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Article

Social capital and HIV/AIDS in the United States: Knowledge, gaps, and future directions

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ABSTRACT

Purpose: Social capital is a well-established predictor of several behavioral health outcomes. However, we know less about the relationship with prevention, transmission, and treatment of HIV/AIDS outcomes in the United States (US).

Methods: In 2017, we conducted a scoping review of empirical studies investigating the relationships between social capital and HIV/AIDS in the US by searching PubMed, Embase, PsycINFO, Web of Science, and Sociological Abstracts with no restriction on publication date, for articles in English language. Sample search terms included: HIV infections OR HIV OR AIDS OR acquired immunodeficiency syndrome OR human immunodeficiency virus AND social capital OR social control, informal OR social participation OR social cohesion OR generalized trust OR social trust OR collective efficacy OR community mob* OR civic participation.

Results: We identified 1581 unique manuscripts and reviewed 13 based on eligibility criteria. The earliest eligible study was published in 2003. More than half ($n=7/13$) focused on HIV or AIDS diagnosis, then prescribing ART and/or adherence ($n=5/13$), then linkage and or engagement in HIV care ($n=4/13$). Fifty eight percent (58%) documented a protective association between at least one social capital measure and an HIV/AIDS outcome. Seven studies used validated social capital scales, however there was substantial variation in conceptual/operational definitions and measures used. Most studies were based on samples from the Northeast. Three studies directly focused on or stratified analyses among subgroups or key populations. Studies were cross-sectional, so causal inference is unknown.

Conclusion: Our review suggests that social capital may be an important determinant of HIV/AIDS prevention, transmission, and treatment outcomes. We recommend future research assess these associations using qualitative and mixed-methods approaches, longitudinally, examine differences across subgroups and geographic region, include a wider range of social capital constructs, and examine indicators beyond HIV diagnosis, as well as how mechanisms like stigma link social capital to HIV/AIDS.

1. Introduction

Social capital, broadly, is conceptualized as collective resources generated through social connections that individuals or groups can access (Kawachi & Berkman 2014). Social capital has been identified in several theoretical models as a potential determinant that influence Human Immunodeficiency Virus (HIV) prevention and transmission at the individual and population levels (Poundstone, Strathdee, & Celentano, 2004; Latkin & Knowlton 2005; Pellowski, Kalichman,

Matthews, & Adler, 2013). However, relative to socioeconomic determinants such as poverty (Johnston 2013; Buot et al., 2014), the association between social capital and HIV has received limited attention.

Social capital research has evolved beyond a debate that considered the construct as either an attribute of individuals or attribute of groups (Lochner, Kawachi, & Kennedy, 1999; Kawachi & Berkman 2014). Studies now typically include indicators that facilitate measuring the construct at multiple levels. Researchers therefore, need to specify beforehand the conceptual definitions, theory of proposed mechanisms/

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pathways, and levels of measurement relevant for their research topic (Halpern 2005; Villalonga-Olives & Kawachi 2015). The validity and choice of measures selected can impact whether empirical studies find that social capital is beneficial, detrimental, or has no association with health (Harpham, Grant, & Thomas, 2002). For instance, social capital has been assessed with numerous indicators that included cognitive-related items such as trust, reciprocity, and a sense of belonging which is conceived of as components of social cohesion. On the other hand, structural-related items include network ties, participation and or membership in civic/social organizations, collective action, and informal social control among residents (Harpham et al., 2002; Kawachi, Kim, Coutts, & Subramanian, 2004).

There has been substantial work documenting the associations between social capital and behavioral health outcomes that include mammography screening (Dean et al. 2014), tobacco use (Lindstrom, Moghaddassi, Bolin, Lindgren, & Merlo, 2003), and dental care use (Pattussi, Hardy, & Sheiham, 2006; Chi & Carpiano 2013). However, there is limited work in relation to sexually transmitted diseases, particularly HIV and Acquired Immune Deficiency Syndromes (AIDS). One systematic review of social capital and health published in 2008 identified only three studies that assessed an association with infectious diseases including gonorrhea, syphilis, Chlamydia, AIDS, and tuberculosis (Kawachi, Subramanian, & Kim, 2008). Based on that 2008 review, there remains a paucity of research today and there is no updated systematic knowledge of the topic since.

To date, many of the studies that investigated the association between social capital and HIV/AIDS outcomes are based on populations within Sub-Saharan African countries (e.g., Zimbabwe, Swaziland, and South Africa) where HIV is characterized by a generalized epidemic (i.e., HIV prevalence > 1% in the population in some regions and among some key populations). Although the direction and significance of associations of findings across these studies are mixed, the larger weight of evidence suggests that social capital has beneficial or protective impacts (both at the population-level and among individuals) on HIV/AIDS-related outcomes such as lower HIV incidence, risk of infection, and increased adherence to antiretroviral medication use (Gregson, Terceira, Mushati, Nyamukapa, & Campbell, 2004; Ware et al., 2009; Gregson et al., 2011; Campbell et al. 2012; Campbell et al., 2013; Frumence et al., 2014). Both qualitative and quantitative research have identified mechanisms through which social capital facilitates beneficial or protective impacts. For instance, social capital was a conduit to: influence social norms that decreased HIV stigma (Nhamo-Murire, Campbell, & Gregson, 2014a; Nhamo-Murire, Campbell, & Gregson, 2014b); to normalize HIV-prevention behaviors; and to increase economic support, which facilitated agency with sexual decision-making among marginalized groups (Frumence, Eriksson, Nystrom, Killewo, & Emmelin, 2011; Frumence et al., 2014). While those studies among international populations provided rich contributions, we know little about the direct associations and pathways/mechanisms between social capital and HIV/AIDS outcomes in the United States (US) population. Findings from the Sub-Saharan African context may differ from the US context because of dissimilarities in geographic location, socio-political environments, resource availability, and because the US is characterized by multiple concentrated HIV epidemics (i.e., HIV is < 1% in the general population but exceed > 5% in at least one subpopulation) (Denning & DiNenno 2013).

In the US, HIV is a persistent public health problem. More than 1.1 million people are living with HIV today with an estimated 39, 782 newly diagnosed in 2016, across the contiguous states (Centers for Disease Control and Prevention 2017). Given the importance of social capital as a potential determinant of HIV prevention and transmission, and because there is limited research on this topic specific to the US context, we conducted a scoping review of empirical studies that investigated the relationships between social capital and primary and secondary HIV care continuum outcomes (e.g., HIV testing, diagnosis, prescription of ART) (Mugavero, Amico, Horn, & Thompson, 2013;

Horn et al., 2016) in the US. In this review, we identify the state of research, current gaps, and discuss implications for prevention, and directions for research.

2. Methods

Scoping reviews are designed to examine the “extent, range, and nature of research activity, summarize and disseminate research findings, and identify gaps in the existing literature” (Levac, Colquhoun, & O’Brien, 2010). Therefore, unlike a systematic review, our scoping review did not assess the quality of included studies nor set out to test a specific hypothesis from the metadata collected within the studies (Levac et al., 2010; Khalil et al. 2016). Rather, this scoping review was intended to assess the breadth and depth of the spectrum of knowledge in these topical areas (Khalil et al., 2016; Tricco et al., 2016). We used a 5-step approach as outlined by Khalil et al. (2016): identifying the research topic; identifying the relevant studies; selecting studies; presenting the data; and collating the results.

2.1. Search strategy

We identified, extracted, and reviewed relevant research studies based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff, & Altman, 2010). We included quantitative, qualitative, and mixed-methods empirical studies that reported original results across all study design types (e.g., observational, or experimental). In January 2017, we searched PubMed, Embase, PsycINFO, Web of Science, and Sociological Abstracts, with no restriction on publication date, for articles in English language. Search terms were: “HIV infections” OR “HIV” OR “AIDS” OR “acquired immunodeficiency syndrome” OR “human immunodeficiency virus” AND “social capital” OR “social control, informal” OR “social participation” OR “social cohesion” OR “generalized trust” OR “social trust” OR “collective efficacy” OR “community mob*” OR “civic participation” OR “group cohesion” OR “community group membership” OR “community engagement”. Additional manuscripts were added through searching forward citations. At this stage, we kept broad terms such as HIV or AIDS because they also included HIV-continuum specific terms such as diagnosis. Similarly, we also searched broad social capital terms such as social cohesion because results frequently included articles that discussed all forms of social capital such as bridging, bonding, and linking.

2.2. Selection criteria

Inclusion criteria were: (1) peer-reviewed journal articles; (2) conducted on or included a US sample; (3) focused on HIV-related outcomes preceding, along, and after the HIV care continuum (Horn et al. 2016), including: HIV testing, HIV diagnosis, linked to or engaged in HIV care, retained in HIV care, prescribed antiretroviral therapy (ART), viral suppression, and HIV/AIDS-related mortality; and (4) measured directly or conceptually aligned with social capital (e.g., social cohesion and organizational participation) to identify operational and conceptual distinctions. We excluded articles that: (1) only focused on sexual or drug use behaviors related to HIV (e.g., condom use or heroin use) as the primary endpoint and did not quantify those behaviors with any HIV continuum outcome; (2) other systematic reviews and meta-analyses; (3) studies that did not report data or results (e.g. theoretical or conceptual papers); and (4) non-empirical papers. We considered social network analysis as conceptually distinct from social capital, so we did not search social network terms such as egocentric or centralization. A protocol for our search was developed and published online at the International Prospective Register of Systematic Reviews/PROSPERO (ID=CRD42017070026). Two researchers (KT, MS) independently screened titles and abstracts against inclusion and exclusion criteria and YR, LD reviewed results with KT. Any discrepancies

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