

The background is a textured, light brown paper. On the right side, there is a large, irregularly shaped piece of paper that has been torn away, revealing a dark purple color underneath. In the bottom right corner, there are two overlapping curved shapes: a brown one on top and a green one on the bottom.

Justice For All

A Population Approach to Health Disparities

By Jasmine Banks & Sharon Tregaskis

Illustrations by Alex Nabaum



Social justice dominated the national news in 2017. Immigration. Transgender rights. White supremacy. The need has never been greater for scholarly research to reveal how stigma and oppression shape America's stark health disparities and how to eliminate them.

Gina Wingood, ScD, MPH, was just launching her career when she landed a job in the late 1980s promoting HIV prevention among black women in southeast San Francisco. She'd previously worked with gay men in the Castro neighborhood, but the condom-promotion materials developed for their needs missed the mark with her new clients. "Women have to negotiate condom use," she says, "which is a very hard thing to do."

In the intervening three decades, Wingood—founding director of the Mailman School's Lerner Center for Public Health Promotion and the Sidney and Helaine Lerner Professor of Sociomedical Sciences—has published more than 225 peer-reviewed papers detailing the evidence she's collected to inform gender- and culture-appropriate HIV prevention interventions. Her initiatives include Sisters Informing Sisters about Topics in AIDS (SISTA) and five other HIV prevention programs, all of which have been endorsed by the U.S. Centers for Disease Control and Prevention and implemented nationwide.

Each program helps participants confront stigma—the stigma of HIV, of condom use, of being a black woman in a society

that affords greater power to men, to those with white skin. Ultimately, says Wingood, problem-solving and communication skills are vital inflection points. "If you can't communicate what you need," she says, "that's not going to work."

Nationwide, HIV rates are falling. But in the South—especially among people of color—the epidemic has rebounded. And so Wingood has begun tailoring programs like SISTA to the places where people need them most. One project addresses the needs of youth in criminal detention. Another engages predominantly black megachurches in ZIP codes where HIV infection rates are particularly high.

"If innovation isn't reaching the community," she says, "we're going to take it to the community."

Here, too, Wingood and her team have collected the data to address participants' values and needs. And as she's spent more

time with faith leaders, a new project has emerged to tackle the burgeoning rate of diabetes among blacks, especially in the South. Like HIV, diabetes comes with a stigma, and social influence helps people overcome the barriers to testing. The nascent project brings high-tech equipment for diagnosing diabetes into churches, where clergy and lay leaders model how quick and relatively painless the blood sugar test is, inviting congregants to join them on the path to prevention and, if needed, earlier, more effective treatment.

While Wingood's interventions leverage interpersonal relationships to overcome shame and stigma, Mark Hatzenbuehler, PhD, has taken a structural approach, studying how societal-level stigma precipitates disparities. By comparing the health of people who are sexual minorities living in places that protect their civil rights with that of LGBTQ people living in places that condone discrimination, the associate professor of Sociomedical Sciences has built a body of evidence documenting the power of civil rights protections to promote health. "Concrete events and experiences like hate crimes or bullying or being the target of stereotypes certainly affect people's health," he says, "but that's



really just the tip of the iceberg, which is the broader social context in which stigmatized individuals live and work.”

In November 2016, Hatzenbuehler and his colleagues reported that in the wake of legislation to recognize same-sex and other civil unions in Illinois, sexual-minority women—particularly those who are people of color or have completed fewer years of formal education—reported reduced levels of stress, depression, and heavy drinking. The paper, in *Social Science & Medicine*, was the latest in a series of studies by Hatzenbuehler and collaborators spanning more than a decade. They’ve found that sexual minorities who live in places where societal-level conditions, cultural norms, and institutional policies constrain their opportunities, resources, and well-being are more likely to experience mood and anxiety disorders, tobacco and alcohol addiction, premature mortality, and chronic stress than sexual minorities of similar age, race, and educational attainment who reside in places with low levels of structural stigma. “Our work has shown that structural forms of stigma affect the lives of LGBT people across a wide range of outcomes,” says Hatzenbuehler. “The research is clear: State laws and social norms that promote stigma and discrimination against sexual and gender minorities harm the health of these populations.”

More recently, Hatzenbuehler has begun extending his analysis of structural discrimination to focus on the lives of people of color and immigrants. In February, *Social Science & Medicine* published his inquiry with colleagues into the effect of state-level policies—on immigration, race and ethnicity, language, and protections for agricultural workers—on mental health among people of Latin-American descent (Latinx), who report more depressive symptoms than whites.

Not surprisingly, the team found that Latinx living in states with a greater number of exclusionary policies experienced higher rates of poor mental health days than those living in states with more-supportive policies. They also found that, while the effect was most intense for Latinx,

all residents of states with exclusionary policies had a higher risk of poor mental health. “The consequences of structural stigma don’t just affect mental health or physical health,” says Hatzenbuehler. “Studies have shown that structural stigma also affects important determinants of health like employment and financial independence.”

Both Wingood’s and Hatzenbuehler’s findings dovetail with a prevailing theory known as the “social stress model.” According to the theory, the intense stress associated with oppression and social disadvantage accounts for the disproportionate rates of noncommunicable diseases (mood disorders, substance use, diabetes, heart disease, and the like) among marginalized groups.

Consider, for example, the “immigrant health paradox.” Newly arrived immigrants frequently exhibit *better* health than their American neighbors. Over time and across generations, however, their health appears to deteriorate—they gain weight, develop heart disease and diabetes, suffer from depression. It’s easy to blame such American staples as fast food and TV, but social epidemiologist Lisa Bates, ScD, suggests that the social stress model may offer a more likely explanation. “As immigrants get farther away from their support systems and bear the weight of stigmatization and structural racism and bias,” she says, “chronic stress and negative health consequences may develop.”

Higher rates of mood disorders among women than men also fit the model. In January 2016, *Social Science & Medicine* published analyses by Bates, assistant professor of Epidemiology and of Population and Family Health—with Katherine Keyes, MPH ’06, PhD ’10, associate professor of Epidemiology; doctoral student Jonathan Platt, MPH ’13; and Seth Prins, MPH ’10, PhD ’16—that show a direct correspondence between structural gender discrimination in the workforce, the gender pay gap, and mood disorders among women.

But sometimes the data don’t fit the model, says Bates, and knowing why is vital to developing meaningful theories

of disease causation and appropriate evidence-based programs to promote well-being. According to the social stress model, for example, the pervasive experience of racism and white supremacy should trigger far higher rates of depression among blacks than among whites. And yet epidemiological survey data suggest the opposite.

Over the last decade, Bates, Keyes, and David Barnes, PhD ’15, have conducted a series of analyses—reported in *Social Science and Medicine*, the *American Journal of Epidemiology*, and *Social Psychiatry and Psychiatric Epidemiology*—seeking an explanation for the paradox. In May, Barnes and Bates reported evidence in *Social Psychiatry and Psychiatric Epidemiology* that they’ve found a second paradox. While rates of major depressive disorder are lower among blacks, their rates of psychological distress are much higher than those among whites. “These and other findings suggest that our standard approaches to measuring depression may not adequately capture the mental health status of blacks in the U.S.,” says Bates, “and lead to insufficient recognition of their mental health needs.”

Sociomedical Sciences PhD student Tracy Pugh, MHS, grapples with the public health implications of the concept of “intersectionality,” a term coined in 1991 by Columbia and UCLA law professor Kimberlé Williams Crenshaw, JD, to describe how overlapping identities affect a person’s movement through the world. Decades of research have demonstrated that race, gender, sexual orientation, disability, and many other factors affect individual health across the lifespan. The farther a body strays from the white, male, heterosexual, able-bodied standard, the more likely that person is to experience stigma, have less access to resources, and face multiple forms of violence.

Understanding how that plays out promises to help public health practitioners address the unique needs of specific populations. For example, in a series of in-depth interviews with people of Puerto Rican descent, Pugh and colleagues plumbed the intersection of criminal justice involvement, substance use, and HIV status. *Drug and*

Alcohol Dependence published their analysis of the effect of substance use on adherence to HIV treatment. While study participants—Puerto Ricans with HIV being held at Rikers Island, the main jail for New York City—reported few experiences of race-based prejudice, most reported that both substance use and treatment had influenced their HIV treatment, suggesting new opportunities to tailor and refine standards of care to address their needs.

In her dissertation, Pugh is reanalyzing data from randomized controlled studies on HIV across 12 cities and 11 states, assessing how HIV outcomes relate to multiple identities. “Oftentimes in the public health sector, we fail to look at structural factors and interventions,” says Pugh. “We develop programs on a small scale and focus in on behavioral change.” It’s time, she says, for public health scholars to think big.

“We have to challenge the ways that our systems of governance perpetuate harm against racial minorities and others with stigmatized identities. Historic discrimination—like racism—is embedded in these systems, and we lose the high ground if we don’t call it out and take responsibility for it while developing meaningful solutions that improve health outcomes for all people.” 🏰

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Bringing It All Home

by Meril Cullinan

Assistant Professor of Sociomedical Sciences Diana Hernández, PhD, grew up in a Section 8 apartment in the South Bronx, where she watched her mother marshal the resources to become a homeowner. The experience illustrated what she would later learn in school: that housing can be a route to opportunity. “Housing can be a launching pad, a chance to live well on a daily basis and in the longterm,” says Hernández, who returned to the neighborhood as an adult. “I grew up in a disadvantaged community that still, 30-odd years later, faces many of the same issues of concentrated poverty, health disparities, and environmental burdens. All of the facets of my work are aligned as a public health researcher, a sociologist, and a neighbor; they are motivated by the fact that this neighborhood sits on my heart.”

Her gaze thus firmly fixed on the South Bronx, Hernández has devoted her scholarship to unraveling the mechanisms by which inequities in housing affect public health and devising ways that policymakers can ameliorate the damage. Take, for example, the experiences that she’s documented of anxiety and depression triggered by an outsize utility bill among people subsisting at or near the federal poverty level. Other projects have investigated the effect of energy-efficiency upgrades on the health of people who live in improved housing and explored the survival strategies used by low-income families coping with inadequate housing situations.

Her current work explores the last bastion for secondhand smoke. In New York City, smoking is regulated in most places: bars and restaurants, public spaces like parks and beaches, even Times Square. While there is no citywide ban on smoking in apartment buildings or homes, most newer buildings have banned tobacco. In her study, Hernández is looking at compliance and enforcement of smoke-free policies in ten affordable-housing developments with more than 900 residential units. “In affordable-housing settings, implementing smoke-free policies is a balancing act,” she says. “We want to reduce smoking to create better health outcomes, but we don’t want these policies to threaten the residents’ sense of housing stability. How do we reduce harm, garner resident buy-in, and make sure the rules are enforced in a humane way? These are the questions we’re looking to answer.”

