Summary of CDC Consultation to Address Social Determinants of Health for Prevention of Disparities in HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis

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SYNOPSIS

In December 2008, the Centers for Disease Control and Prevention (CDC) convened a meeting of national public health partners to identify priorities for addressing social determinants of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), viral hepatitis, sexually transmitted diseases (STDs), and tuberculosis (TB). The consultants were divided into four working groups: (*1*) public health policy, (*2*) data systems, (*3*) agency partnerships and prevention capacity building, and (*4*) prevention research and evaluation. Groups focused on identifying top priorities; describing activities, methods, and metrics to implement priorities; and identifying partnerships and resources required to implement priorities. The meeting resulted in priorities for public health policy, improving data collection methods, enhancing existing and expanding future partnerships, and improving selection criteria and evaluation of evidence-based interventions. CDC is developing a national communications plan to guide and inspire action for keeping social determinants of HIV/AIDS, viral hepatitis, STDs, and TB in the forefront of public health activities.

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Many scientists, physicians, and others are now considering the total ecology of population health outcomes, which includes complex, integrated, and overlapping social structures and economic systems, collectively referred to as social determinants of health (SDH). SDH are the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole. SDH include, but are not limited to, conditions for early childhood development; education, employment, and work; food security, health services, housing, income, and income distribution; social exclusion; the social safety net; job security; and the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole.[1]

In 1988 and 2003, the Institute of Medicine emphasized and reiterated the role of public health as a collective societal function to ensure health for all people.[2,3] Likewise, the World Health Organization (WHO) called for addressing the hegemonic conditions and inequalities that contribute to disease morbidity and mortality in developed and developing countries. The WHO Commission on Social Determinants of Health[4] charged public health officials worldwide to provide action to:

> ". . . improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age. . . . Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally. . . . Measure and understand the problem and assess the impact of action—measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health."[4]

BACKGROUND

During the past 30 years, an increase in published scientific evidence has demonstrated that many chronic and infectious diseases do not occur at random in populations, and genetic predisposition for illness may only minimally explain why some people become sick and others do not.[5–10] Apart from those that are genetically inherited, many diseases and conditions cluster in socially and economically vulnerable populations.[9] Health disparities in diseases may occur by gender, race/ethnicity, education, income, disability, geographic location, and sexual orientation, among many other factors. SDH such as poverty, limited access to health care, lack of education, stigma, and racism are linked to health disparities.[8,11,12]

Despite prevention efforts, some groups of people are affected by human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), viral hepatitis, sexually transmitted diseases (STDs), and tuberculosis (TB) more than other groups.[13] In the United States, studies have examined SDH and health outcomes for people with HIV, viral hepatitis, STDs, or TB. Several studies have focused primarily on demographic social determinants, such as age, area of residence, sex, and race/ethnicity. For example, black people are affected by HIV and other STDs at a rate of six to 18 times—and Hispanic individuals, two to four times—the rate of white people.[14,15] TB is a problem among both Hispanic and black populations, with rates eight to nine times that of white populations.[16] Men who have sex with men (MSM) are disproportionately affected by HIV and STDs.[14,15] In 2007, two-thirds of all new HIV/AIDS diagnoses were among men, and half of all new diagnoses overall were among MSM.[15] Similarly, the male-to-female ratio of primary and secondary syphilis in 2007 was 6:1; this may suggest that a large number of primary and secondary syphilis cases may be among MSM.[14] Rates of hepatitis B remain highest among non-Hispanic black populations, and hepatitis C continues to occur in adult age groups, with injection drug use as the most commonly identified risk factor.[17]

Demographics related to age, race/ethnicity, and gender continue to be critical in identifying disease patterns and health disparities; but studies looking at the socioeconomic determinants of health, such as employment, income, and education level, are revealing equally critical information. For example, studies show that black MSM at lower income levels are more likely to engage in high-risk sexual behaviors that put them at greater risk for acquiring STDs, compared with black MSM with higher income levels.[18,19] Another study shows that although the burden of hepatitis C is greater among some racial/ethnic groups, mortality is largely influenced by the individual's socioeconomic condition.[20] Studies also have shown that HIV-infected people with low literacy levels had less general knowledge of their disease and disease management, and were more likely to be nonadherent to treatment than those with higher literacy levels.[21,22] In addition, a population-based study conducted by Diaz and colleagues found that income was an important predictor of lack of health insurance among people with HIV/AIDS,[23] and, consequently, these people may be less likely to receive treatment.

Environmental social determinants, such as housing conditions, social networks, and social support, are also key drivers for HIV/AIDS, viral hepatitis, STDs, and TB. Kidder et al. conducted a study among housed and

homeless individuals with HIV/AIDS and found that homeless people with HIV/AIDS had poorer health status, were less adherent to medication regimens, and were more likely to be uninsured and to have been hospitalized.[24] Social networks also play a role in fueling the spread of HIV and other STDs[25–28] and have been shown to influence adherence to TB drug therapy.[29]

A recent important focus of public health organizations in the U.S. is the identification of common SDH across subpopulations disproportionately affected by disease so that integrated interventions can be developed. Healthy People (HP) 2010 emphasized the need to collect data that will help drive the elimination of health disparities. Further, HP 2010 stressed the "need for communities, states, and national organizations to take a multidisciplinary approach to achieving health equity—an approach that involves improving health, education, housing, labor, justice, transportation, agriculture, and the environment."[30] Despite such efforts, some health disparities remain.[31] Because of persistent health disparities, HP 2020's overarching framework explicitly states the importance of achieving health equity through the use of a systematic approach for addressing SDH.[32]

Concern for addressing SDH is not new to the Centers for Disease Control and Prevention (CDC). Since at least 1993, CDC scientists have worked to include measurement of social determinants in health outcome studies for HIV/AIDS, STDs, and TB,[23,24,29,33] and more recently have expanded evidence-based behavioral interventions to address ecological contexts of risk behaviors.[27,34–36] Responding to disparities in chronic diseases such as diabetes, CDC took up the charge to address SDH by forming a workgroup on SDH[37] and holding a forum in 2003 to discuss root causes of health disparities.[38] In addition, an Office of Health Disparities for CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention was established in 2003.

PURPOSE OF CONSULTATION

On December 9 and 10, 2008, CDC hosted an external consultation in Atlanta to identify key short- and long-term priorities for addressing social determinants of HIV/AIDS, viral hepatitis, STDs, and TB. The consultation offered an opportunity for leading academic, scientific, public health, and community partners to discuss more effective ways to address social determinants of HIV/AIDS, viral hepatitis, STDs, and TB at CDC in the areas of public health policy, surveillance and epidemiology, agency partnerships and prevention capacity building, and prevention research and evaluation.

DESCRIPTION OF PROCESS

Consultants were charged with developing justifiable suggestions for addressing SDH in four content areas—public health policy, surveillance and epidemiology (including data systems), agency partnerships and prevention capacity building, and prevention research and evaluation. Consultants self-selected into four content-area groups and remained together through a three-tiered, problem-solving series of breakout sessions. The objectives of the three sessions were to (*1*) discuss the most important issues regarding SDH and the content area and identify a list of suggestions for addressing them, (*2*) prioritize the list of suggestions in order of urgency or importance and provide justification of priorities, and (*3*) select the top three priorities from the list and suggest plans for implementation. Implementation plans were to include suggestions for partnerships, resources, program evaluation, and strategies to overcome implementation barriers.

SUMMARY OF KEY SUGGESTIONS FROM CONSULTATION

Consultants provided focused guidance on specific actions CDC should take to develop and advance the SDH effort at the national level. They are as follows:

Public health policy

1. Provide leadership and align efforts with those of the U.S. Department of Health and Human Services (HHS) and WHO.
2. Convene a national agenda-setting meeting.
3. Partner with other federal agencies, nongovernmental organizations, private foundations, and philanthropic organizations that have an interest in reducing health disparities.

Data systems

Identify key data elements and measurements that will be needed to develop and launch the national SDH effort. To achieve this goal, CDC should:

1. Create relevant SDH metrics that would be monitored by subject matter experts.
2. Add SDH to CDC data-collection systems.
3. Share, link, and integrate data to the extent possible, to facilitate analyses and provide an evidence base. Identify and utilize other agencies' datasets and systems where feasible.

Agency partnerships and prevention capacity building

1. Enhance partnerships from both traditional and nontraditional sources to strengthen the SDH effort.
2. Build capacity among partners in SDH by including language in funding-opportunity announcements that would require state and local grantees to collaborate with and reach out to partners at state and local levels.
3. Launch a nationwide social marketing campaign to strengthen the relationship between CDC and at-risk populations and engage a broader group of partners in delivering messages on infectious diseases.

Prevention research and evaluation

1. Reframe traditional strategies based on individuals and broaden targeted groups on the basis of families, communities, systems, partnerships, and organizations, for example.
2. Integrate a holistic and interdisciplinary approach to conducting prevention research.
3. Advance toward participatory research, in which communities are engaged at the beginning stage of conceptualizing studies through the final stages.

CONCLUSION

The consultation was successful in identifying key priorities in four content areas. The priorities and suggestions gleaned from these discussions are an integral part of CDC's development of an SDH strategy, with clear goals and objectives to address health disparities in HIV/AIDS, viral hepatitis, STDs, and TB. Participant input provided the basis from which CDC will create a road map for key goals to assess accountability and evaluate progress in achieving the goals and objectives over time. The consultation demonstrated partners' commitment to address SDH and their enthusiasm to broaden the conversation about SDH to include traditional and nontraditional federal and private-sector partners who are concerned about reducing health disparities. CDC is committed to addressing SDH more broadly and to developing public health programs, research, and initiatives to positively impact the lives of those at risk for disparities in infectious and chronic diseases, with the ultimate goal of promoting health equity for all Americans.

The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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