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Now it's time to implement social capital and STI/HIV interventions in the United States

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To the Editor:

Substantial evidence from international research [1,2] showed that social capital-specific or informed interventions could reduce population-level transmission of sexually transmitted infections (STIs) in low and middle-income settings, and that changes from those interventions appear to be sustainable. However, in the United States (U.S.), public health interventions based on social capital frameworks to lower STIs are rare. [3] While ecological research examining associations between social capital and STIs [4–6] may support the priorities of public health agencies to advance practice-driven research, [7] studies frequently miss opportunities to suggest actionable steps or example scenarios, and are often exploratory in nature, making it difficult to translate findings into theoretically-informed interventions. A recent study [8] for example, found that higher county-level social capital was strongly associated with lower rates of three commonly reported bacterial STIs in the U.S. The study was strengthened by an extensive covariate adjustment and spatial econometric methods. However, the analyses were not conducted in a way that facilitated a discussion of potential concrete actionable social capital interventions.

How do we elevate social capital research to inform practice and priorities for STI prevention intervention funding? [9] First, studies need to address challenges with conceptualizing and measuring social capital to explain subsequent findings. Owusu-Edusei et al. [8] note that social capital includes two domains (cognitive and structural) and that definitions and indices depend on the developer and the researcher's field. While true, the authors were unclear about their rationale for comparing the two selected social capital indices, which could have been addressed by explicitly identifying a theory based upon the study aims and outline specific constructs that enable testing modifiable pathways to the STI outcomes. [10,11] The authors concluded that it may be important to understand communities' associational life, and that findings reinforce the potential to incorporate social capital concepts to control STIs. Such an assertation would have required that they test each social capital sub-index, which was not done. Regarding conceptualizing and measuring social

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capital, [12,13] composite indices are sometimes limited by unhelpful value judgments. [14] Selected items within an index may ignore differences in the creation and distribution of social capital across individual race/ethnicity or racial composition of a geographic unit. [15,16] For example, the *family unity* sub-index included the proportion of births to unmarried women and the proportion of single parent households. How are those two items related to cognitive or structural social capital and to STIs? Positively or negatively? Next, how do we advise health officials to deploy social capital resources when an index fails to distinguish religious (e.g., places of worship) and secular (e.g., civic and social clubs) entities, given that social capital is formed and operates differently across those two entities? [17,18] While we understand that some study designs limit causal inference, to truly promote the integration of social capital within STI prevention interventions, the scientific community should conclude articles with actionable steps, otherwise we will persist with the ongoing stalemate in prevention funding and practice.

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