Article

American Medical Sociology and Health Problems in the Global South

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Abstract

COVID-19 has focused global attention on disease spread across borders. But how has research on infectious and noncommunicable disease figured into the sociological imagination historically, and to what degree has American medical sociology examined health problems beyond U.S. borders? Our 35-year content analysis of 2,588 presentations in the American Sociological Association's (ASA) Section on Medical Sociology and 922 articles within the section's official journal finds less than 15 percent of total research examined contexts outside the United States. Research on three infectious diseases in the top eight causes of death in low-income countries (diarrheal disease, malaria, and tuberculosis [TB]) and emerging diseases—Ebola, Middle East Respiratory Syndrome (MERS), and Severe Acute Respiratory Syndrome (SARS)—was nearly absent, as was research on major noncommunicable diseases. Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) received much more focus, although world regions hit hardest received scant attention. Interviews suggest a number of factors shape geographic foci of research, but this epistemic parochialism may ultimately impoverish sociological understanding of illness and disease.

Keywords

global health, medical sociology, HIV/AIDS, infectious disease, Global South, content analysis, development, global and transnational sociology

The novel coronavirus has transfixed public attention on infectious disease unlike any disease before and has prompted renewed scholarly attention on "global health"—a term that was coined originally to encompass "health problems and interventions extending beyond national boundaries" (Greene et al. 2013:34), most notably infectious disease. While this attention is welcome, it is not the first time a pandemic has magnified scholarly concern about public health challenges that transcend national borders. Amid the HIV/AIDS pandemic, first recognized by the U.S. Centers for Disease Control and Prevention (CDC) in 1981 as Acquired Immunodeficiency Syndrome, development assistance for health soared from $5.6 billion to $21.8 billion between 1990 and 2007 (Ravishankar et al. 2009). New institutions—such as the Global Fund to Fight HIV/AIDS, tuberculosis [TB], and malaria; Joint United Nations Program on AIDS (UNAIDS); the Bill and Melinda Gates Foundation; and the President's Emergency Program for AIDS Relief

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(PEPFAR)—arose to address this new health threat. Alongside these developments, there has been a growing recognition of the problem that noncommunicable diseases (NCDs) pose not only to countries in the Global North but also in the Global South, where mortality rates from chronic illness have grown faster than those in rich countries (Stuckler 2008). Academic interest in global health has skyrocketed, with new schools and degrees devoted to the topic. Scholarship on global health likewise grew substantially, mostly from institutions in North America, and a number of institutions of higher education formed global health initiatives and programs (Macfarlane, Jacobs, and Kaaya 2008:389–91).

Within sociology, the Medical Sociology Section—formally established within the American Sociological Association (ASA) in 1959 (Conrad 1997:92)—would appear well suited to study health beyond the United States, particularly in the Global South, given long-standing attention within the section to health disparities and the relationship between socioeconomic status and health (Link and Phelan 1995). This article builds on other research that has turned the sociological gaze back inward on the discipline, using interviews and content analyses to understand the conduct and aims of the field, as they appear in two of its flagship venues (Abend 2006; Collyer 2012; Crane and Small 1992; Seale 2008). Here, we analyze the geographic settings and disease foci of research appearing in the ASA annual meeting and the *Journal of Health and Social Behavior* (*JHSB*) between 1985 and 2019, a period that tracks the rise of the AIDS pandemic to the beginning of the coronavirus pandemic. This period of investigation is significant as it allows us to understand the degree and geography of sociological interest in major infectious diseases and NCDs over a period in which interest within and outside the academy in global health (broadly defined) was rising, as well as the degree to which research on these issues appeared in the official journal of the section, offering a window into these issues' marginality or prominence within the subfield. To gain insight into the mechanisms responsible for shaping the geography and disease foci of research in the section's flagship venues, we complement this content analysis with interviews with former Medical Sociology section chairs, journal editors, as well as sociologists who have conducted health research outside of the United States. While the two platforms (*JHSB* and ASA Annual Meeting Programs) do not represent the subdiscipline as a whole, investigation of these publication and presentation outlets offers a profound window into what is classified as mainstream research by the section and its participants.

Other work has examined gendered publication patterns in "elite" and "top" journals in sociology, including *American Sociological Review (ASR)* and *American Journal of Sociology (AJS)* (Akbaritabar and Squazzoni 2021). Such prestigious journals exist in a "stratified publication market" (Akbaritabar and Squazzoni 2021:558), with high degrees of competition and gatekeeping by editors, editorial boards, and reviewers. Furthermore, the elite journal publication patterns exhibit "self-reinforcing" patterns in the type of research preferred (Akbaritabar and Squazzoni 2021:570). Other work on publication patterns in top political science journals demonstrates how differential rates of submission by women are "self-enforcing," potentially structured by cultural biases and organizational exclusions (Teele and Thelen 2017:443). Our article builds on this work to analyze scientific production patterns, and their deeper causes, in two flagship sociological knowledge outlets. It addresses some of the institutional and cultural factors underpinning self-reinforcing scholarly activity in mainstream sociological venues. By doing so, it adds to our understanding of the complex, heterogeneous, and always changing organizational processes through which scientific work is made possible and comes to appear in certain spaces.

Simply because more international health research does not appear in these particular venues does not mean that the work has not taken place. Our concern, though, is not whether this sociological work exists at all but rather for what kind of work are the flagship medical sociology publication and presentation venues most hospitable, and why might this be the case? We begin with a background on health research beyond the United States, focusing on HIV/AIDS and infectious disease, as well as NCDs. We then describe the methods used. Next, we present the

results of the analysis, beginning first with trends in *JHSB* and ASA presentations. We then draw on our interview data to demonstrate the institutional and cultural dynamics that impact the production and appearance of research appearing in flagship settings. Our article concludes with directions for future research and broader agenda-setting within the discipline.

Why does investigation of these issues matter? We suggest this research is important for a number of reasons. First, it affords us the opportunity to understand the precise geography of research in the subfield and how the subfield responds (or does not) to issues of growing concern in the real world, elucidating potential mechanisms that may explain disconnects between what we might expect to find and reality. Second, investigation has the potential to bring to light epistemic parochialism that may ultimately harm scientific understanding. If important theories we hold as foundational, which are frequently imagined to have universal application, are largely built on just one (exceptional) case, like the U.S. experience, or a few cases, and have not been subjected to rigorous testing in a broader array of environments, then they may in fact be castles made of sand. Eliding experiences beyond the United States may likewise deprive a subfield of opportunities for cross-fertilization of ideas emerging in other parts of the world (Büyüm et al. 2020), including with leaders, experts, and community members in those nations. Such reciprocal knowledge exchanges would offer the chance to apply concepts, test theories, and draw on existing expertise formed in contexts outside of what is familiar. Third, a full accounting of accrued sociological knowledge related to infectious disease and NCDs offers American medical sociologists and other researchers a valuable evidence base to draw on in responding to the current coronavirus pandemic and other future pandemics. Even if incomplete, such an evidence base helps us to see where the gaps are. Finally, as other recent work has noted, the exclusion of international research from top journals may not only have deleterious effects on the discipline, but also on the career prospects of researchers who engage in international work (Jacobs and Mizrachi 2020). An understanding of the mechanisms that produce and enable epistemic parochialism therefore offers journal editors, funding and educational institutions, and researchers the tools to change the status quo and incorporate more diverse perspectives into the process of scientific knowledge production.

Background

Rising Global Health Interest within the Academy and American Medical Sociology?

No uniform consensus exists on a definition of global health, but scholars have made numerous contributions to the debate (De Maio 2014; Fassin 2006; Fried et al. 2010; Koplan et al. 2009; Collier and Lakoff 2010). While NCDs are a growing problem in the Global South, infectious disease has historically been a much larger problem for poorer nations than wealthier ones. Four infectious diseases figure prominently into the top nine causes of death in low-income countries that do not figure in the top 10 causes of death in high-income countries: diarrheal disease, malaria, TB, and HIV/AIDS (World Health Organization 2020). At the same time, NCDs have been recognized as a growing problem in the Global South (Stuckler 2008), with NCDs and injuries accounting for greater than a third of the burden of disease for the world's poorest people (Bukhman et al. 2020). Important sociological research has pointed to the colonial underpinnings of the modern project of global health, showing how colonial powers' racialized response to different epidemiological threats in colonies was a function of their concern with spread to Europe (White 2018). Even today, many of the inequalities in global health can be traced to colonial legacies and have contributed to suspicion of Western biomedical interventions (Decoteau 2013). While this research shows that global health has a long history, HIV/AIDS, however, continues to stand out as a key inflection point (Brandt 2013), in which the international community began

to recognize the global nature of today's health challenges—and the interdependencies and vulnerabilities that underlay the international system. With nearly 80 million people infected with HIV/AIDS since the early 1980s, and approximately 37 million living with the disease today (UNAIDS 2021), the epidemic led to dramatic new attention, spurring funding not just for HIV/AIDS but also for more general health problems extending beyond national borders. Research interest on health topics outside of the United States also proliferated following the emergence of the HIV/AIDS epidemic. For instance, the number of articles in PubMed using the term "international health" tripled from 16,924 in the 1980s to 49,158 in the 1990s, and the number of articles using the term "global health" nearly quadrupled from 7,176 to 27,794 over the same period—a rate far outpacing that of scientific research globally (Brown, Cueto, and Fee 2006:64; Van Noorden 2014).

Some of the first sociological work published on HIV/AIDS did not take place until the end of the 1980s (Kaplan et al. 1987; Rushing 1995; Weitz 1991), with minimal sociological research about HIV/AIDS emerging until the early 2000s (Lichtenstein 2001) and the first review of work on the sociology of global health not published until 2019 (Harris and White 2019). HIV/AIDS research was mostly confined to interdisciplinary journals (Watkins-Hayes 2014:343) and journals concerned with network analysis. Meanwhile, the degree of sociological focus on other infectious diseases, including TB and malaria—more common in the Global South—and the problem of NCDs, increasingly a scourge in both the Global North and South—has remained largely unstudied, with no systematic analysis of sociological work on these diseases.

Sociologists have been said to mostly study domestic issues associated with "us," while anthropologists study "them" in international settings (Conley 2015:35–36). Medical sociologists had also declared their research distinct from the fields of global health and public health (Mechanic 1966:237). Yet, medical sociology textbooks have traditionally reserved a chapter or two for issues related to health outside of the United States, often comparing health care systems in the United States and Europe. More recent work has examined health issues that transcend national borders (Bird et al. 2010; Weitz 2013:76–94). While these developments represent an acknowledgment of the changing global landscape of health and illness, fundamental questions remain: Amid the great interest and stakes in borderless health problems over the past 30 years, to what extent has health research outside of the United States appeared at the official meeting and journal associated with U.S. medical sociology? And to what extent have infectious diseases and NCDs been a focus of sociological endeavors in the flagship Medical Sociology Section venues? By identifying the geographic foci of research appearing in ASA and *JHSB*, we echo other sociologists who acknowledge that place matters (Brown-Saracino 2015; Gieryn 1999)—both in relation to health and health outcomes, and with regard to knowledge production (Büyüm et al. 2020; Shapin 1995). Where in the world has sociological research focused in the two official platforms where work in the section is presented and published, and why might this be the case?

Methodology

To probe work and publications on global health—including infectious disease and NCDs—this article draws on a content analysis of two sources spanning 35 years, the subfield's flagship journal (*JHSB*) and the ASA Annual Meeting Program. These data provide a unique and multilayered picture of research occurring in two major venues over a period that tracks the rise of the AIDS epidemic up until COVID-19.

While the content analysis offered a clear picture of works studied over that period, it provided less insight on how and why those patterns had come to exist. To address this, we conducted 15 in-depth interviews with Chairs of ASA's Medical Sociology Section and editors of *JHSB*, as well as five interviews with sociologists whose primary work has focused on international health research to understand how they have navigated the institutional and cultural

dynamics of the ASA. The interviews prompted further content analysis of editorial statements made by *JHSB* editors (to see what issues they sought to prioritize), and the section's Eliot Freidson Outstanding Publication Award (to see what publications the subfield chose to reward).

Content Analysis

JHSB articles and ASA programs were selected because they provide a window into the substantive topics of focus by the subfield in its flagship journal and in presentations at the discipline's official meeting. While other venues exist for disseminating research by U.S. medical sociologists about health issues in international contexts, such as *Social Science and Medicine* and the *Sociology of Health and Illness*, our aim was to understand what appears at the official meeting and journal associated with U.S. medical sociology. We acknowledge that research on health outside the United States finds a home in these and other journals, and may also take the form of books. However, their rate of appearance within the official journal of the section demonstrates the prominence or marginality of these topics within the subfield. Comparison of the two rates indicates the degree to which work originally presented in the section appears in other places, with the caveat that not all presented work is published.

Publications and presentations on four infectious diseases (diarrheal disease, malaria, TB, and HIV/AIDS), that figure into the top nine causes of death in low-income countries but not high-income countries, as well as other highly salient transmissible diseases—including Ebola, Severe Acute Respiratory Syndrome (SARS), and Middle East Respiratory Syndrome (MERS)—offer some indication of both the substance and location of concerns of sociologists in the flagship settings. Examination of five of the most highly visible NCDs—heart disease, cancer, diabetes, respiratory illness, and stroke—offers a window into sociological concern with diseases of global importance and the places where sociologists study them.

Four coders read the entirety of *JHSB* articles and categorized them according to whether or not the articles focused on the United States or other countries, which country or countries the articles dealt with, and whether or not infectious disease was a major focus. Comparative studies that included the United States were coded as international. Originally, HIV/AIDS, which has disproportionately affected people outside the United States, and particularly in the Global South, was our sole focus. However, a single coder later examined the incidence of the other infectious diseases of interest, with two coders examining the incidence of the five major NCDs. In addition, we coded whether or not the institutional affiliation of the researcher(s) was outside of the United States so that we might better understand whether domestic or international researchers conducted health research outside of the United States. We excluded literature reviews and purely theoretical/methodological contributions (and comments/replies) from the sample, because these were not grounded in a particular place, and including them would only have served to paint a more domestic-focused picture of *JHSB* research.

Two coders analyzed the ASA meeting programs for presentations officially sponsored or co-sponsored by the Medical Sociology Section, including special sessions, invited sessions, roundtables, paper/regular sessions, plenary sessions, graduate student sessions, and luncheon sessions. Undergraduate presentations and poster sessions were not included. Based on title, the coder determined which presentations focused on countries outside of the United States and which diseases they focused on, if any, based on defined search criteria (for "diabetes," for example, we included articles that mentioned any of the following key terms—diabet-, glucose, sugar, or insulin—clearly in reference to the disease). While presentation titles do not fully convey the content of a presentation, they provide insight into presentations' main focus. Some presentation titles did not explicitly reference HIV/AIDS, despite focusing on sexual health behaviors of gay men or condom use and disease prevention. Even if they appeared in a venue that referenced HIV/AIDS, we did not include presentations with titles that did not explicitly mention HIV/AIDS to

maintain integrity in our coding schema, because they could have been concerned only with related subject matter. Our inclusion criterion for articles counting as having focused on a particular disease in *JHSB* was set at 10 mentions or more of any defined search terms. We included in our counts a handful of articles that did not meet our threshold criteria, but, for example, had a disease explicitly mentioned in a title, sample, or abstract. A single coder later performed a more limited content analysis of the geographic focus of presentations within the Section on Racial and Ethnic Minorities, another major long-standing section within the ASA producing work of vital importance against which to compare our findings on presentations within the Medical Sociology Section.

The pairing of our content analysis of *JHSB* with the ASA Conference Program allowed us to see how and where knowledge and dialogues about health issues have taken shape in two major platforms within the subfield. If global health research, focusing on countries outside of the United States and/or infectious disease, featured at a similarly low proportion at the flagship conference and within the flagship journal, then we might surmise that it is simply not of prominent concern in these two official venues. However, if global health research featured much more prominently at the conference than in the journal, this might suggest that a significant amount of research on these topics is being published elsewhere.

Recent work on sociological knowledge production has drawn out the differences between the *JHSB* and *Social Science and Medicine* (Clair et al. 2007), and compared the content of the *American Sociological Review*, *American Journal of Sociology*, and *Social Problems* to argue that mainstream sociology journals "serve to clarify and unify the field" (Karides et al. 2001:111). An analysis of nine journals helped to elucidate new research directions in medical sociology (Seale 2008), while book-length work has explored differences between the conduct of the sociology of health and medicine in the United States, Britain, and Australia (Collyer 2012). In addition, a content analysis of topics studied in *Social Problems* in 1976 explicated a lack of articles on the "exploitation of the 'have-not' nations" (Henslin and Roesti 1976:65). Building on this work, we argue that analysis of *JHSB* content and ASA presentations showcases some of the intellectual terrains of the subfield, as well as those that are missing.

In-depth Interviews

We conducted 20 total in-depth interviews, with 5 sociologists whose work has focused on global health, and 15 informants who were chairs of the ASA's Medical Sociology Section, or who held editorships at *JHSB* during the study period. This included in-depth interviews with 12 section chairs over the study period and 3 *JHSB* editors, as well as 1 former editor who provided information by e-mail.

We used an open-ended interview script which explored issues such as the role of section chairs and journal editors in setting the research agenda of ASA or *JHSB*, the different issues and themes explored during the informant's tenure, and reasons why research in *JHSB* or ASA has taken shape in the way that it has. While these data might be considered subjective, we consider it a complementary insight by key actors into various mechanisms shaping the degree of engagement with non-U.S. health and infectious disease research, and work on infectious disease, in these two venues. Approval for human subjects research was granted by the university's Institutional Review Board.

Below we present the findings of our content analysis in the context of more general developments within the subfield of medical sociology. We then present the major themes from our in-depth interviews with past section chairs of the ASA's Medical Sociology Section and past *JHSB* editors. We conclude with implications for the subfield and discipline more broadly, and suggest further areas of research to build on these findings.

A limitation of this study is that it probes global health research along two different dimensions: as research focused on infectious disease and NCDs, and as research involving a geographic profile that extends beyond U.S. borders, including the Global South. We recognize that this does not capture every element of global health research, which is itself a contested term and fluid field. However, the study does allow us to build a geographically sensitive understanding of research on major diseases commonly associated with global health. In some cases, difficult coding rules had to be made: For instance, we categorized studies on immigration, war, social media, cross-cultural issues, and traditional medicine that took place in the United States as domestically focused. Given that "'local' environments are always connected to global processes" (Neely and Nading 2017:58), we acknowledge that non-U.S. research can include topics about or taking place in the United States. While a strong argument can be made for coding those studies as focusing on issues outside of the United States, they were relatively small in number and frequently spoke to concerns based in the United States. By categorizing global health research by its country of focus, we examine the distribution of sociological resources across time and location, tracking the focus of *JHSB* and ASA health and infectious disease research, and then analyze why this is. One additional limitation is that publication bias privileges articles with statistically significant findings, which may be less of a concern among presentations made at ASA. In presenting both presentations made at ASA and publications in *JHSB*, we seek to overcome some of those limitations.

Results

Health Research beyond the United States in JHSB *and ASA*

The content analysis revealed that 87 percent of health research in *JHSB* was focused on the United States. Just 122 of 922 articles appearing in *JHSB* between 1985 and 2019, or 13.23 percent of the total, explored issues in contexts outside of the United States. Fewer than half of those 122 studies, or about 4 percent of total studies in the study period, explored health issues in industrializing nations in the Global South.[1] There is an upward trend in non-U.S. health research over time, driven largely by three recent years that each featured eight or nine articles on health outside the United States (2015, 2017, and 2019), although that growth must be tempered by the fact that issues have generally grown larger over time. Otherwise, 1989 remains the high water mark in terms of non-U.S. studies published in *JHSB*, due to a special issue devoted to health and health care in the "Third World," published that year (Figure 1).

Most studies (64 out of 122, or 52.5 percent) published in *JHSB* during the study period that focused on health issues in a country outside the United States included at least one author at a foreign institution, underscoring the greater tendency of non-U.S. researchers to conduct health research beyond the United States. More generally, *JHSB* authorship has been mostly American: just 105 out of the 922 studies included authors from institutions outside the United States (11.4 percent of the total), with the vast majority of the studies by foreign authors coming from Canada, Australia, New Zealand, or Europe.

The number of medical sociology presentations at ASA with a non-U.S. scope shows growth over time—from a low of one in 1985, to a high of 20 in 2006 and 2011. However, as the size of the Medical Sociology Section has changed over time, the percentage of medical sociology presentations at ASA involving non-U.S. health research is even more revealing. This number was slightly higher relative to the proportion of non-U.S. research published in *JHSB*, at 14.3 versus 13.23 percent. This number has reached 22 percent or more on two occasions, with a high water mark of 28 percent in 2006 and a low of 3 percent in 1985 (Figure 2).

A content analysis of presentations of the ASA's Section on Racial and Ethnic Minorities exhibits similar trends to what we find in the Medical Sociology Section. Presentations focused

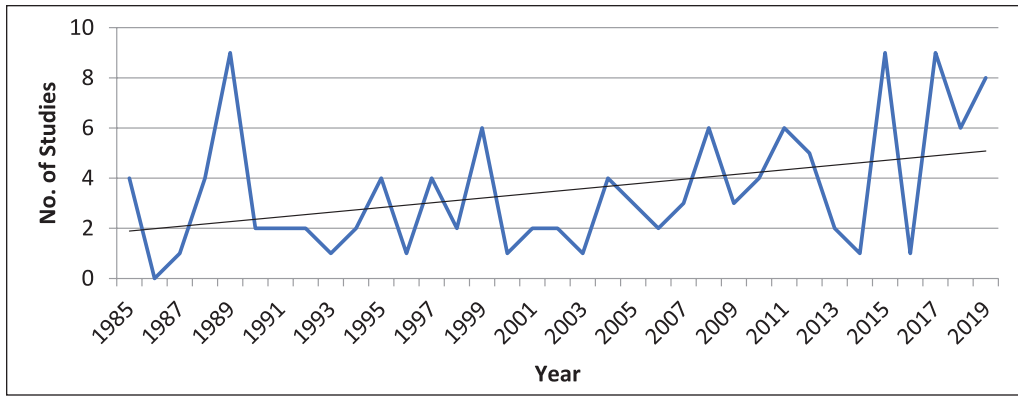

Figure 1. Number of international studies in the *Journal of Health and Social Behavior* by year from 1985 to 2019 ($n = 922$).

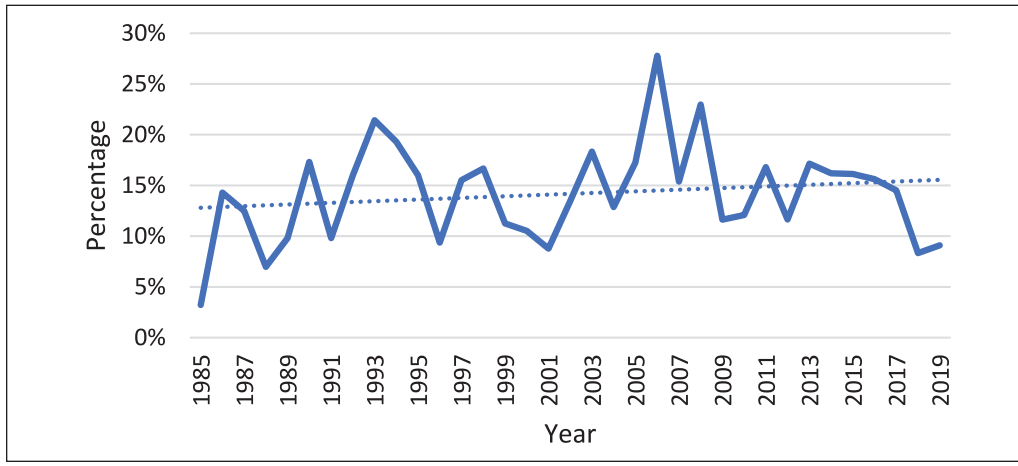

Figure 2. Percentage of international presentations in the Section on Medical Sociology by year at ASA, 1985–2019 ($n = 2,588$).
Note. ASA = American Sociological Association.

on non-U.S. cases constitute 10.5 percent and grew to 12 percent in 2019, with some variation by year (including 22 percent in 2014).

The first substantive appearances of research outside of North America at ASA came in the late 1980s. In 1989, an ASA paper session sponsored by the Medical Sociology Section included five presentations on Singapore, South Korea, Taiwan, Nepal, and Cuba, which were grouped under the broader theme of "Issues in Third World Health and Healthcare," which also appeared in the *JHSB* special issue described above. In the 1990s, medical sociologists at ASA made further efforts to examine health and health care in the non-Western world. The Medical Sociology Section hosted sessions in 1994 and 1995 on the theme of Global Perspectives on Healthcare, which included papers from various regions. A 2009 ASA session titled "What Do We Know? Key Findings from 50 Years of Medical Sociology," which included 11 presentations, did not focus at all on countries outside of the United States, nor HIV/AIDS. A year later, a session titled "50 Years of Medical Sociology: Key Findings and Policy Implications" featured nine presentations, all of which were

U.S.-focused. The primacy of domestic research within ASA and *JHSB* was also reflected in the discipline's reward system: Of the 27 Eliot Freidson Outstanding Publication Awards within medical sociology given out since its beginning in 1993 to 2019, just three works (11 percent) made non-U.S. health research their primary focus.

Engagement with Infectious Disease

HIV/AIDS has been featured in the largest number of presentations and publications of any infectious disease or NCD studied, but still occupies a relatively small proportion of overall research presented within the section on Medical Sociology at ASA or published in *JHSB.* There were 156 presentations within the section on HIV/AIDS over the 35-year study period, compared with the 79 presentations on cancer, 30 on diabetes, and 17 on heart disease (the next closest in number of the diseases studied). However, just 33 of those 156 presentations on HIV/AIDS, or 1.3 percent of the overall number of medical sociology presentations, focused explicitly on issues related to HIV/AIDS in non-U.S. contexts, where the vast majority of HIV/AIDS infections and deaths were occurring. Just 27 of 922 *JHSB* articles appearing between 1985 and 2019, or 2.93 percent of all articles published dealt with HIV/AIDS. Of the 27 articles published in the journal over that period, 8 of those explored HIV/AIDS in settings beyond the United States, or 0.87 percent of all articles published over that period.

Beginning in the early years, the focus of ASA Medical Sociology Section presentations on HIV/AIDS tended to reference HIV/AIDS in the United States, under more generic session titles such as "The Social Aspects of AIDS." A regular session on "The Social Dimension of AIDS" was added in 1986. However, this session was not affiliated with the section. In an effort to mainstream attention to HIV/AIDS in the discipline of sociology, a number of "pioneers" began publishing, teaching, and organizing sessions at annual sociology meetings, and building a *Sociologists' AIDS Network* beginning in the mid-1980s (Watkins-Hayes 2014:433–34). While a luncheon session in 1987 explicitly centered around the question, "Can Sociology Contribute towards a Solution to the AIDS Crisis?" the year 1989 proved one of the first significant periods for research on AIDS at the ASA meetings: The ASA devoted the plenary to "AIDS and the Sociological Enterprise," a theme the program itself declared as "untraditional." It was also 1989 when AIDS was first listed in the ASA program as an official topic under the heading of Medical Sociology. Members of the Sociologists' AIDS Network played a role in developing some of these sessions and roundtables—for example, co-sponsoring a domestically focused session with the section.

Conversations about HIV/AIDS within the section at ASA reached a high point in 1991, when 11 presentations were devoted to HIV/AIDS in domestic contexts. While presentations focused on HIV/AIDS outside of the United States have grown since the beginning of the study period, the Medical Sociology Section hosted its first presentation in 1993 on HIV/AIDS outside of the United States. In 1994, AIDS became a distinct topic listed in the conference program index. From 1989 on, the number of presentations on HIV/AIDS hosted by sections other than Medical Sociology has dwarfed those hosted by the section. Presentations on HIV/AIDS outside of the section have totaled 30 or more on four occasions (1994, 2005, 2009, and 2010), with more than 15 of those presentations being international in 2005, 2009, and 2010. These presentations have not been concentrated in any one single section but, for example, took place across 19 different sessions and roundtables in 2005 sponsored by various sections. In 2007, the *Annual Review of Sociology* published its first review of sociological literature related to HIV/AIDS (Heimer 2007).

Even as the number of people who fell victim to AIDS mounted globally, research on the international dimension of HIV/AIDS within the Medical Sociology Section venues did not appear at ASA at all for 17 of the 35 years under study. The number of presentations on HIV/

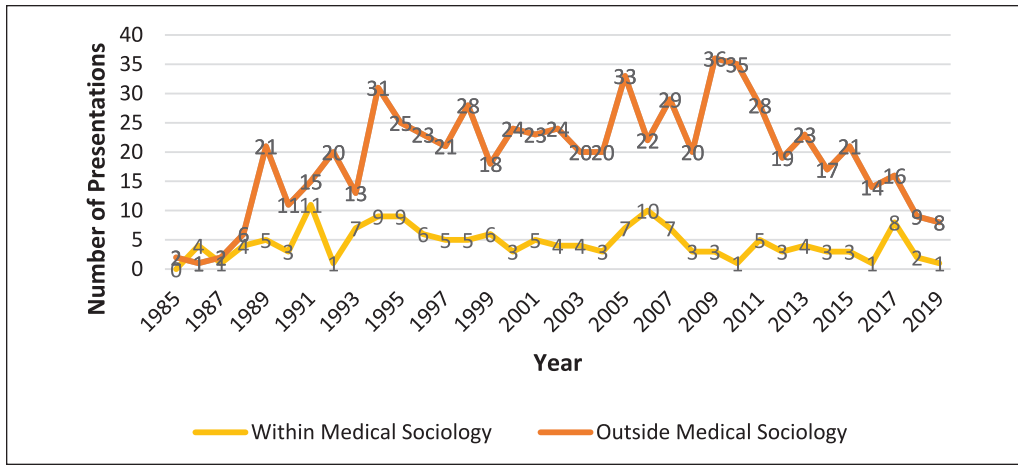

Figure 3. Number of presentations on HIV/AIDS inside and outside medical sociology at ASA, 1985–2019.

Note. HIV = human immunodeficiency virus; AIDS = Acquired Immunodeficiency Syndrome; ASA = American Sociological Association.

AIDS in medical sociology shows a slight downward trend, with less than five per year on average, and the proportion of presentations on HIV/AIDS actually falls. Since 2008, with the exception of 2011 and 2017, the number of presentations on HIV/AIDS within the Medical Sociology Section has been below the average for the study period. More broadly, within the ASA, the number of presentations on HIV/AIDS has grown over time but has remained relatively flat since the early 1990s. There have been about 5.94 times as many presentations on HIV/AIDS in non-U.S. contexts *outside of* sessions and roundtables sponsored by the Medical Sociology Section than those within it, with 196 presentations taking place outside the section compared with just 33 presentations within it (Figure 3). Yet these 196 presentations represent all of the presentations taking place *across all sections* within the discipline at ASA over 35 years, and these presentations have occurred in venues sponsored by a wide range of sections.

More generally, infectious disease research has not been a major research focus at presentations within the Medical Sociology Section or within the section's official journal. We find a miniscule number of presentations on other major infectious diseases that have been prominent in the Global South. Over the same 35-year period, there were just seven presentations within the Medical Sociology Section on TB, with six of the seven focused on either the United States or Canada. There were three presentations on SARS (two by Chinese researchers) and no presentations within the section on malaria, diarrheal disease, Ebola, or MERS. We see similar trends on infectious diseases more generally within the ASA as a whole. The first presentation on diarrheal disease did not take place until 1995 (on Ecuador), with the next and only other one in 2000 (on Vietnam). There were seven total presentations on malaria, with the first not appearing until 2009 (with four of those by the same person and two others by another). There was also a total of 11 presentations on TB at the ASA over 35 years, including the ones within the Medical Sociology Section, with the first taking place in 1998. Of those, eight focused on TB in the United States and/or Canada. SARS generated relatively more interest, because it surfaced in 2002, in a shorter time period with eight presentations (nearly all by scholars from Asia) taking place over an 11-year period (2004–2014). There were three presentations on Ebola (two by the same person) and none on MERS over the study period. The amount of published work in the official journal of the section on other infectious diseases is even fewer. There was just one article on diarrheal

disease (on the United States), one article on malaria (on Guinea in 1989), and two articles on TB (one on the United States). There were no articles published in *JHSB* on SARS, MERS, or Ebola during the study period.

NCDs

With the exception of stroke, on which there were just nine presentations in total over 35 years, research on NCDs at ASA was comparatively plentiful, with 16 on respiratory illness, 51 on heart disease, 63 on diabetes, and 200 on cancer. However, the total number of presentations on HIV/AIDS at ASA (834) dwarfed the number on cancer by more than four to one (within medical sociology by 2:1 with 156 on HIV/AIDS and 79 on cancer), underscoring the exceptional attention that the AIDS pandemic has received relative to other diseases (Benton 2015). And even though the problem of NCDs has been recognized as a growing problem among industrializing countries for some time, sociological research on NCDs was almost exclusively focused on the United States, including all of the ASA presentations on stroke, 13 of the 16 presentations on respiratory illness, 58 of the 63 on diabetes, 47 of the 51 on heart disease, and 190 of the 200 on cancer.

In all cases, presentations on NCDs took place more frequently outside of the section on medical sociology than within it. The number of publications on NCDs in *JHSB* largely mirrored the frequency of presentations at ASA except by a lower magnitude. Over the 35-year period, 6 articles were published on stroke, 8 on respiratory illness, 15 on diabetes, 19 on heart disease, and 22 on cancer. Once again, research on NCDs was almost exclusively focused on the United States, including all of the presentations on stroke and heart disease, 6 of the 8 on respiratory illness, 14 of the 15 on diabetes, and 21 of the 22 on cancer. An article on Indonesia was the only non-Western country featured in *JHSB* on respiratory illness over the period. The findings presented here suggest that research in two mainstream sociological platforms is not always responsive to trends related to disease itself, or the surrounding aspects of disease occurring in government, higher education, international agencies, media, or the public. The AIDS epidemic may have received more funding and attention than other diseases due to "HIV exceptionalism," and work on AIDS dwarfs that of research on TB and malaria in these venues. However, research on these topics as a whole—as well as work on noncommunicable and infectious diseases—occupies a somewhat marginal position at the official meeting and journal of U.S. medical sociology. In addition, non-U.S. HIV/AIDS research is a fairly recent phenomenon, despite the fact that affordable technologies turned a fatal illness into a chronic one beginning in the late 1990s. If the data demonstrate a lack of flagship research on infectious disease, NCDs, and health outside of the United States, then an important question remains: why?

Theory-building, Journal Reputations, and Temporality

Interviews revealed interlocking cultural processes and institutional arrangements that have shaped how and why certain sociological knowledge finds a "home" in *JHSB* and at ASA.

While *JHSB* editorial statements can "indicate a desire to broaden the scope of submissions" (Clair et al. 2007:255), our data show that health research beyond the United States did not appear significantly more during these editors' tenures. More than half of the eight editorials from new *JHSB* editors during the study period explicitly called for international, global, or cross-national work. The editors wrote of a desire to expand research to include "comparisons of different national health care systems" (1994), "health in a global context" (2001), "[p]apers that place the U.S. system of health or mental health care in an international or comparative context" (2005), and "studies of national or international health care systems" (2008). Likewise, ASA section chairs have some power to set agendas by selecting session themes; however,

chairs are also constrained by the research conducted, submitted, and selected by persons appointed as organizers.

One international health researcher acknowledged that the tendency of American medical sociologists to focus on the United States was "understandable. It is the American Sociological Association. Most of its members are American, most of its members are trained in the U.S." Two others described international health research within medical sociology as being marginal or a concern of a subset of researchers. According to one ASA officer, it is "not uniquely the charge of the field" to focus on health beyond the United States because "we have national and international groups whose focus that is," although one international health researcher pointed to a decline in involvement in the International Sociological Association's (ISA) Research Committee 15 (Sociology of Health) by Americans in his lifetime. Editors and ASA officers mentioned that scholarship on HIV/AIDS—similar to broader international work—has often lacked theoretical implications, making it less relevant to sociologists and therefore less likely to appear in mainstream research settings. Several editors and chairs also stated that health demographers had carved out a role conducting mostly theory-free and "pragmatic" international and global health research. According to one former editor, global health research is "chiefly demographic—things like infant mortality—and epidemiological things, like feeding programs . . . so real pragmatic stuff." With the mission of *JHSB* to both apply and advance sociological theory, several respondents agreed that international work, and research about HIV/AIDS, is not very theoretical, making it less relevant to sociologists. "God love the demographers, but they're not what we would call theoreticians," one former chair commented. In addition, some demographers' institutional affiliations in schools of public health, for instance, might predispose them to seek to publish more in medical and public health journals where they have a policy impact.

Although *JHSB* has sporadically featured some research on the Global South, including work on macro-organizational issues such as health care systems, it has become defined by micro-level issues, including health disparities. As two scholars conducting international health research noted, research published in *JHSB* has traditionally focused on individual-level analyses (including individual health behaviors, experiences, and outcomes), mainly on the United States—in contrast to research on macro-organizational structures, global governance, policy making at the national level, or policy outcomes. This is in part due to the availability of large data sets, "like Add Health . . . that just allow [for] a lot of exploration," but also perhaps because public health research has historically focused on the individual, even with improvements "accounting for social determinants of health [and other] contextual issues." Even though *JHSB* remains the flagship journal of the subfield, other journals – such as *Social Science and Medicine* – may informally be becoming more accepted venues for publications in areas related to non-U.S., global, or international health.

This is not to say that publishing research from and/or on the Global South in the premier journal of the section is impossible. However, perceptions of editors and researchers can dictate both where work is sent and how it is received. One international health researcher with deputy editor experience at *JHSB* noted that while *JHSB*

> doesn't specialize in international studies, it does print "good work" . . . [by contrast] *Social Science & Medicine* . . . has taken it upon itself to publish papers from Third World Countries in particular that might not otherwise be published, so you do see more international work in their pages.

One international health researcher explained that a manuscript he or she submitted to *JHSB* had been rejected on the grounds of lack of good fit with the journal, even though the work fell within the journal's stated scope and aims. These kinds of experiences call into question how editors and reviewers assemble notions of what constitutes "good work" (beyond issues related to formatting

and theoretical engagement), and may also help to explain why international health researchers sometimes look beyond the official journal of the section for publication homes for their work, even if it might be less beneficial for tenure and promotion. As one editor explained,

> One of the reasons why *JHSB* wasn't heavily focused on [international] work was that there were other health journals and sociology journals and multidisciplinary journals that specialized in that kind of thing. So there's a sense in which journals have their mind space that they cover, and a lot of that was covered in other journals, and so people sending things to a journal would rather send it and see it published in those other journals because that's where people looking for that kind of work would go.

With the different "mind space" of journals, *JHSB* editors commented they did not receive much non-U.S. research. Another officer summarized the process of research submissions: "If you don't see it there you won't send it there; if you don't send it there you won't see it there." This "mirror theory" of published sociology contributes to a "self-fulfilling prophecy," in which "authors submit articles that look like the articles they read in particular journals" (Clair et al. 2007:255).

Informants also noted how the journal production timeline impacts submissions on emergent health issues beyond the United States, such as infectious disease. Some described the publication process as a "slow" and "extended" conversation, which made *JHSB* an insufficient venue for addressing HIV/AIDS in the beginning of the epidemic. Said one officer: "You can't have news of the minute that's going to affect an epidemic with [*JHSB*'s] long queue, so you have to publish in a public health journal where the news gets out because people are dying." As the publication lag delimits the ability for sociologists to respond to an immediate "crisis" such as SARS or Ebola, we can see how ASA roundtables can instead serve as a platform to address timely issues—for instance, in a 2005 session titled "Situational Responses to SARS," scholars gathered to focus on the international outbreak.

This again illustrates how perceptions govern publication choices, and helps explain why some feel that work on HIV/AIDS and other diseases may be better suited in other journals and presentation outlets. In some cases, sociologists publishing work on HIV/AIDS have done so in other specialty journals, such as the *Journal for Substance Abuse Treatment* and *AIDS*. Medical and epidemiological journals can often have higher impact factors, which might attract global researchers; for instance, the *New England Journal of Medicine*'s impact factor is 70.67, compared with 2.419 for *JHSB*. Although demographers and epidemiologists have contributed to work on AIDS in other journals and conferences, research on HIV/AIDS in two highly visible venues of "professional sociology" (Burawoy 2005) surveyed here came late in the course of the epidemic, perhaps in part due to the time it takes to make large survey data publicly available.

Despite the fact that editors and section chairs maintain their own research agenda and theoretical focus, respondents emphasized that "the field just has its own momentum," independent of who is in charge. One editor explained the process of journal editorship as:

> watching an amoeba move across space . . . You're publishing the best of what comes in, and the best of what comes in kind of has this amorphous shape—but it does have a shape, it has some boundaries, it is going in a certain direction—kind of self-directed and with occasional pods helping to move it forward.

This momentum of research appearing in different journals or conference venues demonstrates that individual actors, such as editors and chairs, may only play so much of a role in gatekeeping given broader disciplinary divisions, timelines, and "mind space" of these knowledge outlets. In addition, the field is fragmented across different sections. One international health researcher

noted that his or her work on health issues in the Global South was not a perfect fit in any one section, as it "kind of falls in this place where it's partially medical sociology and partially a different subfield like—sociology of development, or global transnational sociology." Putting out a broad editorial call is not typically enough to generate certain research, although special issues can attract particular topics. Instead, the "momentum of the field"—combined with timelines, methods, and theories—shapes the "mind space" of research that appears in these knowledge outlets.

Funding Constraints, Data Sets, and Professional Rewards

Informants mentioned how material constraints—such as funding, data technologies, and professional rewards—impact the production of sociological research beyond the United States that then appears in mainstream venues. Jeffrey Michael Clair et al. (2007) suggested that medical sociologists take advantage of new branches of NIH (National Institutes of Health) funding to "embark on new disciplinary shifts." While one of our informants did point to the way in which NIH research had enabled some international health research, 15 interviewees emphasized that funding agencies do not encourage international work, privileging instead biomedical, individually focused paradigms, which are "rigged" toward "normal science," as one former editor stated. One international health researcher noted that there was no analogous funding agency that existed to support research on health-related organizations (as opposed to individuals). Twelve respondents explicitly named NIMH (National Institute of Mental Health) and/or NIH as federal agencies with importance for medical sociologists. These opportunities prove especially important for those at major R1 universities or in "soft money" jobs at Schools of Public Health. Yet, according to one former section chair,

> The NIH has moved away from focusing on different countries. Certainly they're not interested in multiple country studies . . . American sociology has always been fairly ethnocentric and it is also affected by funding: by the unwillingness—or "we have to sell your first child to the NIH" if you want to do something outside the U.S.

While it is important for sociologists to "drive the new basic research agenda at NIH" (Hillsman 2003:2 cited in Clair et al. 2007:256), there exist constraints in how many training grants are made available and opportunities for sociologists to access resources. According to a former editor, NIH funding "creates a particular mindset . . . [and] there is a path dependence with a vengeance." The "mindset" of the field as a whole—a recurring theme in our interview data—is structured by funding agencies that privilege U.S. work. The Robert Wood Johnson Foundation has also helped fund the training of medical sociologists, although long-standing programs typically focus on health in the United States. The potential of major funding streams to move the subfield in a more international direction had thus far proved elusive.

Editors and ASA officers alike mentioned that the discipline of sociology has historically lacked the "technology" of international health data sets to provide comparative examples. This then limits what research appears in the section's flagship research venues. "We have to have surveys here similar to surveys there and vice versa, and that just has to grow over time," said one former editor. Another agreed that with "so many major and longitudinal data sets available in the U.S. . . . it's very easy to focus inward." The absence of large data sets, according to a former officer, limits sociologists' abilities to make "larger, bolder structural comparisons." With the emergence of data sets and an increased sharing of research via the Internet, respondents also affirmed that sociologists could do more work beyond the United States, as the "quality and comparability" of data improve. Two major exceptions are Demographic and Health Survey data and the Gateway to Global Aging Database.

Six informants also described how producing health research outside of the United States might not pay off given the discipline's professional rewards system. With the current trends of the discipline—or, as one respondent said, its "fads and fashions"—research that analyzes the functioning of different health care systems often lacks a dependent variable or process, which, according to a former officer, are key elements that sociologists are "fundamentally interested in now." Said one former officer:

> If you're doing a comparative study of many countries, you're going to get the same kind of credit as you are if you do a study of a single community where you're living, so that the incentives are not there to do more ambitious kinds of work. I think international work by its nature is going to take a lot more time. So just the whole system of professional rewards is such that it's set up so there's really a disincentive in sociology to do international work.

One international health researcher likewise noted that long-term ethnographic international work poses a "career challenge," in that it is difficult to "find the resources and time . . . doing detailed research in other national settings." Two international health researchers explicitly mentioned the additional challenge scholars conducting international health research face in having to justify the relevance of their work to and/or make their work legible for a "mainstream" U.S. audience, with one pointing out that the U.S. centrism of the field is often implicit: "I'm often amazed articles about the U.S. do not explicitly reference the U.S. in their abstracts." Another international health researcher added, "There's a kind of assumed [methodological] nationalism and an assumption that one can generalize about broad social political questions from work just in the U.S."

With scholars seeking tenure and publications, what some called the "ambitious" work of non-U.S. research might prove too cumbersome for those seeking professional advancement. This sentiment was further reflected in the low percentage of Eliot Freidson awards given to non-U.S. health research by the subfield since its inception (just 11 percent of the total). These findings harmonize with Clair et al.'s (2007:256) assessment that "[t]here are no incentives currently in pace to reward the more time-consuming endeavours" of health research beyond the United States, which is not only expensive, but frequently involves investment in language and cultural competency. However, these more time-intensive endeavors could find homes more in books.

With all of these factors, our informants noted that such cultural and institutional factors are always subject to change. Informants stated how several ASA sessions focusing on health research beyond the United States served to gather those interested in health issues outside of Europe and the United States, while a past chair noted that ASA panels related to global health have "allowed people to congregate and . . . to see who's doing work and how they conceive of global health . . ." This seems to coincide with the idea that "[t]he ASA can play a major role in helping to generate new types of work," by "applying [the discipline's] social knowledge to everyday life" (Clair et al. 2007:256). ASA panels can also feed scholarship down the "pipeline" to journals, not only formalizing academic networks but also catalyzing scholarly publications. Greater coordination between the ASA and ISA could also serve as a foreground to "stimulate more diverse submissions" (Clair et al. 2007:256). As informal and often invisible divisions become institutionalized and accepted as assumed features of the discipline, sociologists have begun to reorient the boundaries by suggesting, for instance, that research draws on anthropology to "decenter the West" (Bell and Figert 2012:781).

Conclusion

Amid new global health events and calls for sociological research on COVID-19, we have provided some insights about where the sociological "eye" (Collins 1998) has historically focused

in two prominent platforms, and why this has been the case. By charting the empirical and geographic landscapes of health and global health research presented at the section's annual conference and published in the official journal, the article underscores the "constitutively social" elements of knowledge production (Shapin 1995:289), including economic, structural, and cultural components that shape research (Casper 2016). Our findings highlight the powerful constraints that channel research in self-reinforcing directions, which may curtail scientific revolutions, or new knowledge paradigms, from emerging (Kuhn 1962:10; Pierson 1993). Especially as important empirical changes take place in the real world—such as shifting global health resources, alliances, virus spread, and containment—this analysis sheds light on the institutional and cultural factors that influence the direction and geographic scope of scientific research in prominent venues.

Content analyses of *JHSB* and ASA Conference programs illuminate the topics and locations of research within the section's official presentation and publication forums. Despite the subfield's comparatively larger focus on issues such as health disparities, social stress, and the life course in the United States, flagship research has hardly addressed how such paradigms might be lived out or rewritten in non-U.S. contexts. While medical sociologists have long been concerned with the relationship between place and health/illness, the findings suggest that research and knowledge production within ASA and *JHSB* is shaped and constrained by the interactions between different stakeholders (e.g., scholars, editors, and conference participants), institutional arrangements (e.g., funding structures, professional rewards, and journal production timelines), dataset availability, epidemiological knowledge, journal reputations, theoretical paradigms, and disciplinary expectations/boundaries. The comments from editors, chairs, and international health researchers instead demonstrate how sociological research that appears in *JHSB* or ASA is constructed within broader scientific paradigms, echoing the idea that "the scope of most studies remains defined by the institutions of biomedicine" (Collyer 2012:3). Our content analysis illustrates how the United States often remains an implicit reference point in research by American medical sociologists. We report these findings as *JHSB* publishes important new research on the underrepresentation of certain issues in relation to health inequalities (problematically in our view) grounded entirely in U.S.-focused articles (Link and García 2021).

The division between sociological research and the "pragmatic" concerns of HIV/AIDS scholarship, demography, and international/global health research raises deeper questions about the ways in which sociological research advances theory, reaches a broader audience, and/or impacts policy. Informants remarked that health economists and demographers have more of a public role than medical sociologists in reaching policy makers and media, echoing previous assessments that the discipline is "falling short on reaching a broader scientific audience" (Clair et al. 2007:256). Interviewees also affirmed the informal divisions of academic labor, both within and across disciplines, as a reason for the apparent lack of engagement in non-U.S. health and infectious disease/NCD research in *JHSB* and ASA.

While Clair et al. (2007:255–56) placed the onus on journal editors to "identify and solicit authors" and "expand calls for integrative work in other association publications," it is clear that such solicitations cannot compete with entrenched funding priorities and mindsets that shape where research is ultimately conducted, presented, or published. To a certain extent, editors may guide the content of journals by determining what is valuable and attractive research, or what does and does not belong under the heading of medical sociology, as more than 80 percent of journal submissions are typically rejected, which is not the case with ASA presentations. Section chairs contribute to agenda-setting in a small way by selecting the themes for section-sponsored sessions at ASA, as well as inviting certain scholars as session presiders and organizers.

Informants also emphasized the importance of interdisciplinarity and working in teams to broaden the aims of sociological research. For instance, interdisciplinary scholarship has conceptualized a "critical political economy of global health," which identifies how "health and disease

are produced via societal structures" and geopolitical arrangements (Birn, Pillay, and Holtz 2017:92). Sociologists can aim not only to diversify their locations of study but contribute to knowledge on the structural and cultural dynamics of health, development, and globalization (Noy 2019; see, for example, Bell 2019; McDonnell 2016; Mojola 2014; Walkover 2019). Sociological research about the "international bioeconomy" of pharmaceuticals demonstrates how global clinical trials intersect with global power relations (Bell and Figert 2012:21; Heimer 2012), exposing new layers of actors, policies, and events that extend beyond U.S. borders. And comparative research about Attention Deficit Hyperactivity Disorder (ADHD) worldwide has expanded sociological insights on medicalization by offering case studies in different country contexts (Conrad and Bergey 2014).

These more recent empirical analyses train our attention not only to different cases in geographic settings but also the distinct interconnections and global processes that reshape health and health care in various parts of the world. Furthermore, the suicide tourism industry, which offers euthanasia to foreign travelers, speaks to how end-of-life decisions are augmented in a global health care context (Sperling 2019), adding to our understanding of the relationships between place, access to resources, and death (Carr 2016). Using a global lens adds complexity to sociological insights and social processes, and might transform fundamental theories that were based on cases in the United States. For instance, gentrification operates differently in the Global South (López-Morales 2015)—and ongoing global inequalities in resources impact health and collective action on a world scale (Connell 2021).

Future research might seek to understand the geographic and empirical foci of other sections within the ASA, those of other national associations and their sections, as well as the content of other knowledge outlets to which sociologists contribute. The preliminary evidence suggests that the research landscape is indeed changing. We know, for example, that the ASA's best dissertation award has been bestowed on three people who have worked on AIDS (two in non-Western contexts), and the ASA's best book award has recently been given to two books on HIV/AIDS (including one on Kenya). Some respondents spoke about seemingly innate characteristics of sociology, but they also acknowledged its potential to shift, perhaps generating new "pods" of research and scientific paradigms. Both editors and section chairs noted the emergence of the ASA Sections on Development and Global/Transnational as being "new and different," with a potential to reshape knowledge trends; recent research has also charted the growing work in various sections of sociologists concerned with health and development worldwide (Noy 2019:4–5). Where does this work "fit"? Undergraduate and graduate curricula in sociology can also incorporate more non-U.S. research, helping to diversify student insights and interest. A former section chair noted that teaching a "decent" course in medical sociology requires a comparative and global focus. Incorporating theorists and researchers from the Global South into sociology classes is an important step to better understanding health in a global context, as well as decentering Western theories (Büyüm et al. 2020).

This article points to a number of substantive areas and places that are ripe for sociologists to contribute to research on health in a global era. With continued shifts in funding structures and new calls for research on COVID-19, how might a new generation of sociological knowledge emerge that extends beyond U.S. borders? While researchers writing about the epidemiologic transition like Abdel R. Omran (2001) and others may have initially emphasized the biomedical nature of infectious disease (and the social causes of man-made chronic illness), COVID-19 has brought the social implications of infectious disease into stark relief. Merging a sociology of pandemics (Dingwall, Hoffman, and Staniland 2013) with large COVID-19 data collection efforts by institutions such as Johns Hopkins—which have allowed for real-time tracking and analysis—might prompt greater global engagement with the social dimensions of infectious disease. If historical legacies may have unwittingly led to theoretical, empirical, and geographic gaps, understanding the contours and origins of those occlusions is one important step to

remedying them. With an awareness of the lack of research on NCDs and infectious disease in the Global South, the current moment offers sociologists an opportunity to build a more robust theory of disease and health in a global context.

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Note

1. Articles in *Journal of Health and Social Behavior* (*JHSB*) have taken up the following countries (in general order of frequency): the United States, Canada, the United Kingdom, Germany, China, Taiwan, Japan, Sweden, Russia, Thailand, Netherlands, Indonesia, Philippines, South Africa, Australia, Norway, Finland, Israel, Peru, Nepal, Kenya, Malawi, Denmark, Croatia, Austria, Italy, France, Switzerland, Belgium, Iceland, Singapore, South Korea, India, Soviet Union, Chile, Mexico, Czech Republic, Egypt, Saudi Arabia, Ghana, and Guinea. There have also been a number of cross-national/multicountry samples (a number focused on Europe but some on Organisation for Economic Co-operation and Development [OECD], Low-Income Countries, Communist Countries, Africa, South America, Latin America, Eastern Europe, Asia Pacific, and Global).

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