

Understanding Sexual Health Disparities among Minority Women in the U. S.: “Theory of Fundamental Social Causes”

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Abstract

Previous research findings consistently indicate the adverse outcomes of sexual risk behaviors among racial/ethnic minority adolescent and young adult women in the United States. The purpose of this study is to advance the state of multicultural knowledge about sexual risk behaviors among racial/ethnic minority women including Blacks, Hispanics, and Asian American and Pacific Islanders (API). Using a framework based on "the theory of fundamental social causes", this study illustrates pathways by which racial/ethnic disparities may impact sexual health status. This study suggests further attention to sexual health of these populations in order to develop adequate strategies for reducing the adverse impact of the risky behavior.

Keywords: *Racial/ethnic minority women, Sexual health, Socioeconomic status, Theory of fundamental social causes.*

1. Introduction

The level of sexual health crisis is increasing among racial/ethnic minority women. These women who suffer from the persistent hardship of sexually transmitted diseases (STDs) comprise nearly 30 percent of all women in the U.S. [1, 2]. African American, Native American, and Hispanic women have higher rate of STD such as chlamydia, gonorrhea, herpes, and the human papilloma virus than Caucasian women do [3].

Sexual risk behaviors of these groups also display the increased likelihood of transmitting and contracting STDs in addition to the burden of STDs born by their racial/ethnic origin. Early experience of sexual intercourse, unprotected sex, and having multiple sex partners are reported to be their major sexual risk behaviors [4].

Notably, the possibility of a women's exposure to partners who may have an STD increases as they are exposed to either sequential or concurrent multiple sexual partners. Thus, as a result, the risk of STD and HIV infection among women increases [5]. In case of the unprotected sex, a recent finding reports that Asian and Pacific Islander (API) and Hispanic women with the ages between 15 and 24 were less likely to have used any type of contraceptive

method when compared to their White counterparts [6]. Although most negative outcomes caused by early initiation of sexual intercourse do not emerge until adulthood, this problem carries its own risks. The suggestion that early initiation of sexual intercourse is associated with sexually transmitted infections [7, 8], depression [9, 10], and hazardous lifestyle and problematic life situation [11] has been consistently supported by from previous studied. Therefore, the consequences of sexual risk behaviors during adolescence among racial/ethnic minority women are quite problematic.

The ‘fundamental cause’ view adapted in this study focuses on ‘how and why’ by demonstrating flexible resources of knowledge, money, power, prestige, and beneficial social connections. To better understand the sexual health disparities among women in the U.S., we will try to illustrate sexual risk behaviors among this population by synthesizing previous empirical works based on "Theory of Fundamental Social Causes", and establish a novel conceptual paradigm.

2. Theoretical Framework: Theory of Fundamental Social Causes

2.1 Description of Social Causes

Fundamental social causes are social conditions or resources that determine the extent to which people can evade the risks for morbidity and mortality (Link et al., 1995). To put it another way, these are conditions that have an impact on the risk factors themselves. The resources in the theory of fundamental social causes include knowledge, money, power, prestige, and social connections. These resources strongly influence people's ability to avoid risk and to minimize the consequences of risk once it occurs [12]. For example, individuals with power and status can try every possible resource to avoid

risks and adopt protective strategies. On the other hand, individuals without power and status have less room for flexible resources. In other words, the unequal social distribution of flexible resources attracts individuals to risky condition and decreases their ability to avoid disease and consequences of risk. Link and Phelan [13] emphasized the structural pattern of inequalities, which emphasizes socioeconomic status as a key construct of fundamental cause.

2.2 Association between Health Status and Socioeconomic Status (SES)

Historically, the academic fields of medical sociology and epidemiology have looked into the disease from the view of social pattern, and the most frequent association was made between health status and SES. These studies reported that lower SES is associated with lower life expectancy, higher overall mortality rates and higher rates of infant and perinatal mortality [14].

The fundamental social causes that affect health status are macro-structural determinants of disease, social dynamics (i.e., control over resources) or social distribution of resources [15]. These fundamental causes become more noticeable under conditions of social change. According to Link & Phelan [13], the fundamental social cause would be an insufficient answer for health disparities if everyone had equal resources and equal SES just like a static system; however, especially for our health issues, this has been a rare case. Fundamental causes are expected to take place in a dynamic and interactive situation, mainly because the resources represented in fundamental causes can be transferred from one situation to another.

A fundamental social cause theory describes that the dynamic reproduction of the association between SES and health status arises because of the flexible and transferable nature of resources which allows the association to be reproduced in broadly mercurial conditions. The significance of the flexibility in resources should be recognized in two ways. First, flexible resources can have direct influences on health behaviors of an individual. Second, resources can shape connections in broader contexts including neighborhoods, social networks, and occupations. Therefore, it is important to understand that the process of fundamental social cause can be operated at the individual as well as the contextual levels.

2.3 Fundamental Social Causes and Sexual Health among Racial/Ethnic Minority Women

Focusing on hierarchical patterns of inequality at the individual and contextual levels at the same time, the fundamental social causes perspective can be applied to STDs and sexual risk behaviors among racial/ethnic

minority women. Previous studies have mentioned that racial/ethnic minority women do not have as much access to important socio-economic resources as their counterparts do (i.e., less knowledge of sexual risks, low SES, and a lower level of social connections) [5, 16, 17]. Consequently, such limitations result racial/ethnic minority women at risk when engaging in sexual behaviors. And, this, eventually, increases the likelihood of the STD spread.

Based on the theory of fundamental social causes, the characteristic of flexibility and transferability becomes more pronounced with the diseases that can be prevented. Compared to cancer or cardiovascular disease, STDs can be more easily prevented; prevention on the individual level can take place with the application of contraceptives and routine screenings, or by reducing other sexual risk behaviors. Importantly, these behaviors can be adopted by prevention campaigns or health education.

For cancer or cardiovascular disease, flexible socioeconomic resources may have a greater contribution to extending life or quality of care. However, such resources often introduce a minimal or even a negative influence on cancer or cardiovascular diseases. However, in case of the STDs, flexible socioeconomic resources may play an important role in its prevention. For instance, buying condoms to prevent STDs may not be a critical challenge with individuals with the least economic resources. Consequently, it can be inferred that the theory of fundamental social causes may be more suitable to the case of STDs among racial/ethnic minority women as they are more exposed to STDs and sexual risk behaviors through their lower socio economic resources

3. Review of the Evidence

3.1 Sexual Risk Behavior among Racial/Ethnic Minority Women

This section provides a synthesis of the existing literature to increase the understanding of the issue regarding the sexual health status among three racial/ethnic minority groups: African American, Hispanic and API women.

Sexual Risk Behaviors among African American Women.

Among African Americans, STDs, including HIV, are at epidemic proportions [1]. To make the situation even worse, the STD and HIV epidemics have disproportionately affected African American women, particularly in the Southern region of the United States [1, 18]. Young, socioeconomically challenged, and inner-city African American women are being infected with HIV at

increasingly younger ages and at higher rates than their male counterparts [1]. In addition to the gender difference among African Americans, the racial characteristic young African American women was a significant factor of HIV prevalence (approximately 4 times greater) when compared to their Caucasian counterparts [19].

Further, Bachanas et al. [20] showed that many African American girls (158 African American girls, ages 12-19) reported their sexual debut at younger ages. In their study, the first consenting experience with sexual intercourse of majority of teens (57%) took place at the age of 14 or younger [19]. These findings suggest that African American women, as compared to White women, are at greater risk for sexual risk behaviors.

Sexual Risk Behaviors among Hispanic Women.

The rates of chlamydia, gonorrhea, and primary and secondary syphilis are two to three times higher than those of their White counterparts among Hispanic population [21]. Also, the rates of STDs among Hispanic women are higher than those among White women. Hispanic women in the United States are at great risk for HIV infection and transmission [22]. In 1999, the rate of AIDS cases per 100,000 among Hispanic women was more than seven times of White women [23].

Furthermore, behaviors with higher sexual risks, particularly less frequent use of contraceptives, were more frequent among Hispanic women. Specifically, Cuban American, Mexican American, and Puerto Rican women were at greater risk because of their lack of contraceptives usage during their last sexual encounter as compared to their White counterparts (odds ratios = 1.9 - 2.9) [6, 24]. Hispanic women are the least likely ethnic group to use contraceptives and have the longest intervals between first intercourse and the use of contraceptives compared to other ethnic groups [25, 26]. Also, when compared to White women, Hispanic women are less likely to have sex partners who use condoms regularly, and Hispanic women have less information about sex [27].

Another significant sexual risk among Hispanic women is the unplanned pregnancy [28]. In Los Angeles County, the rate of women giving birth before 19 years of age was 75% for Hispanic women, compared to 9% for Whites, 13% for African Americans [29]. In 1995, Hispanic adolescent women' birth rate (107 per 1,000) exceeded that of African Americans 99 per 1,000), with both groups more than twice as likely as the Whites (39 per 1,000) to become teen mothers [30]. Hence, these findings indicate the high rates of HIV and other STDs, as well as sexual risks in general, among Hispanic women.

Sexual Risk Behaviors among API Women.

Relatively few studies have reported STDs and sexual risk behaviors for API women, even though the API population is one of the fastest growing racial/ethnic minorities in the United States [31]. From 1999 to 2003, the number of gonorrhea cases increased among API women by 27.1%, which is the highest increase for any racial/ethnic group [32]. Between 2000 and 2004, the rate of syphilis among African American women and White women decreased. On the other hand, rates of syphilis increased among API women from 0.1 cases to 0.2 cases per 10,000 [33]. Moreover, recent studies have reported that API women in the U.S. have a significantly higher level of risk for HIV infection [34, 35, 36, 37]. In 2001, the HIV infection rate through heterosexual transmission among API women was 42%, the highest level among women of all the racial/ethnic groups [19].

In general, API adolescents showed lower level of sexual activity than all other racial/ethnic age matched groups. However, once they start engaging in sexual activity, API adolescents have sexual behavior patterns comparable to other adolescent groups [38]. Furthermore, API high school students were less knowledgeable about the HIV transmission and prevention than other racial/ethnic groups were [39]. In turn, sexually active API women tend not to use condoms consistently than other racial/ethnic groups [40]. These findings also confirm the significance of the study investigating the sexual risk behavior of this at-risk subgroup.

Implications of this review for all three of the racial/ethnic minority women discussed here are alarming. There is an added dimension that makes the situation even more sobering. While racial/ethnic minority women display grievous sexual health, and have increased level of sexual risk behaviors, they are less likely to receive adequate sexual and reproductive health care, including medically appropriate contraceptives, annual gynecological exams, and prenatal care [17].

3.2 Socioeconomic Status (SES) and Sexual Risk Behaviors

Measuring SES.

Socioeconomic status (SES) has been one of the most frequently reported variable known to be correlated with the STDs and sexual risk behaviors, and has been assessed in the following ways: annual household income, parental educational attainment, and family structure [4, 24, 41]. SES is widely used as a proxy for social class in studies investigating the variations in the disease distribution, and continues to be a strong indicator of illness and death rate [42]. This section reviews various ways of measuring SES and various challenges in identifying appropriate SES measures.

The social science and social epidemiology literatures continually consider SES to be a multidimensional structure comprising various socioeconomic indicators (typically, economic resources, power, and/or prestige) [43, 44]. Furthermore, various constructs are pressed into service to assess SES: income, educational attainment, and occupational status are the most common. Although SES tends to be connected with health outcomes regardless of the indicator used, each SES measure has its own set of advantages and limitations.

First of all, education is considered to be the most stable and robust indicator of SES or the most practical and convenient measure [42]. However, the education measure presents several challenges. First, because education measure cannot be completed when there is a lack of data, it is sometimes difficult to assess the impact of SES on health status for many adults. Second, most studies that consider education as an indicator of SES are based on individualistic approaches, and do not integrate data about the level of education among other members of the household. Lastly, it is essential to keep in mind that the economic return for a given education varies significantly by race and gender.

Occupation is a common measure of SES in Europe [45, 46, 47], whereas education or income is more frequently used in the United States [48]. Occupational status is likely to be a better indicator of long-term income than is of income at a single point in time. The occupational measure, however, contains several limitations for classifying persons outside of the paid labor force (thus disproportionately affecting women in this case) or the chronically unemployed [28].

In addition to education and occupation, there are several problems when we consider income as a measure of SES. Because questions regarding income may be specifically sensitive for some respondents, income questions might not be answered more frequently than other SES measures are. Income measurement can also be time consuming and expensive [42]. In addition, recent studies reported that income was commonly a poor indicator of STD risks among African American and White adolescents. Newbern et al. [49] found that income had weaker associations relative to other SES measures such as maternal educational attainment, maternal occupation, and family structure did with STD. Although this weak association between income and STD risks can be explained by measurement error and missing data as described above, income may not be enough to reflect the complicated nature of SES [49].

SES and Race: Studying Sexual Risk Behaviors among Women.

Race is an important indicator of current social and economic conditions and a proxy for specific historical experiences. Kessler and Neighbors [50] highlighted the significance of systematically testing the interactions between SES and race. By reanalyzing data from eight epidemiologic surveys, they demonstrated that low-SES African Americans had higher rates of psychological distress than did low-SES Whites, although the association between race and distress reduced to non-significance when SES was controlled. Correspondingly, low-SES African American women had higher levels of substance abuse disorders than did their White peers [50].

Furthermore, several studies found that adjustment of SES considerably reduces but does not eliminate racial disparities in health. For example, within each level of SES, the health status of African Americans was generally worse than that of Whites [51]. Also, African Americans' and Whites' mortality ratio actually increased with rising SES. This was obviously the case for infant mortality where the discrepancy between African Americans and Whites is least among women who have not completed high school and highest among women with a college education [43].

Studies have produced substantial evidence that family SES is associated with sexual risks among women. Newbern et al. [49] indicated that lower maternal education and nonprofessional maternal occupation were associated with higher STD reports in all groups except White women. Specifically, African American women whose mother had a high school or less education were nearly two times more likely to report STDs than African American women with mothers who were college graduates. Moreover, young African American women with mothers who did office work, service or manual labor were more likely to report STDs than African American women whose mothers had professional occupations [49]. Furthermore, Rostosky et al. [52] also found that women who had a mother with at least a college education were significantly less likely to have an early sexual debut. Consistent findings suggest that maternal/parental educational attainment is negatively associated with STD acquisition among minority women.

4. Discussion

This study has presented a framework based on the theory of fundamental social causes to illustrate both the pathways whereby disparity may impact sexual health status and the potential avenues for intervention to ameliorate those effects.

Because of the critical nature of this issue, it is important to acknowledge which explanation or explanations are legitimate. By highlighting the access for the important

social and economic resources, the theory of fundamental social causes suggests that health inequalities can be reduced by addressing the underlying social inequalities. In other words, as long as social inequalities exist, the health inequalities will continue among racial/ethnic minorities. The theory of fundamental social causes argues that SES disparities in sexual health arise because people of higher SES use flexible resources to avoid risks and adopt protective strategies.

Link and Phelan [13] have proposed that there is an interactive association between socio-demographic factors and risks for disease. As a result, as health-related situations change, people with the most resources have the better ability to avoid diseases and their consequences. Therefore, regardless of the profile of diseases and known risks at any given time, people with greater access to essential social and economic resources will have better health status and outcomes. Social inequality in health status will continue as long as social inequality in general continues, and the greater the social inequality, the greater the health inequality. In order to decrease inequalities in health status, the social inequalities must be addressed.

It has long been established that women live longer than men, yet they have higher morbidity rates. Men experience more life-threatening chronic diseases and die younger, whereas women live longer but face more non-fatal acute and chronic conditions and disability. Furthermore, there are gender differences in the outbreak of mental health disorders although men's and women's overall rate of serious mental illness are tantamount. There is considerable evidence suggesting that both biological systems and social processes underlie these perplexing patterns, but what is missing in our understanding of these gender differences is an explanation of how the social and biological factors combine to construct these paradoxical differences in health for men and women. Gaps still exist in our understanding of the antecedents of gender differences in health. This paradox about the multifaceted connections between social and biological processes is still in question. For the most part, the current study, as well as previous studies, has failed to assess gender and to explain why rational people are not effectively making health a priority in their everyday lives. Existing influential models of social determinants of health and disparities are not enough to clarify why the health of men and women differs in such puzzling ways. Therefore, the social science community should address the paradoxical differences in men's and women's health and think in new ways about this important issue.

It is important to note that this study has limitations. Although the theory of fundamental social causes explains racial/ethnic and socio-economic disparities in sexual health status, it cannot provide enough answers to explain

gender disparities among racial/ethnic minorities. Second, the theory of fundamental social causes only considers individual SES or individual access to socioeconomic resources, not the individual characteristics himself/herself (i.e., individual developmental or psychological processes). By discussing the individual's limited socioeconomic resources, the theory of fundamental social causes overlooks psychological and biological conditions at the individual level. Furthermore, the theory of fundamental social causes provides little explanation for factors such as family, peers, and school.

Considered together, this study also points the need for sexual health in multicultural society. In order to reduce sexual health disparities among minority women, culturally specific practice and policy strategies for intervention at the individual and programmatic levels should be adopted. Identifying the groups at risk of sexual health is a useful starting point for the development of an understanding of sexual health risks and for the design and implementation of preventive programs.

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