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Social Determinants of Health for HIV Among Hispanic Women

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Population health outcomes are influenced by complex, integrated, and overlapping social structures and economic systems. From the time people are born, they are placed at a particular level of social status. These concepts are included in what the World Health Organization (WHO; 2014) defines as the Social Determinants of Health (SDH): "Conditions, in which people are born, live, grow, work and age" (para. 1). In other words, health is determined in part by the social, economic, political, cultural, and environmental contexts in which people live. Oftentimes, individuals are not able to directly control their SDH (WHO, 2014). The SDH are defined or shaped by money, power, and other resources at multiple levels, from local to global, affecting a wide range of individuals (Mumtaz & Salway, 2009; WHO, 2014).

The WHO has recognized that dealing with these social determinants is a fundamental priority in order to improve the health of people and to decrease inequalities (WHO, 2010a). For instance, while HIV prevention for Hispanic women has been a challenge for health care workers and policymakers, the conceptualization of SDH helps recognize HIV among Hispanic women in the context of sociocultural and economic inequalities (e.g., level of education, financial constraints, immigration, culture, substance abuse, and access to health care; Raphael, 2004; WHO, 2010a).

A particular concern for both health care workers and policymakers is that relative to other races/ethnicities, Hispanic women are disproportionately affected by HIV (Centers for Disease Control and Prevention [CDC], 2014). Disparities have persisted in the rate of new HIV infections among Hispanic women for some time; in 2010, for example, the rate of new HIV infections for Hispanic women was 4.2 times that for White women (CDC, 2013a). According to a study by the Kaiser Family Foundation (2009), women of color fare worse on a variety of measures of health and health care access than do their White counterparts. Specifically, being HIV positive is one of the indicators associated with greater disparity (Kaiser Family Foundation, 2009). While Hispanics represent diverse nationalities and demographics, they share SDH, which present challenges for HIV prevention, contributing to the rise of HIV infection among Hispanic women across nationalities (CDC, 2009a, 2009b).

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Level of Education

Adequate acquisition of education may be hindered in many Hispanic areas by factors such as intense neighborhood segregation, school segregation, language barriers, and economic resources. For most families, these barriers may seem beyond the scope of what most schools can reasonably address. However, other factors, such as teacher quality, school facilities, and resources, and a rich curriculum, are very much within the purview of schools and could be addressed (Gandara, 2010).

As a result of a variety of factors, the gap persists between Hispanic and White women with regard to completing secondary and postsecondary education. As reported by the U.S. Census Bureau (2012), 64.4% of Hispanic women had high school diploma or greater educational attainment in 2010, compared with 88.2% of White women. In terms of college education, 29.9% of White women had reached this educational level or higher, in comparison with 14.9% of Hispanic women (U.S. Census Bureau, 2012). In a 2014 *National Journal* poll, 66% of Hispanics who got a job or entered the military directly after high school cited the need to help support their family as a reason for not enrolling in college, compared with 39% of Whites (Pew Research Center, 2015).

The educational differences between these groups can have a long-standing impact on their health. People with more education are likely to live longer, experience better health outcomes, and practice health-promoting behaviors such as HIV prevention (Braveman & Egerter, 2008; Cutler & Lleras-Muney, 2010). Level of education has been related to increased knowledge about health, problem-solving, and coping skills, enabling individuals to make better-informed choices about health-related options available to themselves and their families, including those related to obtaining and managing medical care (Cutler & Lleras-Muney, 2010; Goldman & Smith, 2002; Robert Wood Johnson Foundation, 2011). Of particular interest, research has been conducted indicating the importance of knowledge in HIV prevention (Ugarte-Gil et al., 2013; Villegas, Cianelli, Ferrer, & Peragallo, 2011). Furthermore, studies have shown negative correlations between levels of education and HIV testing (Idris, Elsamani, & Elnasri, 2015; Montealegre, Risser, Selwyn, McCurdy, & Sabin, 2012; Orish et al., 2014).

Financial Constraints

Hispanic women in the United States are more likely to be unemployed, earn less, and have fewer educational opportunities than women in other ethnic groups (U.S. Bureau of Labor Statistics, 2013). For instance, in 2013, 13.8% of Hispanic women were working-class poor, compared with 6.6% of White women. Moreover, Hispanic women make proportionately less than their male and non-Hispanic White counterparts (U.S. Bureau of Labor Statistics, 2013).

Furthermore, according to the (U.S. Bureau of Labor Statistics (2013), 32.2% of Hispanic women work in the service sector, compared with only 20% of White women. Among Hispanic women working in the service sector, almost 20% are less likely to have either paid sick leave or retirement benefits compared with White women in service. These disparities

are leaving a growing portion of the Hispanic population increasingly vulnerable to poverty and its implications (e.g., unemployment, inadequate education, and limited access to quality health care; Center for American Progress, 2015; Kaiser Family Foundation, 2009).

The perpetuation of these disparities has led to the concentration of poverty in certain geographic locations, contributing to the formation of communities well known for risky health behaviors such as drug dealing and prostitution, which have been identified as risk factors for HIV infection (Latkin, Curry, Hua, & Davey, 2007). Research has suggested that when women are unemployed, less educated, and poorer, they have a more difficult time negotiating safer sex or condom use with their partners (Henao-Martinez & Castillo-Mancilla, 2012; Salabarria-Pena, Lee, Montgomery, Hopp, & Muralles, 2003; Saul et al., 2000).

Immigration

As migration movements increase worldwide, SDH affect the many individuals who choose to or are forced to leave their homelands for survival, work, safety, and, in some cases, to establish a new home in another land ((Castañeda et al., 2015). The WHO estimates that the lives of at least one billion migrants across the world have been negatively shaped by social determinants in their homelands and who face new social, economic, and political conditions in their destination countries ((Castañeda et al., 2015; (Willen, 2012).

One important group of Hispanic immigrant women to consider when planning for HIV prevention are the refugees who are seeking refugee status in the United States. A refugee is someone who fled his or her home and country due to fear of persecution for reasons such race, religion, nationality, social group, or political beliefs (United Nations, 2015). This group has been increasing in recent years due to a variety of factors, including gang violence, drug wars, and natural disasters in their countries of origin (Moloney, 2014). A recent study observing risk behaviors among Hispanic immigrant women reported a general decrease in condom use and increases in the number of sexual partners after immigration (Sastre, Sanchez, & De La Rosa, 2015).

Hispanic Culture

Hispanic women possess a constellation of unique Hispanic cultural SDH that interfere with HIV prevention and may contribute to HIV risk (Cianelli et al., 2012; Jacobs & Thomlison, 2009). The Catholic/Christian religions play a central role in Hispanic society, with a majority of Hispanics identifying as Catholic/Christian. These religions advocate faithful commitment of the wife to the husband, abstinence, and monogamy. Catholicism and some other Christian religions oppose the use of condoms and maintain that sex is intended for procreation, not for pleasure (British Broadcasting Corporation, 2009; Hernandez, Zule, Karg, Browne, & Wechsberg, 2012). This belief leads to lack of partner communication about condom use and helps explain why many Catholic/Christian Hispanic women, born or raised in a Hispanic culture, do not discuss sex with their partners (Cianelli, Ferrer, & McElmurry, 2008; Peragallo, Gonzalez-Guarda, McCabe, & Cianelli, 2012). These beliefs and practices with regard to condom use can put a Hispanic woman at risk for HIV.

Another essential theme in Hispanic culture is *el fatalismo*, or fatalism. Fatalism is a belief, closely associated with religion, in the inevitability of bad things happening and the placing of all things in "God's hands." (Cianelli et al., 2008). Hispanic women with this worldview may not be concerned about HIV infection—or taking measures to prevent it—because they are "going to die anyway." Their belief is manifested in a decreased willingness to take active steps that reflect HIV risk reduction intention, such as protecting their health, using condoms, being tested for HIV, and seeking early HIV treatment (Cianelli et al., 2013; Peragallo et al., 2005).

Another relevant cultural value is *marianismo*, which encourages women to be sexually passive and to accept male partners' sexual behaviors and decisions on sexual matters, including intimate partner violence (IPV), condom usage, and acceptance of infidelity, placing women at risk for contracting HIV (Jones, 2008; Roberto et al., 2007). IPV is a risk factor for acquiring HIV (Jones, 2008) and poses a serious threat to women's health. Silence about and acceptance of IPV have been associated with *marianismo*, premature morbidity/mortality, and HIV (Cianelli et al., 2008; Jones, 2008). Unfortunately, some Hispanic women are reluctant to disclose IPV to others, including health care providers they do not trust (Obregon, 2005).

An additional relevant factor is *machismo*, a cultural standard that encourages men to be dominant in their relationships and that promotes sexual prowess, risk-taking behaviors, and multiple partners. Having more than one sexual partner is considered part of being "macho" and increases men's chances of acquiring HIV and then infecting their partners (Estrada, Rigali-Oiler, Arciniega, & Tracey, 2011; Marin, 2003; Marin & Marin, 1990). For Hispanic men, being sexually active and having sexual relationships outside of marriage may be seen as expressions of virility, and this view frequently continues into midlife and beyond.

Substance Use

Drugs and alcohol intake alter judgment, causing impulsive and unsafe sexual behaviors (e.g., lack of condom use) and increasing the risk of acquiring HIV (Aral, Douglas, & Lipshutz, 2007; Binswanger et al., 2010; Tuchman, 2010). Moreover, injection drug use is a direct risk for HIV because users often share needles with other users, exposing them to infected blood (Prado et al., 2006).

Among Hispanics, alcohol is the most common substance used and the most studied (Center for Substance Abuse Treatment, 2009). Hispanics tend to drink less than non-Hispanics, but when Hispanics choose to drink, they are more likely to consume high amounts of alcohol (National Institute on Alcohol Abuse and Alcoholism, 2013). Regardless of the country of origin, Hispanic women tend to have lower rates of alcohol consumption and drink alcohol less frequently than Hispanic men (Center for Substance Abuse Treatment, 2009). However, this cultural norm is changing, and alcohol consumption is increasing among Hispanic women, with recent evidence indicating that young Hispanic women are drinking as much or even more than young Hispanic men (National Institute on Alcohol Abuse and Alcoholism, 2013).

In the United States, the literature about substance use behavior among Hispanic women is inconclusive. Some Hispanic women tend to resist social pressure for substance use, while others tend to increase their frequency and amount. These differences are associated with factors such as age, generational status, level of acculturation, and country of origin (Center for Substance Abuse Treatment, 2009).

In addition, language barriers, feelings of being intimidated by and/or being discriminated against by large service systems and institutions, issues of legal residency documentation, and a lack of familiarity with the goals and methods of treatment can keep Hispanic women who are struggling with addiction away from the treatment they need to recover from a substance abuse problem (Amaro & Cortes, 2007).

Access to Health Care

It has been established that the low average income and educational attainment of Hispanics are obstacles to receiving timely and appropriate health care. Hispanic women often lack health coverage, as more than 38% of Hispanic women are uninsured (Center for American Progress, 2015). The gap in access to care persists among even those who do have health insurance coverage, as low-income people are less able to afford the out-of-pocket costs of care (Tienda & Mitchell, 2006). In addition, limited levels of education and language barriers may impede communication with health care providers and cause difficulty in understanding providers' instructions (Tienda & Mitchell, 2006). At the same time, concerns about immigration status or related paperwork may impair people's ability to navigate the complex health care delivery system (Tienda & Mitchell, 2006).

Nondocumented immigration status is a major barrier to accessing health care due to program ineligibility and fear of stigma and deportation (Perez-Escamilla, Garcia, & Song, 2010). Having inadequate health insurance, or lacking it entirely, makes the costs of health care services prohibitive for many Hispanic people, constituting one of the most important barriers to accessing adequate health care, which includes HIV prevention, testing, diagnosis, and treatment. Therefore, expanding access to health care may increase HIV prevention practices among Hispanic immigrant women (Montealegre et al., 2012).

Conclusion

The WHO focuses its strategic plan on the social and economic well-being of families and communities, eliminating health disparities, and achieving health equity (WHO, 2010b). To achieve these goals, special attention should be given to SDH, taking into consideration their influence on risk factors, access to health care services, and health outcomes. Failure to address these important factors can impede progress in addressing existing health problems (WHO, 2015).

Regarding HIV, an aggressive global response to the disease has been able to lower HIV incidence and mortality; however, the progress has not been uniform across individuals and communities (CDC, 2013b). This is clearly reflected among Hispanic women who confront SDH (e.g., lower educational level, fewer working opportunities, marginalization, financial dependence on male partners, gender power inequalities, and substance use) while being

disproportionately affected by HIV as well as experiencing poorer health outcomes compared with other individuals with the disease (Sharpe et al., 2012; WHO, 2015).

HIV prevention strategies should concentrate prevention efforts on Hispanic women who are confronting inequitable SDH. For instance, one important aspect that should be considered as part of the SDH is the cultural context in which Hispanic women live, which may influence their risk for HIV. As an example, Hispanic women have a more difficult time communicating and negotiating safer sex or condom use with their partners, and they tend to have less access to care and to HIV testing (Cianelli et al., 2008; Henao-Martinez & Castillo-Mancilla, 2012; Peragallo, 1996; Peragallo et al., 2005; Salabarria-Pena et al., 2003; Saul et al., 2000). In addition, for Hispanic women the care of their families is their highest priority, frequently coming before their own personal health care and needs (Latino Commission on AIDS, 2010). Further complicating matters, the Hispanic culture is generally not comfortable addressing controversial issues, and the subject of HIV has been often been considered taboo and thus not discussed for fear of shame or rejection, making HIV education still more difficult (Kramer, Ivey, & Ying, 1999).

As noted by the WHO, when women have decent life conditions, such as fair employment and access to higher education, they can obtain higher-paying jobs that provide the necessary income to live in health-promoting environments that encourage and enable them to adopt and maintain healthy behaviors (WHO, 2015). Interventions and policies should be designed to address the SDH that systematically produce an inequitable distribution of the determinants of health among the population (WHO, 2015).

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