS – 2</td><td colspan="2">Year of training:</td></tr>
<tr><td>The total number of hours – 60</td><td>2</td><td></td></tr>
<tr><td>Number of modules – 2</td><td colspan="2">Semester:</td></tr>
<tr><td rowspan="6">Weekly hours for full-time study:
classroom – 2,7</td><td>3</td><td></td></tr>
<tr><td colspan="2">Lectures:</td></tr>
<tr><td>10</td><td></td></tr>
<tr><td colspan="2">Clinical practical:</td></tr>
<tr><td>44</td><td></td></tr>
<tr><td colspan="2"></td></tr>
<tr><td rowspan="2">Type of final control: credit</td><td colspan="2">Laborator:</td></tr>
<tr><td></td><td></td></tr>
<tr><td rowspan="2">Form of final control: oral answer</td><td colspan="2">Individual work:</td></tr>
<tr><td>6</td><td></td></tr>
</table>

2. PURPOSE OF THE COURSE

The main purpose of medical sociology as an academic discipline is to help students to gain basical knowledge in sociology and, especially, in its medical field of research. Which means researching people`s behavior in medical sphere, their knowledge about the functioning of the body, physical and psychological health, spreading of the diseases, medical system and medical help. Another task is to teach students analyzing various social phenomena from the medical-sociological point of view and to form an interest in solving modern social problems related to health, diseases, access to medical services. Also one of the discipline`s tasks is to teach students how to held a sociological research and process the data properly.

At the end of the course **students will be able to**:

1. understand main sociological categories and definitions;
2. understand health and medicine as social institutions;
3. talk about main theoretical approaches in medical sociology;

4. understand all the range of social determinants of health and their influence on different countries and people from different classes;
5. held a sociological research;
6. process the data properly.

According to the educational program, the study of the discipline contributes to the formation of higher education in the following competencies: the ability to think abstractly, analyse and synthesize; the ability to learn and master modern knowledge; the ability to apply knowledge in practical situations; knowledge and understanding of the subject area and understanding of professional activity; the ability to make reasoned decisions; information and communication technology skills; determination and persistence to the given tasks and responsibilities.

Since the discipline “Medical sociology” is studied in the 2nd year of medical school and is elective, the prerequisites for its study are:
- CC 1. English Language Basic Course (for foreign applicants who study in English)
- EC 1. Culturology / Basics of scientific research
- EC 4. Foreign language for medical purposes (1st year)

According to the educational program of “Medical sociology”, the study of the discipline should ensure that higher education students achieve the following program learning outcomes (PLO):

Program learning outcomes	**PLO code**
Collect data on patient complaints, medical history, life history, conduct and evaluate the results of physical examination.	PLO1
Evaluate information on the diagnosis, using a standard procedure based on the results of laboratory and instrumental investigations.	PLO 2
Identify negative environmental factors; analyse the state of health of a certain contingent; determine the presence of the relationship between the state of the environment and the state of health of a particular contingent; develop preventive measures based on data of the relationship between the state of the environment and the state of health of a particular contingent. Carry out analysis of disease incidence of the population, identifying risk groups, risk areas, time of risk, risk factors. Assess the impact of socio-economic and biological determinants on the health of the individual, family, population.	PLO 18
Adhere to a healthy lifestyle, use the techniques of selfregulation and self-control.	PLO22
To be aware of and guided in their activities by civil rights, freedoms and responsibilities, to raise the general cultural level.	PLO 23

3. DIAGNOSTICS AND CRITERIA FOR EVALUATION OF LEARNING RESULTS

Assessment tools and methods for demonstrating learning outcomes

Means of assessment and methods of demonstrating learning outcomes in the discipline are:

- current control – is carried out for all types of classes during their conduct. The purpose of the current control is to determine the level of achievement of students in learning a particular topic of the working program of the discipline, in practical classes, in individual work;
- modular control aims to assess the knowledge, skills and practical skills of the student acquired during the assimilation of theoretical and practical material after studying the logically completed part of the discipline;
- final control provides a comprehensive assessment of the level of formation of learning outcomes in the discipline.

Forms of control and criteria for evaluating learning outcomes

Forms of the current control: individual work, essay, presentation.

Students' knowledge, skills and abilities are assessed through the determination of the quality of performance of specific tasks. Quantitative assessment of a certain current control over a specific type of training is defined as the sum of points for certain types of training. The maximum number of points that a student can receive based on the results of the current control during one module is 120.

Form of the modular control: written test. Each question of modular control work is estimated separately (5 tasks). The total score is calculated as the sum of the scores for each individual question (16 points each). Total for the test – 80 points. The final grade for each module consists of the sum of points for the current assessment and the result of the module test (maximum – 200 points).

Form of the final semester control: credit in the form of an oral answer.
The result of the examination control is defined as the arithmetic mean of the two modules. If the student agrees with the number of points scored, this grade can be put in the exam sheet. If the student has not received a sufficient number of points (less than 120) or does not agree with the final grade, he makes a test in the form of an oral answer. The maximum score for answering the exam is 200 points.

Distribution of points received by applicants for higher education (module 1)

T1	T2	T3	T4	T5	T6	T7	T8	Modular control work	Sum
15	15	15	15	15	15	15	15	80	200

Distribution of points received by applicants for higher education (module 2)

T1	T2	T3	T4	T5	T6	T7	Modular control work	Sum
17	17	17	17	17	17	18	80	200

Rating scale: national and ECTS

<table>
<tr><td rowspan="2">Total points for all the educational activities</td><td rowspan="2">Score scale ECTS</td><td colspan="2">National scale</td></tr>
<tr><td>For exam</td><td>For test</td></tr>
<tr><td>180 – 200</td><td>A</td><td>Excellent</td><td rowspan="5">Passed</td></tr>
<tr><td>164-179</td><td>B</td><td rowspan="2">Good</td></tr>
<tr><td>148-163</td><td>C</td></tr>
<tr><td>128-147</td><td>D</td><td rowspan="2">Satisfactory</td></tr>
<tr><td>120-127</td><td>E</td></tr>
<tr><td>70-119</td><td>FX</td><td>Fail, may re-take the exam</td><td>Not passed may re-up test</td></tr>
<tr><td>0-69</td><td>F</td><td>Fail in the compulsory, re-learning courses</td><td>Not credited with the compulsory re-learning courses</td></tr>
</table>

4. STRUCTURE OF DISCIPLINE

4.1. The contents of the discipline

Semantic module 1.

Theme 1. Social system, its structure and functions

The definition of the social system. Elements of the social system. Characteristics of the social system. Types of the social system. Maintenance of the social system. Functions of the social system.

Theme 2. Health and medicine as a social institution

The definition of health as a social institution.The definition of medicine as a social institution. The sociological approach to health and medicine. Sociological perspectives on health and medicine.

Theme 3. Theoretical approaches in medical sociology

Functionalism. Conflict theory. Symbolic interactionism.

Theme 4. Social determinants of health (Social inequality)

What are the social determinants of health? The influence of SDOH. Social stratification. Systems of stratification. Social gradient.

Theme 5. Social determinants of health (Stress)

Stress and health: some key findings. Types of stress and health hazards. Acute stress. Episodic acute stress. Chronic stress. Health problems related to stress.

Theme 6. Social determinants of health (Life course)

The importance of a life course approach to health. Constitutional and biological factors. Contextual factors. Key stages of the life course. Before birth. Pregnancy. Newborn and early childhood. Early child development.

Theme 7. Social determinants of health (Social exclusion)

The concept of social exclusion. Key forms of social exclusion. The consequences of social exclusion. The key drivers of social exclusion. Macro drivers. Structural drivers. Socio-economic drivers.

Theme 8. Social determinants of health (Work)

Full-time permanent employment. Unemployment. Precarious employment. Informal employment. Child labour. Slavery and bonded labour. Working conditions and health.

Semantic module 2.

Theme 9. Social determinants of health (Unemployment)

Unemployment. Job insecurity. Financial impact. Impact on the budget. Psychological impact. Family relationships. Health consequences. Consequences for the wider community.

Theme 10. Social determinants of health (Addictions)

Addictive behaviours. Gaming and gambling disorders. Psychoactive substances. Tobacco. Alcohol. Health consequences.

Theme 11. Social determinants of health (Social support)

What is social support? The psychobiological mediators of social support. The impact of social support on health outcomes. Morbidity and mortality studies.

Theme 12. Social determinants of health (Food)

Nutrition and healthy diet. Malnutrition. Forms of malnutrition. Food safety. Food insecurity.

Theme 13. Social determinants of health (Gender)

The definition of gender. Gender discrimination. Sex, gender and health. Gender differences in acces to health care.

Theme 14. Applied research in medical sociology (Research methods)

Types of sociological research. Surveys. Field research. Case study. Experiments. Observational studies. Intensive interviewing. Secondary data analysis.

Theme 15. Applied research in medical sociology (Data processing)

Stages in sociological research process. Quantitative and qualitative studies. Methods of communicating and displaying analysed data.

4.2. Structure of the discipline

Names of content modules and themes	Number of hours					
	Full-time teaching					
	total	including				
		lectures	clinical practical	laborator	individual work	self-work
Module 1						
Theme 1. Social system, its structure and functions	4	4				
Theme 2. Health and medicine as social institution	4	4				
Theme 3. Theoretical approaches in medical sociology	2	2				
Theme 4. Social determinants of health (Social inequality)	4		4			
Theme 5. Social determinants of health (Stress)	4		4			
Theme 6. Social determinants of health (Life course)	4		4			
Theme 7. Social determinants of health (Social exclusion)	4		4			
Theme 8. Social determinants of health (Work)	4		4			
Module test 1	2		2			
Total Module 1	32	10	22			
Module 2						
Theme 9. Social determinants of health (Unemployment)	2		2			
Theme 10. Social determinants of health (Addictions)	2		2			
Theme 11. Social determinants of health (Social support)	4		4			
Theme 12. Social determinants of health (Food)	4		4			
Theme 13. Social determinants of health (Gender)	4		4			

Theme 14. Applied research in medical sociology (Research methods)	4		2			2
Theme 15. Applied research in medical sociology (Data processing)	6		2			4
Module test 2	2		2			
Total Module 2	28		22			6
Total	**60**	**10**	**44**			**6**

4.3. Topics of practical classes

№	Theme	Number of hours
1	Social determinants of health (Social inequality)	4
2	Social determinants of health (Stress)	4
3	Social determinants of health (Life course)	4
4	Social determinants of health (Social exclusion)	4
5	Social determinants of health (Work)	4
6	Social determinants of health (Unemployment)	2
7	Social determinants of health (Addictions)	2
8	Social determinants of health (Social support)	4
9	Social determinants of health (Food)	4
10	Social determinants of health (Gender)	4
11	Applied research in medical sociology (Research methods)	2
12	Applied research in medical sociology (Data processing)	2
	Total	**44**

4.4. Self-work

№	Theme	Number of hours
1	Applied research in medical sociology (Research methods)	2
2	Applied research in medical sociology (Data processing)	4
	Total	**6**

Tasks for the self-work

Choose a theme and make a questionnaire following this 9 steps:

1. Decide the information required.
2. Define the target respondents.
3. Choose the method(s) of reaching your target respondents.

4. Decide on question content.
5. Develop the question wording.
6. Put questions into a meaningful order and format.
7. Check the length of the questionnaire.
8. Pre-test the questionnaire.
9. Develop the final survey form.

5. LECTURES

THEME 1: **SOCIAL SYSTEM; ITS STRUCTURE AND FUNCTIONS**

What is the Social System?

In sociology, the social system refers to the network of relationships which are configurated in such a way that there's a harmonious unity amongst individuals, groups and institutions. It is a structure in which there is decorum in the role and status that stabilizes even small groups [1]. An individual may belong to multiple social systems at once [2]; Examples of social systems include nuclear family units, communities, cities, nations, college campuses, corporations, and industries. The organization and definition of groups within a social system depend on various criteria such as location, socioeconomic status, race, religion, societal function, or other distinguishable features [3].

What is Social Structure?

In the social sciences, social structure shows patterns of social arrangements in society that emerges from and determines the actions of individuals [4]. Likewise, society is believed to be grouped into structurally-related groups or sets of roles, with different functions, meanings, or purposes. Examples of social structure include family, religion, law, economy, and class. It signifies how these structures fit in to form the social system; the foundation of the establishment of society. Thus, social structures significantly influence larger systems, such as economic systems, legal systems, political systems, cultural systems, etc. Social structure determines the norms and patterns of relations between the various institutions of the society.

One can divide social structure into; macro, meso and micro levels.

Macro Level: Actually, when sociologists use the term "social structure" they are typically referring to macro-level social forces including social institutions and patterns of institutionalized relationships. The major social institutions recognized by sociologists include family, religion, education, media, law, politics, and economy. These are understood as distinct institutions that are interrelated and interdependent and together help compose the overarching social structure of a society.

Meso Level: The meso level is somewhat of a middle ground between macro and micro level. This demarcation is bordered by social institutions and institutionalized social relationships. An example is systemic racism fosters segregation within U.S. society, which results in some racially homogenous networks. Another is a manifestation of social stratification, whereby social relations between people are structured by class differences, differences in educational attainment, and differences in levels of wealth.

Micro Level: Social structure manifests at the micro level in the everyday interactions' humans have with one another in the forms of norms and customs. It is present in the way patterned institutionalized relationships shape interactions within certain institutions like family and education, and it is present in the way institutionalized ideas about race, gender, and sexuality shape form stereotypes and affect how people interact together.

What is the major aim of the social system?

The primary function of social system is pattern maintenance and tension maintenance. In order for the structure explained above to remain in place, certain functions have to be carried out. A-four function paradigm was formed by Talcott Parsons to break down and explain these functions. This paradigm has a four-letter abbreviation; AGIL.

1. Adaptation:

The problems of adapting the social system to its physical and social environments. The most important problems in this respect are procuring resources needed for its activities, providing for protection against physical and social threats, and developing information relating to these.

2. Goal Attainment:

The social system ensures collective effort to attain aims and goals to promote the well-being, growth and development of the society.

3. Integration:

The internal problem of maintaining satisfying relations among the interacting, members and avoiding disrupting conflicts. For small groups, this concerns inter-personal relations. For larger organization, it concerns inter-group relations.

4. Latent Pattern Maintenance:

The internal organizational problem of ordering activity patterns of the system, and also of adjusting the role demands on members, so that these are compatible with their other role commitments.

A social system can be defined as a patterned collection of individual constituents that form a conjugated whole. It can be divided into social structure and social functions. The social structure consists of a layout of bits of a society that unifies it. The social functions are the respective roles each person has to play to keep the structure in place.

THEME 2: **HEALTH AND MEDICINE AS A SOCIAL INSTITUTION**

What is Health as a Social Institution?

Health refers to the extent of a person’s physical, mental, and social well-being. This definition, taken from the World Health Organization’s treatment of health, emphasizes that health is a complex concept that involves not just the soundness of a person’s body but also the state of a person’s mind and the quality of the social environment in which she or he lives. The quality of the social environment in turn can affect a person’s physical and mental health, underscoring the importance of social factors for these twin aspects of our overall well-being.

What is Medicine as a Social Institution?

Medicine is the social institution that seeks both to prevent, diagnose, and treat illness and to promote health as just defined. Medicine is set deep in society as ailments, diseases and health are an essential part of the society. Dissatisfaction with the medical establishment has been growing. Part of this dissatisfaction stems from soaring health-care costs and what many perceive as insensitive stinginess by the health insurance industry, poverty, unqualified physicians, inadequate medical professionals, etc. Some of the problem also reflects a growing view that the social and even spiritual realms of human existence play a key role in health and illness. This view has fueled renewed interest in alternative medicine.

The sociological approach to health and medicine

The concepts health, illness and medicine are usually viewed individually. We usually think of health, illness, and medicine in individual terms. When a person becomes ill, the illness is seen as a medical problem with biological causes, and a physician treats the individual accordingly. A sociological approach takes a different view. Unlike physicians, sociologists and other public health scholars do not try to understand why any one person becomes ill. Instead, they typically examine rates of illness to explain why people from certain social backgrounds are more likely than those from others to become sick. Social location in society i.e social class, race and ethnicity, and gender, makes

a critical difference. Here, as we will see, one's social location in society—our social class, race and ethnicity, and gender—makes a critical difference.

The knowledge that social backgrounds affect health can be a difficult pill to swallow. This does not change the authenticity of the fact. It is seen in everyday life where close and distant family relations and friends fall ill; some reasons known, others not. But societal lifestyle is definitely a factor to consider. Physicians try hard to find the etiology and make a diagnosis in order to prevent reoccurrence. However, they cannot always be successful. This can be due to the fact they omit potential causes that sociologists do not overlook; the society and lifestyles embedded in it. A sociological approach also emphasizes that a society's culture shapes its understanding of health and illness and practice of medicine. Knowing about a society's culture, helps to understand how it perceives health and healing. By the same token, knowing about a society's health and medicine aids in understanding important aspects of its culture.

The sociological perspectives of health and medicine

As culture changes over time, it is also true that perceptions of health and medicine may also change. A society's culture matters in these various ways, but so does its social structure, in particular its level of economic development and extent of government involvement in health-care delivery. It is well-known that poor societies have much worse health than richer societies. At the same time, richer societies have certain health risks and health problems, such as pollution and liver disease (brought on by high alcohol use), that poor societies avoid. The degree of government involvement in health-care delivery also matters. Although illness is often a matter of bad luck or bad genes, this society we live in, nonetheless, suggests chances.

THEME 3: **THEORETICAL APPROACHES IN MEDICAL SOCIOLOGY**

Functionalism

Functionalism is a theory about the nature of mental states. According to functionalism, mental states are identified by what they do rather than by what they are made of. Functionalism is a theory about the nature of mental states. Functionalism is the most familiar or "received" view among philosophers of mind and cognitive science. This can be understood by thinking about artifacts like mousetraps and keys. In particular, the original motivation for functionalism comes from the helpful comparison of minds with computers. But that is only an analogy. The main arguments for functionalism depend on showing that it is superior to its primary competitors: identity theory and behaviorism. Contrasted with behaviorism, functionalism retains the traditional idea that mental states are internal states of thinking creatures. Contrasted with identity theory, functionalism introduces the idea that mental states are multiply realized.

Objectors to functionalism generally charge that it classifies too many things as having mental states, or at least more states than psychologists usually accept. The effectiveness of the arguments for and against functionalism depends in part on the particular variety in question, and whether it is a stronger or weaker version of the theory. This article explains the core ideas behind functionalism and surveys the primary arguments for and against functionalism.

Conflict theory

Conflict theory, first purported by Karl Marx, is a theory that society is in a state of perpetual conflict because of competition for limited resources. Conflict theory holds that social order is maintained by domination and power, rather than by consensus and conformity. According to conflict theory, those with wealth and power try to hold on to it by any means possible, chiefly by suppressing the poor and powerless. A basic premise of conflict theory is that individuals and groups within society will work to try to maximize their own wealth and power.

Conflict theory has been used to explain a wide range of social phenomena, including wars, revolutions, poverty, discrimination, and domestic violence. It ascribes most of the fundamental developments in human history, such as democracy and civil rights, to capitalistic attempts to control

the masses (as opposed to a desire for social order). Central tenets of conflict theory are the concepts of social inequality, the division of resources, and the conflicts that exist between different socioeconomic classes.

Many types of societal conflicts throughout history can be explained using the central tenets of conflict theory. Some theorists, including Marx, believe that societal conflict is the force that ultimately drives change and development in society.

Marx's version of conflict theory focused on the conflict between two primary classes. Each class consists of a group of people bound by mutual interests and a certain degree of property ownership. Marx theorized about the bourgeoisie, a group of people that represented members of society who hold the majority of the wealth and means. The proletariat is the other group: it includes those considered working class or poor.

With the rise of capitalism, Marx theorized that the bourgeoisie, a minority within the population, would use their influence to oppress the proletariat, the majority class. This way of thinking is tied to a common image associated with conflict theory-based models of society; adherents to this philosophy tend to believe in a pyramid arrangement in terms of how goods and services are distributed in society; at the top of the pyramid is a small group of elites that dictate the terms and conditions to the larger portion of society because they have an out-sized amount of control over resources and power.

Uneven distribution within society was predicted to be maintained through ideological coercion; the bourgeoisie would force acceptance of the current conditions by the proletariat. Conflict theory assumes that the elite will set up systems of laws, traditions, and other societal structures in order to further support their own dominance while preventing others from joining their ranks. Marx theorized that, as the working class and poor were subjected to worsening conditions, a collective consciousness would raise more awareness about inequality, and this would potentially result in revolt. If, after the revolt, conditions were adjusted to favor the concerns of the proletariat, the conflict circle would eventually repeat but in the opposite direction. The bourgeoise would eventually become the aggressor and revolter, grasping for the return of the structures that formerly maintained their dominance.

Symbolic interactionalism

Symbolic Interactionism is a theoretical framework in sociology that describes how societies are created and maintained through the repeated actions of individuals (Carter and Fuller, 2015). Symbolic interactionalism is a theoretical perspective in sociology that addresses the manner in which society is created and maintained through face-to-face, repeated, meaningful interactions among individuals.

In simple terms, people in society understand their social worlds through communication — the exchange of meaning through language and symbols.

Instead of addressing how institutions objectively define and affect individuals, symbolic interactionism pays attention to these individuals' subjective viewpoints and how they make sense of the world from their own perspective (Carter and Fuller, 2015).

The objective structure of a society is less important in the symbolic interactionist view than how subjective, repeated, and meaningful interactions between individuals create society. Thus, society is thought to be socially constructed through human interpretation.

According to Blumer (1969), social interaction thus has four main principles:

1. Individuals act in reference to the subjective meaning objects have for them. For example, an individual that sees the "object" of family as being relatively unimportant will make decisions that deemphasize the role of family in their lives;
2. Interactions happen in a social and cultural context where objects, people, and situations must be defined and characterized according to individuals' subjective meanings;
3. For individuals, meanings originate from interactions with other individuals and with society;
4. These meanings that an individual has are created and recreated through a process of interpretation that happens whenever that individual interacts with others.

THEME 4: **SOCIAL DETERMINANATS OF HEALTH (SOCIAL INEQUALITY)**

What are Social Determinants of Health?

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, worship and age. They refer to a specific group of social and economic factors within the broader determinants of health. These relate to an individual's place in society, such as income, education or employment. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.

Addressing social determinants of health is important for improving health and reducing health disparities. Though health care is essential to health, it is a relatively weak health determinant. Research shows that health outcomes are driven by an array of factors, including underlying genetics, health behaviors, social and environmental factors, and health care. While there is currently no consensus in the research on the magnitude of the relative contributions of each of these factors to health, studies suggest that health behaviors, such as smoking, diet, and exercise, and social and economic factors are the primary drivers of health outcomes, and social and economic factors can shape individuals' health behaviors. For example, children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health such as lack of safety, exposed garbage, and substandard housing. They also are less likely to have access to sidewalks, parks or playgrounds, recreation centers, or a library. Further, evidence shows that stress negatively affects health across the lifespan and that environmental factors may have multi-generational impacts. Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages.

Social stratification

Noted sociologist and humanistic scholar Pitirim A. Sorokin penned one of the most comprehensive definitions of social stratification. He wrote:

"Social stratification means the differentiation of a given population into hierarchically superposed classes. It is manifested in the existence of upper and lower social layers. Its basis and very essence consist in an unequal distribution of rights and privileges, duties and responsibilities, social values and privations, social power and influences among the members of a society."\

Systems of stratification

Systems of stratification vary in their degree of vertical social mobility. Some societies are more open in this regard, while some are more closed. The major systems of stratification are slavery, estate systems, caste systems, and class systems.

1. Slavery: The most closed system is slavery, or the ownership of people, which has been quite common in human history.
2. Estate Systems: Estate systems are characterized by control of land and were common in Europe and Asia during the Middle Ages and into the 1800s. In these systems, two major estates existed: the landed gentry or nobility and the peasantry or serfs. The landed gentry owned huge expanses of land on which serfs toiled. The serfs had more freedom than slaves had but typically lived in poverty and were subject to arbitrary control by the nobility.
3. Caste Systems: In a caste system, people are born into unequal groups based on their parents' status and remain in these groups for the rest of their lives. For many years, the best-known caste system was in India, where, supported by Hindu beliefs emphasizing the acceptance of one's fate in life, several major castes dictated one's life chances from the moment of birth, especially in rural areas (Kerbo, 2009). People born in the lower castes lived in abject poverty throughout their lives. Another caste, the *harijan*, or *untouchables*, was considered so low that technically it was not thought to be a caste at all. People in this caste were called the untouchables because they were considered unclean and were prohibited from coming near to people in the higher castes. Traditionally, caste membership in India almost totally determined

an individual’s life, including what job you had and whom you married; for example, it was almost impossible to marry someone in another caste.

4. Class Systems:_Many societies, including all industrial ones, have class systems. In this system of stratification, a person is born into a social ranking but can move up or down from it much more easily than in caste systems or slave societies. This movement in either direction is primarily the result of a person’s own effort, knowledge, and skills or lack of them. Although these qualities do not aid upward movement in caste or slave societies, they often do enable upward movement in class societies. Of the three systems of stratification discussed so far, class systems are by far the most open, meaning they have the most vertical mobility.

SOCIAL GRADIENT

The social gradient in health is a term used to describe the phenomenon whereby people who are less advantaged in terms of socioeconomic position have worse health (and shorter lives) than those who are more advantaged. This inverse and graded relationship in individuals is consistently observed both with educational and occupational status and is commonly known as the social gradient in health and disease, also referred to as the status syndrome**.** Inequalities in health appear in the form of a 'social gradient of health', so that in general, *the higher a person's socioeconomic position, the healthier they are.*

What is Social Inequality?

Social inequalities, in terms of health, refer to the systematic differences in health that exist between socioeconomic positions, social classes, genders, ethnicities, sexual orientations or other social groups with differentiated access to material and non-material resources. Socioeconomic inequalities, related to e.g. income, employment, education, as well as demographic differences, such as age or gender, are associated with unequal exposure to environmental risk factors. They contribute to health inequities and most often put disadvantaged groups, people living with poverty, at significantly higher risk for environmental health effects. Many of these people live in damp homes, with insufficient heating and inadequate sanitary equipment. As health inequality researchers have been keen to point out, the very term *inequality* implies a difference which is unfair, harmful and avoidable.

How does Social Inequality affect Health?

First and foremost, health inequalities are a problem of *injustice*, because they unfairly deprive people of life-chances based on their position in society. Secondly, health inequalities are a *public health* problem, because they prevent the full health potential of populations from being fulfilled. Social inequalities in health are also an *economic* problem, because they negatively impact employment, economic growth and public expenditure, threatening the sustainability and political legitimacy of the Scandinavian welfare states.

THEME 5: **SOCIAL DETERMINANTS OF HEALTH (STRESS)**

What are Social Determinants of Health?

Social determinants of health are the conditions in which people are born, grow, live, work and age. They refer to a specific group of social and economic factors within the broader determinants of health. These relate to an individual's place in society, such as income, education or employment. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.

What is Stress?

Stress is the feeling of being overwhelmed or unable to cope with mental or emotional pressure. It is the body’s response to pressure. Many different situations or life events can cause stress. It is often triggered when one experiences something new, unexpected or that threatens the sense of

self, or when a person feels they have little control over a situation. Humans deal with stress differently. The ability to cope can depend on genetics, early life events, personality and social and economic circumstances. When one encounters stress, the body produces stress hormones that trigger a fight or flight response and activate the immune system. This helps to respond quickly to dangerous situations.

Sometimes, this stress response can be useful: it can help to push through fear or pain so as to overcome stressful situations. The stress hormones will usually go back to normal quickly once the stressful event is over, and there won't be any lasting effects.

However, too much stress can cause negative effects. It can leave a person in a permanent stage of fight or flight, leaving such individual overwhelmed or unable to cope. Long term, this can affect physical and mental health.

There are several types of stress, including:

- acute stress
- episodic acute stress
- chronic stress

1. Acute Stress: Acute stress happens to everyone. It's the body's immediate reaction to a new and challenging situation. It's the kind of stress one might feel when one narrowly escapes a car accident. Acute stress can also come out of an enjoyable activity; it's the somewhat-frightening, yet thrilling feeling one gets on a roller coaster or when skiing down a steep mountain slope. These incidents of acute stress don't normally do any harm. They might even be good. Stressful situations give the body and brain practice in developing the best response to future stressful situations. Once the danger passes, the body systems should return to normal.

2. Episodic Acute Stress: Episodic acute stress is when a person has frequent episodes of acute stress. This might happen if such person is often anxious and worried about things they suspect may happen. Feelings of anxiousness and loss of control might manifest. Certain professions, such as law enforcement or firefighters, might also lead to frequent high-stress situations. As with severe acute stress, episodic acute stress can affect physical health and mental well-being.

3. Chronic Stress: When you have high-stress levels for an extended period of time, you have chronic stress. Long-term stress like this can have a negative impact on your health. Chronic stress can also lead to frequent ailments such as headaches, an upset stomach, and sleep difficulties.

How does Stress affect Health?

The human body is designed to experience stress and react to it. Stress can be positive (eustress), such as a getting a job promotion or being given greater responsibilities, keeping one alert and ready to avoid danger. Stress becomes negative ("distress") when a person faces continuous challenges without relief or relaxation between challenges. As a result, the person becomes overworked and stress-related tension builds.

Distress can lead to physical symptoms including headaches, upset stomach, elevated blood pressure, chest pain, and problems sleeping. Research suggests that stress also can bring on or worsen certain symptoms or diseases.

Stress also becomes harmful when people use alcohol, tobacco, or drugs to try to relieve their stress. Unfortunately, instead of relieving the stress and returning the body to a relaxed state, these substances tend to keep the body in a stressed state and cause more problems.

Stress can give rise to some health problems including, but not limited to; heart diseases, asthma, obesity, depression, anxiety disorder, headaches, diabetes, gastrointestinal disorders, Alzhiemer's Disease, accelerated aging and even death.

THEME 6: **SOCIAL DETERMINANTS OF HEALTH (LIFE COURSE)**

What is Life Course?

The life course approach, also known as the life course perspective or life course theory, refers to an approach developed in the 1960s for analyzing people's lives within structural, social, and cultural contexts. Life course theory, more commonly termed the life course perspective, refers to a multidisciplinary paradigm for the study of people's lives, structural contexts, and social change. This approach encompasses ideas and observations from an array of disciplines, notably history, sociology, demography, developmental psychology, biology, and economics. In particular, it directs attention to the powerful connection between individual lives and the historical and socioeconomic context in which these lives unfold.

What is the Importance of Life Course Approach to Health?

A life course perspective enables the identification of a high-risk phenotype and markers of risk early, supporting current efforts for primary prevention of NCDs by providing timely interventions in early life.

CONSTITUTIONAL AND BIOLOGICAL APPROACH

There has been considerable interest in the identification of genes that are responsible for Non-Commutable Diseases (NCDs). A study found several new genetic loci and genes that influence an individual's susceptibility to bipolar disorder, coronary heart 14 disease, type 1 and type 2 diabetes, rheumatoid arthritis, Crohn’s disease and hypertension. Identifying the variants, genes and pathways involved in particular diseases opens prospective pathways to new therapies, diagnostic methods and better disease prevention. However, purely fixed genetic effects have not to date been shown to account for a substantial proportion of the NCD risk at the population level. Of late, there has been increasing interest in epigenetic mechanisms as determinants of NCDs. Epigenetic modification does not result from changes to DNA itself but rather from changes to gene expression caused by DNA methylation or chromatin modification as an adaptive response to the environment in which they find themselves. There is increasing evidence that maternally mediated environmental modulation of gene expression in offspring and gene-environment interactions are important determinants of later disease risk.

CONTEXTUAL FACTORS

Behavioural factors

Risk factors such as smoking, alcohol consumption, excess weight and dietary factors are responsible for a large share of the global disease burden.3 This can be directly or through conditions such as high blood pressure and elevated blood glucose and cholesterol levels, ultimately responsible for raising the risk of chronic diseases such as heart disease, diabetes and cancers. The transition in Health risks occurring in different populations due to decrease in incidence of infectious disease, changing patterns of physical activity and diet and an ageing population has led to issues such as a double burden of increasing chronic, noncommunicable conditions, as well as the communicable diseases in LMICs.

Environmental factors

Environmental determinants of health include all the physical, chemical, and biological factors external to a person, and all the related factors impacting behaviours.29 A growing amount of evidence shows the close relation between risk factors for NCDs and greenhouse-gas emissions in sectors such as household energy, electricity generation, transport (especially in urban environments) and food and agriculture.

Microenvironmental and macroenvironmental determinants of dietary patterns exist that lead to obesity in different age group.43 The microenvironmental factors include parents’ body mass index (BMI) and dietary pattern, and a family environment in which parents strongly control children’s food intake, which reduces the children’s ability to self-regulate their eating behavior. The

macroenvironmental factors are: the country's policies that affect food pricing and availability; industrialization of agriculture; food supply and the associated decline in prices; rising income and affordability; and mass media, education and information conveyed through product labelling that influence consumer's food choices.

Psychosocial factors

The first principle of a life course perspective on social status and health is that social status can affect health at any point from birth (or even before) until death.

KEY STAGES OF LIFE COURSE

Before Birth

The way that a fetus obtains and allocates nutritional resources has profound consequences for its lifelong health. Research based on the developmental origins of health and disease (DOHaD) has shown that multiple developmental factors operate from preconception through early life to affect the risk for later NCDs. The possibilities of preventing NCDs by achieving optimal fetal development are now increasing, as early life programming is now thought to be important in the etiology of obesity, type 2 diabetes and cardiovascular diseases.5 Influences on obesity and other NCDs in early life fall into biological, behavioural and contextual domains.

There is an increasing amount of evidence supporting the need to target the preconception period to prevent future NCD risk in offspring. This can provide potential benefits to the health of the next generation – achieved by adopting healthy habits prior to conception.

Pregnancy

Healthy weight management, diet, physical activity, contraception, healthy sexual relationships, folic acid intake and smoking avoidance are essential preconceptional issues that are often not discussed with women before pregnancy. The pregnancy period presents another opportunity for intervention, and there is some evidence that women improve health behaviours, such as decreasing smoking, alcohol and caffeine consumption at this time.

Newborn and Early Childhood

Infancy (birth to one year) along with early childhood involves children attaining a number of important developmental milestones relating to their physical development, along with social and emotional development. This includes establishing healthy patterns of eating and activity, developing a capacity for self-regulation, language and cognitive development and wider learning skills.
Low maternal age and educational attainment, and a low socioeconomic status, negatively impact on infant feeding, and that exclusive breastfeeding for the first six months does not cause weight loss but does protect from issues such as gastrointestinal infections.

Childhood

Relative poverty has a wide range of effects on health, and there has been a persistent inverse association between socioeconomic status and childhood mortality in high-income countries.81 The socioeconomic environment through childhood also affects adult health and disease through different pathways linking educational statues attained, health behaviours adopted during childhood and adolescence and parental socioeconomic position.

The influence of parents and peers on social and emotional development during childhood cannot be overlooked and it is suggested that the parent-child relationship may be a lifecourse health determinant.

THEME 7: **SOCIAL DETERMINANTS OF HEALTH (SOCIAL EXCLUSION)**

What is Social Exclusion?

Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole.

Social exclusion describes a situation where not everyone has equal access to the opportunities and services that allow them to lead a decent, happy life. This includes not being able to give input and have their voice heard on the rules of the society in which they live. The opportunities and services that are inaccessible are things like infrastructure – even basic things like electricity and running water – and services like public education, healthcare or the social welfare system.

Forms of social exclusion

Exclusionary processes can have various dimensions:

1. Political exclusion: It can include the denial of citizenship rights such as political participation and the right to organize, and also of personal security, the rule of law, freedom of expression and equality of opportunity.
2. Economic exclusion: It includes lack of access to labor markets, credit and other forms of 'capital assets'.
3. Social exclusion: It may take the form of discrimination along a number of dimensions including gender, ethnicity and age, which reduce the opportunity for such groups to gain access to social services and limits their participation in the labor market.
4. Cultural exclusion: It refers to the extent to which diverse values, norms and ways of living are accepted and respected.

Impact of social exclusion

Social exclusion results in the following main consequences:

1. It leads to various kinds of deprivations—economic, educational, cultural and social.
2. It leads to the impoverishment of human life and develops a poorer sense of well-being.
3. It leads to inequality, poverty, unemployment and involuntary migration.
4. It leads to social stigmatization and marginalization.
5. It develops fear complex among the excluded.
6. It puts various restrictions on the excluded about their free and full participation in the economic, cultural and political activities.
7. On the whole, it puts an intense negative impact on the quality of life.

Key drivers of social inequality

The drivers of social exclusion are complex and multifaceted. A number of high-level exclusionary processes that impact on and maintain social exclusion have been identified.

1. Demographics –high rates of youth unemployment, increases in lone parenting, ageing and migration are all demographic factors that can drive exclusion.
2. Labor market –increases in low pay and the dispersion of income between groups can drive social exclusion.
3. Social policy –changes in benefits, expenditure on housing, health and social services can increase financial divides, reduce and hinder equity of access

THEME 8: **SOCIAL DETERMINANTS OF HEALTH (WORK)**

Full time permanent employment

A permanent full-time employee is someone who works the "ordinary hours" for the occupation defined by the award or agreement covering the work. Ordinary hours usually mean regular and ongoing work for at least 38 hours per week.

Unemployment

The term unemployment refers to a situation when a person who is actively searching for employment is unable to find work. Unemployment is considered to be a key measure of the health of the economy. The most frequent measure of unemployment is the unemployment rate, which is the number of unemployed people divided by the number of people in the labor force. Many governments offer unemployment insurance to certain unemployed individuals who meet eligibility requirements.

Precarious employment

While there is no legal definition, the term precarious refers to a type of work whereby the individual in question is poorly paid, unprotected and insecure. In practice, this captures situations where workers are not aware of their employment status, lack an employment contract and have no access to basic employment rights such as paid leave or breaks. More seriously, this includes workers who are paid cash in hand, below the National Minimal Wage, and who may inadvertently be working on the black market.

Informal employment

There is no unique definition for informal employment. However, a generally accepted way to define it is by considering individuals (and their employers) who engage in productive activities that are not taxed or registered by the government.

Though this type of work has always existed—picture the fruit vendor at the farmers' market who only accepts cash for payment—the expansion of online platforms that facilitate these arrangements has increased their visibility and fueled their popularity.

Child labour

Not all work performed by children is child labour. Child labour is defined by international standards as work that is hazardous, demands too many hours, or is performed by children who are too young. **Children work because their survival depends on it**, because adults take advantage of their vulnerability, and because national education systems are weak. Child labour is sometimes the result of ingrained customs and traditions.

Child labour refers to the exploitation of children through any form of work that deprives children of their childhood, interferes with their ability to attend regular school, and is mentally, physically, socially and morally harmful.

Slavery and bonded labour

Slavery or enslavement is a condition or state in which one human being is owned by another. A slave was considered by law as property, or chattel, and was deprived of most of the rights ordinarily held by free persons. Slavery was a form of dependent labour performed by a nonfamily member. The slave was deprived of personal liberty and the right to move about geographically as he desired. There were likely to be limits on his capacity to make choices with regard to his occupation and sexual partners as well. Slavery was usually, but not always, involuntary. If not all of these characterizations in their most restrictive forms applied to a slave, the slave regime in that place is likely to be characterized as "mild"; if almost all of them did, then it ordinarily would be characterized as "severe."

Bonded labor, also known as debt bondage and peonage, happens when people give themselves into slavery as security against a loan or when they inherit a debt from a relative. It can be made to look like an employment agreement but one where the worker starts with a debt to repay – usually in brutal conditions – only to find that repayment of the loan is impossible. Then, their enslavement becomes permanent.

Bonded labor is designed to exploit workers. The cyclical process begins with a debt, whether acquired or inherited, that cannot be paid immediately. Then, while the worker labors to repay the debt, the employer continues to add on additional expenses. For instance, a laborer may begin with an initial debt of $200. While working and unable to leave, this worker needs a shelter, food and water. The employer tacks on $25 per day to the debt to cover those expenses. Consequently, the employee only grows his debt while continuing to labor for his debtor, and repayment is impossible.

Working conditions and health inequalities

Access to, and quality of work and employment define one such specific, socially graded aspect of the social environment that is primarily relevant to adult populations. Health-adverse effects of poor quality of work and employment are not restricted to physical, chemical or biological hazards, but extend to precarious employment conditions and exposure to stressful psychosocial work environments. These features are highly prevalent in modern societies, and they contribute to the unequal burden of disease within populations. 'Toxic' components of these 'non-material' characteristics of work were identified with the help of theoretical models that emphasize the continued importance of low control and autonomy, and of low reward and recognition, for health and wellbeing in a world of work that is characterized by economic threats and disparities as well as by far-reaching technological challenges.

THEME 10: **SOCIAL DETERMINANTS OF HEALTH (ADDICTIONS)**

Addictive behavior's

An addictive behavior is a behavior, or a stimulus related to a behavior (e.g., sex or food), that is both rewarding and reinforcing, and is associated with the development of an addiction. Apart from the aforementioned addictive behaviors the most common one would be substance addiction (including alcohol, tobacco, and cannabis).[5] Addictions involving addictive behaviors are normally referred to as behavioral addictions.

According to Science Direct, behavioral addictions are defined as, "an intense desire to repeat some action that is pleasurable or perceived to improve wellbeing or capable of alleviating some personal distress." What classifies some behaviors as addictive is the difficultly those affected have with stopping or reducing their participation in it. Some motivating factors for behavioral addictions include the perception of temporary decreased depression and anxiety, making it a seemingly logical way to achieve calm or happiness. For example, gambling addiction lights up similar parts of the brain as some drugs, providing a dopamine rush to the user or player.

Gaming and gambling disorders

In order to survive, our brains generate neurotransmitters which reward behaviors that keep us alive. Gambling and gaming generate brain rewards similarly to engaging in other survival activities. Gambling is not just a financial problem. Gambling and gaming are emotional issues where a person feels the need to gamble or do gaming to alleviate stress or because they feel a certain type of euphoria when they gamble or play games. Addictive gambling and gaming has a very negative impact not just on psychological health but on social aspects of life. It can lead to the loss of relationships, unemployment, mental health issues, shame, guilt and even suicide. Teens people who fall into this cycle may neglect educational pursuits, in search of immediate gratification.

Psychoactive substances

Psychoactive substances are drugs or other substances that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior. Examples of psychoactive substances include alcohol, caffeine, nicotine, marijuana, and certain pain medicines. Many illegal drugs, such as heroin, LSD, cocaine, and amphetamines are also psychoactive substances. They are also called psychotropic substances.

Psychoactive substances are found in a number of medications as well as in alcohol, illegal and recreational drugs, and some plants and even animals. Alcohol and caffeine are psychoactive drugs that people most commonly use to alter their mental state. These drugs are legally available, but can still be physically and psychologically harmful if taken to excess.

Usually, people decide when and how they want to use psychoactive drugs. In some situations, however, psychoactive drugs are used to alter someone's mental state in order to exploit the person.

THEME 10: **SOCIAL DETERMINANTS OF HEALTH (FOOD)**

Nutrition and healthy diet

Consuming a healthy diet throughout the life-course helps to prevent malnutrition in all its forms as well as a range of noncommunicable diseases (NCDs) and conditions. However, increased production of processed foods, rapid urbanization and changing lifestyles have led to a shift in dietary patterns. People are now consuming more foods high in energy, fats, free sugars and salt/sodium, and many people do not eat enough fruit, vegetables and other dietary fibre such as whole grains. A balanced diet gives your body the nutrients it needs to function correctly.

The exact make-up of a diversified, balanced and healthy diet will vary depending on individual characteristics (e.g. age, gender, lifestyle and degree of physical activity), cultural context, locally available foods and dietary customs. However, the basic principles of what constitutes a healthy diet remain the same.

Malnutrition

Malnutrition is the condition that develops when the body is deprived of vitamins, minerals and other nutrients it needs to maintain healthy tissues and organ function.

Malnutrition occurs in people who are either undernourished or over nourished. In the United States, more children suffer from malnutrition due to dietary imbalances than due to nutritional deficiencies.

Undernutrition occurs when not enough essential nutrients are consumed or when they are excreted more rapidly than they can be replaced. Overnutrition occurs in people who eat too much, eat the wrong things, don't exercise enough or take too many vitamins or other dietary replacements. Risk of overnutrition is increased by being more than 20 percent overweight or consuming a diet high in fat and salt.

Forms of malnutrition

1. Undernutrition: which includes wasting (low weight-for-height), stunting (low height-for-age) and underweight (low weight-for-age);
2. Micronutrient-related malnutrition: which includes micronutrient deficiencies (lack of important vitamins and minerals) or micronutrient excess; and
3. Overweight, obesity and diet-related noncommunicable diseases (such as heart disease, stroke, diabetes and some cancers).

THEME 12: **SOCIAL DETERMINANTS OF HEALTH (FOOD)**

Nutrition and healthy diet

Nutrients are the good things that humans get through food which we need to nourish and nurture ourselves, and to be happy and healthy people. In scientific terms, nutrition is the supply of food that is needed by organisms to feed their cells and keep them alive. One can get nutrients from

products such as vitamin supplements, however when we talk about nutrition, we mostly mean the nutrients we get from food.

Nutrition means getting the food and nourishment one need for health and growth. Without nutrition, living things can grow weak, sick and at the very worst can even die. We miss developmental milestones and can't put our bodies through the daily mental and physical tasks that we need them to. We aren't able to grow and may also be unable to reproduce.

Nutrients are the fuel we need to enable the body to break down food and then put this to use in the body to repair and build cells and tissue, which is basically our metabolism.

The healthy human body needs seven different kinds of nutrients to thrive; proteins, carbohydrates, fats, vitamins, minerals, fiber and water. Macronutrients are the ones we need lots of, while with micronutrients (the vitamins and minerals) we can get by with a bit less.

Many of them fuel energy, while others have other important roles like digestion and hydration.

Consuming a healthy diet throughout the life-course helps to prevent malnutrition in all its forms as well as a range of noncommunicable diseases (NCDs) and conditions. However, increased production of processed foods, rapid urbanization and changing lifestyles have led to a shift in dietary patterns. People are now consuming more foods high in energy, fats, free sugars and salt/sodium, and many people do not eat enough fruit, vegetables and other dietary fiber such as whole grains.

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Forms of malnutrition

1. Undernutrition: There are 4 broad sub-forms of undernutrition: wasting, stunting, underweight, and deficiencies in vitamins and minerals. Undernutrition makes children in particular much more vulnerable to disease and death. Low weight-for-height is known as wasting. Low height-for-age is known as stunting. Children with low weight-for-age are known as underweight. A child who is underweight may be stunted, wasted, or both.
2. Overweight and Obesity: Overweight and obesity is when a person is too heavy for his or her height. Abnormal or excessive fat accumulation can impair health. Body mass index (BMI) is an index of weight-for-height commonly used to classify overweight and obesity. It is defined as a person's weight in kilograms divided by the square of his/her height in meters (kg/m^2). In adults, overweight is defined as a BMI of 25 or more, whereas obesity is a BMI of 30 or more. Overweight and obesity result from an imbalance between energy consumed (too much) and energy expended (too little). Globally, people are consuming foods and drinks that are more energy-dense (high in sugars and fats), and engaging in less physical activity.

Food safety

Food safety (or food hygiene) is used as a scientific method/discipline describing handling, preparation, and storage of food in ways that prevent food-borne illness. The occurrence of two or more cases of a similar illness resulting from the ingestion of a common food is known as a food-borne disease outbreak. This includes a number of routines that should be followed to avoid potential health hazards. In this way, food safety often overlaps with food defense to prevent harm

to consumers. The tracks within this line of thought are safety between industry and the market and then between the market and the consumer. In considering industry to market practices, food safety considerations include the origins of food including the practices relating to food labeling, food hygiene, food additives and pesticide residues, as well as policies on biotechnology and food and guidelines for the management of governmental import and export inspection and certification systems for foods. In considering market to consumer practices, the usual thought is that food ought to be safe in the market and the concern is safe delivery and preparation of the food for the consumer.

Food insecurity

Food insecurity is defined as a lack of consistent access to enough food for every person in a household to live an active, healthy life. This can be a temporary situation for a household or can last a long time. Food insecurity is one way we can measure how many people cannot afford food.
he causes of food insecurity are complex. Some of the causes of food insecurity include:

- Poverty, unemployment, or low income
- Lack of affordable housing
- Chronic health conditions or lack of access to healthcare
- Systemic racism and racial discrimination.

THEME 13: **SOCIOLOGICAL RESEARCH**

Sociologists examine the social world, see a problem or interesting pattern, and set out to study it. They use research methods to design a study. Planning the research design is a key step in any sociological study. Sociologists generally choose from widely used methods of social investigation: **primary source data collection** such as survey, participant observation, ethnography, case study, unobtrusive observations, experiment, and **secondary data analysis**, or use of existing sources. Every research method comes with plusses and minuses, and the topic of study strongly influences which method or methods are put to use. When you are conducting research think about the best way to gather or obtain knowledge about your topic, think of yourself as an architect. An architect needs a blueprint to build a house, as a sociologist your blueprint is your research design including your data collection method.

When entering a particular social environment, a researcher must be careful. There are times to remain anonymous and times to be overt. There are times to conduct interviews and times to simply observe. Some participants need to be thoroughly informed; others should not know they are being observed. A researcher wouldn't stroll into a crime-ridden neighborhood at midnight, calling out, "Any gang members around?"

Making sociologists' presence invisible is not always realistic for other reasons. That option is not available to a researcher studying prison behaviors, early education, or the Ku Klux Klan. Researchers can't just stroll into prisons, kindergarten classrooms, or Klan meetings and unobtrusively observe behaviors or attract attention. In situations like these, other methods are needed. Researchers choose methods that best suit their study topics, protect research participants or subjects, and that fit with their overall approaches to research.

Surveys

As a research method, a **survey** collects data from subjects who respond to a series of questions about behaviors and opinions, often in the form of a questionnaire or an interview. The survey is one of the most widely used scientific research methods. The standard survey format allows individuals a level of anonymity in which they can express personal ideas.At some point, most people in the United States respond to some type of survey. The 2020 U.S. Census is an excellent example of a large-scale survey intended to gather sociological data. Since 1790, United States has conducted a survey consisting of six questions to received demographical data pertaining to residents. The

questions pertain to the demographics of the residents who live in the United States. Currently, the Census is received by residents in the United Stated and five territories and consists of 12 questions.

Not all surveys are considered sociological research, however, and many surveys people commonly encounter focus on identifying marketing needs and strategies rather than testing a hypothesis or contributing to social science knowledge. Questions such as, “How many hot dogs do you eat in a month?” or “Were the staff helpful?” are not usually designed as scientific research. The Nielsen Ratings determine the popularity of television programming through scientific market research. However, polls conducted by television programs such as *American Idol* or *So You Think You Can Dance* cannot be generalized, because they are administered to an unrepresentative population, a specific show’s audience. You might receive polls through your cell phones or emails, from grocery stores, restaurants, and retail stores. They often provide you incentives for completing the survey.

Sociologists conduct surveys under controlled conditions for specific purposes. Surveys gather different types of information from people. While surveys are not great at capturing the ways people really behave in social situations, they are a great method for discovering how people feel, think, and act—or at least how they say they feel, think, and act. Surveys can track preferences for presidential candidates or reported individual behaviors (such as sleeping, driving, or texting habits) or information such as employment status, income, and education levels.

A survey targets a specific **population**, people who are the focus of a study, such as college athletes, international students, or teenagers living with type 1 (juvenile-onset) diabetes. Most researchers choose to survey a small sector of the population, or a **sample**, a manageable number of subjects who *represent* a larger population. The success of a study depends on how well a population is represented by the sample. In a **random sample**, every person in a population has the same chance of being chosen for the study. As a result, a Gallup Poll, if conducted as a nationwide random sampling, should be able to provide an accurate estimate of public opinion whether it contacts 2,000 or 10,000 people.

After selecting subjects, the researcher develops a specific plan to ask questions and record responses. It is important to inform subjects of the nature and purpose of the survey up front. If they agree to participate, researchers thank subjects and offer them a chance to see the results of the study if they are interested. The researcher presents the subjects with an instrument, which is a means of gathering the information.

A common instrument is a questionnaire. Subjects often answer a series of **closed-ended questions**. The researcher might ask yes-or-no or multiple-choice questions, allowing subjects to choose possible responses to each question. This kind of questionnaire collects **quantitative data**—data in numerical form that can be counted and statistically analyzed. Just count up the number of “yes” and “no” responses or correct answers, and chart them into percentages.

Questionnaires can also ask more complex questions with more complex answers—beyond “yes,” “no,” or checkbox options. These types of inquiries use **open-ended questions** that require short essay responses. Participants willing to take the time to write those answers might convey personal religious beliefs, political views, goals, or morals. The answers are subjective and vary from person to person. *How do plan to use your college education?*

Some topics that investigate internal thought processes are impossible to observe directly and are difficult to discuss honestly in a public forum. People are more likely to share honest answers if they can respond to questions anonymously. This type of personal explanation is **qualitative data**—conveyed through words. Qualitative information is harder to organize and tabulate. The researcher will end up with a wide range of responses, some of which may be surprising. The benefit of written opinions, though, is the wealth of in-depth material that they provide.

An **interview** is a one-on-one conversation between the researcher and the subject, and it is a way of conducting surveys on a topic. However, participants are free to respond as they wish, without being limited by predetermined choices. In the back-and-forth conversation of an interview, a researcher can ask for clarification, spend more time on a subtopic, or ask additional questions. In an interview, a subject will ideally feel free to open up and answer questions that are often complex.

There are no right or wrong answers. The subject might not even know how to answer the questions honestly.

Questions such as "How does society's view of alcohol consumption influence your decision whether or not to take your first sip of alcohol?" or "Did you feel that the divorce of your parents would put a social stigma on your family?" involve so many factors that the answers are difficult to categorize. A researcher needs to avoid steering or prompting the subject to respond in a specific way; otherwise, the results will prove to be unreliable. The researcher will also benefit from gaining a subject's trust, from empathizing or commiserating with a subject, and from listening without judgment.

Surveys often collect both quantitative and qualitative data. For example, a researcher interviewing people who are incarcerated might receive quantitative data, such as demographics – race, age, sex, that can be analyzed statistically. For example, the researcher might discover that 20 percent of incarcerated people are above the age of 50. The researcher might also collect qualitative data, such as why people take advantage of educational opportunities during their sentence and other explanatory information.

The survey can be carried out online, over the phone, by mail, or face-to-face. When researchers collect data outside a laboratory, library, or workplace setting, they are conducting field research, which is our next topic.

Field Research

The work of sociology rarely happens in limited, confined spaces. Rather, sociologists go out into the world. They meet subjects where they live, work, and play. **Field research** refers to gathering **primary data** from a natural environment. To conduct field research, the sociologist must be willing to step into new environments and observe, participate, or experience those worlds. In field work, the sociologists, rather than the subjects, are the ones out of their element.

The researcher interacts with or observes people and gathers data along the way. The key point in field research is that it takes place in the subject's natural environment, whether it's a coffee shop or tribal village, a homeless shelter or the DMV, a hospital, airport, mall, or beach resort.

While field research often begins in a specific *setting*, the study's purpose is to observe specific *behaviors* in that setting. Field work is optimal for observing *how* people think and behave. It seeks to understand *why* they behave that way. However, researchers may struggle to narrow down cause and effect when there are so many variables floating around in a natural environment. And while field research looks for correlation, its small sample size does not allow for establishing a causal relationship between two variables. Indeed, much of the data gathered in sociology do not identify a cause and effect but a **correlation**.

Participant Observation

In 2000, a comic writer named Rodney Rothman wanted an insider's view of white-collar work. He slipped into the sterile, high-rise offices of a New York "dot com" agency. Every day for two weeks, he pretended to work there. His main purpose was simply to see whether anyone would notice him or challenge his presence. No one did. The receptionist greeted him. The employees smiled and said good morning. Rothman was accepted as part of the team. He even went so far as to claim a desk, inform the receptionist of his whereabouts, and attend a meeting. He published an article about his experience in *The New Yorker* called "My Fake Job" (2000). Later, he was discredited for allegedly fabricating some details of the story and *The New Yorker* issued an apology. However, Rothman's entertaining article still offered fascinating descriptions of the inside workings of a "dot com" company and exemplified the lengths to which a writer, or a sociologist, will go to uncover material.

Rothman had conducted a form of study called **participant observation**, in which researchers join people and participate in a group's routine activities for the purpose of observing them within that context. This method lets researchers experience a specific aspect of social life. A researcher might go to great lengths to get a firsthand look into a trend, institution, or behavior. A researcher might work as a waitress in a diner, experience homelessness for several weeks, or ride along with

police officers as they patrol their regular beat. Often, these researchers try to blend in seamlessly with the population they study, and they may not disclose their true identity or purpose if they feel it would compromise the results of their research.

Aquestion: “What really goes on in the kitchen of the most popular diner on campus?” or “What is it like to be homeless?” Participant observation is a useful method if the researcher wants to explore a certain environment from the inside.

Field researchers simply want to observe and learn. In such a setting, the researcher will be alert and open minded to whatever happens, recording all observations accurately. Soon, as patterns emerge, questions will become more specific, observations will lead to hypotheses, and hypotheses will guide the researcher in analyzing data and generating results.

In a study of small towns in the United States conducted by sociological researchers John S. Lynd and Helen Merrell Lynd, the team altered their purpose as they gathered data. They initially planned to focus their study on the role of religion in U.S. towns. As they gathered observations, they realized that the effect of industrialization and urbanization was the more relevant topic of this social group. The Lynds did not change their methods, but they revised the purpose of their study.
This shaped the structure of *Middletown: A Study in Modern American Culture*, their published results (Lynd & Lynd, 1929).

The Lynds were upfront about their mission. The townspeople of Muncie, Indiana, knew why the researchers were in their midst. But some sociologists prefer not to alert people to their presence. The main advantage of covert participant observation is that it allows the researcher access to authentic, natural behaviors of a group’s members. The challenge, however, is gaining access to a setting without disrupting the pattern of others’ behavior. Becoming an inside member of a group, organization, or subculture takes time and effort. Researchers must pretend to be something they are not. The process could involve role playing, making contacts, networking, or applying for a job.

Once inside a group, some researchers spend months or even years pretending to be one of the people they are observing. However, as observers, they cannot get too involved. They must keep their purpose in mind and apply the sociological perspective. That way, they illuminate social patterns that are often unrecognized. Because information gathered during participant observation is mostly qualitative, rather than quantitative, the end results are often descriptive or interpretive. The researcher might present findings in an article or book and describe what he or she witnessed and experienced.

This type of research is what journalist Barbara Ehrenreich conducted for her book *Nickel and Dimed*. One day over lunch with her editor, Ehrenreich mentioned an idea. *How can people exist on minimum-wage work? How do low-income workers get by?* she wondered. *Someone should do a study*. To her surprise, her editor responded, *Why don’t you do it?*

That’s how Ehrenreich found herself joining the ranks of the working class. For several months, she left her comfortable home and lived and worked among people who lacked, for the most part, higher education and marketable job skills. Undercover, she applied for and worked minimum wage jobs as a waitress, a cleaning woman, a nursing home aide, and a retail chain employee. During her participant observation, she used only her income from those jobs to pay for food, clothing, transportation, and shelter.

She discovered the obvious, that it’s almost impossible to get by on minimum wage work. She also experienced and observed attitudes many middle and upper-class people never think about. She witnessed firsthand the treatment of working class employees. She saw the extreme measures people take to make ends meet and to survive. She described fellow employees who held two or three jobs, worked seven days a week, lived in cars, could not pay to treat chronic health conditions, got randomly fired, submitted to drug tests, and moved in and out of homeless shelters. She brought aspects of that life to light, describing difficult working conditions and the poor treatment that low-wage workers suffer.

The book she wrote upon her return to her real life as a well-paid writer, has been widely read and used in many college classrooms.

Ethnography

Ethnography is the immersion of the researcher in the natural setting of an entire social community to observe and experience their everyday life and culture. The heart of an ethnographic study focuses on how subjects view their own social standing and how they understand themselves in relation to a social group.

An ethnographic study might observe, for example, a small U.S. fishing town, an Inuit community, a village in Thailand, a Buddhist monastery, a private boarding school, or an amusement park. These places all have borders. People live, work, study, or vacation within those borders. People are there for a certain reason and therefore behave in certain ways and respect certain cultural norms. An ethnographer would commit to spending a determined amount of time studying every aspect of the chosen place, taking in as much as possible.

A sociologist studying a tribe in the Amazon might watch the way villagers go about their daily lives and then write a paper about it. To observe a spiritual retreat center, an ethnographer might sign up for a retreat and attend as a guest for an extended stay, observe and record data, and collate the material into results.

Institutional Ethnography

Institutional ethnography is an extension of basic ethnographic research principles that focuses intentionally on everyday concrete social relationships. Developed by Canadian sociologist Dorothy E. Smith (1990), institutional ethnography is often considered a feminist-inspired approach to social analysis and primarily considers women's experiences within male- dominated societies and power structures. Smith's work is seen to challenge sociology's exclusion of women, both academically and in the study of women's lives (Fenstermaker, n.d.).

Historically, social science research tended to objectify women and ignore their experiences except as viewed from the male perspective. Modern feminists note that describing women, and other marginalized groups, as subordinates helps those in authority maintain their own dominant positions (Social Sciences and Humanities Research Council of Canada n.d.). Smith's three major works explored what she called "the conceptual practices of power" and are still considered seminal works in feminist theory and ethnography (Fensternmaker n.d.).

Case Study

Sometimes a researcher wants to study one specific person or event. A **case study** is an in-depth analysis of a single event, situation, or individual. To conduct a case study, a researcher examines existing sources like documents and archival records, conducts interviews, engages in direct observation and even participant observation, if possible.

Researchers might use this method to study a single case of a foster child, drug lord, cancer patient, criminal, or rape victim. However, a major criticism of the case study as a method is that while offering depth on a topic, it does not provide enough evidence to form a generalized conclusion. In other words, it is difficult to make universal claims based on just one person, since one person does not verify a pattern. This is why most sociologists do not use case studies as a primary research method.

However, case studies are useful when the single case is unique. In these instances, a single case study can contribute tremendous incite. For example, a feral child, also called "wild child," is one who grows up isolated from human beings. Feral children grow up without social contact and language, which are elements crucial to a "civilized" child's development. These children mimic the behaviors and movements of animals, and often invent their own language. There are only about one hundred cases of "feral children" in the world.

As you may imagine, a feral child is a subject of great interest to researchers. Feral children provide unique information about child development because they have grown up outside of the parameters of "normal" growth and nurturing. And since there are very few feral children, the case study is the most appropriate method for researchers to use in studying the subject.

At age three, a Ukranian girl named Oxana Malaya suffered severe parental neglect. She lived in a shed with dogs, and she ate raw meat and scraps. Five years later, a neighbor called authorities

and reported seeing a girl who ran on all fours, barking. Officials brought Oxana into society, where she was cared for and taught some human behaviors, but she never became fully socialized. She has been designated as unable to support herself and now lives in a mental institution (Grice 2011). Case studies like this offer a way for sociologists to collect data that may not be obtained by any other method.

Experiments

You have probably tested some of your own personal social theories. "If I study at night and review in the morning, I'll improve my retention skills." Or, "If I stop drinking soda, I'll feel better." Cause and effect. If this, then that. When you test the theory, your results either prove or disprove your hypothesis.

One way researchers test social theories is by conducting an **experiment**, meaning they investigate relationships to test a hypothesis - a scientific approach.

There are two main types of experiments: lab-based experiments and natural or field experiments. In a lab setting, the research can be controlled so that more data can be recorded in a limited amount of time. In a natural or field- based experiment, the time it takes to gather the data cannot be controlled but the information might be considered more accurate since it was collected without interference or intervention by the researcher.

As a research method, either type of sociological experiment is useful for testing *if-then* statements: *if* a particular thing happens (cause), *then* another particular thing will result (effect). To set up a lab-based experiment, sociologists create artificial situations that allow them to manipulate variables.

Classically, the sociologist selects a set of people with similar characteristics, such as age, class, race, or education. Those people are divided into two groups. One is the experimental group and the other is the control group. The **experimental group** is exposed to the independent variable(s) and the **control group** is not. To test the benefits of tutoring, for example, the sociologist might provide tutoring to the experimental group of students but not to the control group. Then both groups would be tested for differences in performance to see if tutoring had an effect on the experimental group of students. As you can imagine, in a case like this, the researcher would not want to jeopardize the accomplishments of either group of students, so the setting would be somewhat artificial. The test would not be for a grade reflected on their permanent record of a student, for example.

And if a researcher told the students they would be observed as part of a study on measuring the effectiveness of tutoring, the students might not behave naturally. This is called the **Hawthorne effect**—which occurs when people change their behavior because they know they are being watched as part of a study. The Hawthorne effect is unavoidable in some research studies because sociologists have to make the purpose of the study known. Subjects must be aware that they are being observed, and a certain amount of artificiality may result (Sonnenfeld 1985).

Secondary Data Analysis

While sociologists often engage in original research studies, they also contribute knowledge to the discipline through **secondary data analysis**. Secondary data does not result from firsthand research collected from primary sources, but are the already completed work of other researchers or data collected by an agency or organization. Sociologists might study works written by historians, economists, teachers, or early sociologists. They might search through periodicals, newspapers, or magazines, or organizational data from any period in history.

Using available information not only saves time and money but can also add depth to a study. Sociologists often interpret findings in a new way, a way that was not part of an author's original purpose or intention. To study how women were encouraged to act and behave in the 1960s, for example, a researcher might watch movies, televisions shows, and situation comedies from that period. Or to research changes in behavior and attitudes due to the emergence of television in the late 1950s and early 1960s, a sociologist would rely on new interpretations of secondary data. Decades

from now, researchers will most likely conduct similar studies on the advent of mobile phones, the Internet, or social media.

Social scientists also learn by analyzing the research of a variety of agencies. Governmental departments and global groups, like the U.S. Bureau of Labor Statistics or the World Health Organization (WHO), publish studies with findings that are useful to sociologists. A public statistic like the foreclosure rate might be useful for studying the effects of a recession. A racial demographic profile might be compared with data on education funding to examine the resources accessible by different groups.

One of the advantages of secondary data like old movies or WHO statistics is that it is **nonreactive research** (or unobtrusive research), meaning that it does not involve direct contact with subjects and will not alter or influence people's behaviors. Unlike studies requiring direct contact with people, using previously published data does not require entering a population and the investment and risks inherent in that research process.

Using available data does have its challenges. Public records are not always easy to access. A researcher will need to do some legwork to track them down and gain access to records. To guide the search through a vast library of materials and avoid wasting time reading unrelated sources, sociologists employ **content analysis**, applying a systematic approach to record and value information gleaned from secondary data as they relate to the study at hand.

Also, in some cases, there is no way to verify the accuracy of existing data. It is easy to count how many drunk drivers, for example, are pulled over by the police. But how many are not? While it's possible to discover the percentage of teenage students who drop out of high school, it might be more challenging to determine the number who return to school or get their GED later.
Another problem arises when data are unavailable in the exact form needed or do not survey the topic from the precise angle the researcher seeks. For example, the average salaries paid to professors at a public school is public record. But these figures do not necessarily reveal how long it took each professor to reach the salary range, what their educational backgrounds are, or how long they've been teaching.

When conducting content analysis, it is important to consider the date of publication of an existing source and to take into account attitudes and common cultural ideals that may have influenced the research. For example, when Robert S. Lynd and Helen Merrell Lynd gathered research in the 1920s, attitudes and cultural norms were vastly different then than they are now. Beliefs about gender roles, race, education, and work have changed significantly since then. At the time, the study's purpose was to reveal insights about small U.S. communities. Today, it is an illustration of 1920s attitudes and values.

6. INSTRUMENTS, EQUIPMENT AND SOFTWARE USED BY THE COURSE

Hardware - computer, multimedia projector.
Software - office applications, Internet connection.

7. RECOMMENDED SOURCES OF INFORMATION

1. Introduction toSociology. OpenStax College. https://openstax.org/books/introduction-sociology/pages/1-introduction-to-sociology
2. Research Methodology: A Step-by-Step Guide for Beginners. Third Edition. Ranjit Kumar. 2011. http://www.sociology.kpi.ua/wp-content/uploads/2014/06/Ranjit_Kumar-Research_Methodology_A_Step-by-Step_G.pdf

3. World health organization. https://www.who.int/teams/social-determinants-of-health
4. Social determinants of health: the solid facts. 2nd edition. Edited by R. Wilkinson, M. Marmot. https://www.euro.who.int/en/publications/abstracts/social-determinants-of-health.-the-solid-facts
5. Social Determinants of Health 101 for Health Care: Five Plus Five. By Sanne Magnan. https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/
6. The importance of a life-course approach to health: Chronic disease risk from preconception through adolescence and adulthood: White paper. Chandni Maria Jacob, Janis Baird, Mary Barker, Cyrus Cooper, Mark Hanson. https://www.who.int/life-course/publications/life-course-approach-to-health.pdf
7. The implications for training of embracing: a life course approach to health. World Health Organization. 2000. https://apps.who.int/iris/bitstream/handle/10665/69400/WHO_NMH_HPS_00.2_eng.pdf?sequence=1&isAllowed=y
8. Poverty, social exclusion and health systems in the WHO European Region. Copenhagen, WHO Regional Office for Europe, 2010. https://www.euro.who.int/__data/assets/pdf_file/0004/127525/e94499.pdf
9. Leaving no one behind: the imperative of inclusive development. Report on the World Social Situation 2016. United Nations New York, 2016. https://www.un.org/esa/socdev/rwss/2016/full-report.pdf
10. Employment Conditions and Health Inequalities Final Report to the WHO. Commission on Social Determinants of Health (CSDH). Employm ent Conditions Knowledge Network (EMCONET). Final Report, 20 September 2007. https://www.who.int/social_determinants/resources/articles/emconet_who_report.pdf
11. Consequences of Long-Term Unemployment. Austin Nichols, Josh Mitchell, and Stephan Lindner. Washington, District of Columbia: Urban Institute, 2013. https://www.urban.org/sites/default/files/publication/23921/412887-Consequences-of-Long-Term-Unemployment.PDF
12. Health effects of unemployment. Wirral Performance & Public Health Intelligence Team. H. Moller, 2011. Published: August 2012. https://www.wirralintelligenceservice.org/media/1086/unemployment-2-sept-12.pdf
13. Social exclusion. https://youtu.be/eejmYz0O3YE
14. Social support. https://youtu.be/gZMvA2Apg2A
15. Social inequality. https://youtu.be/JYxspCbwZVs