Drivers of ethnic disparities in sexual health in the UK

See Articles page e458

Ethnic and racial disparities in sexually transmitted infections (STIs) and other sexual health outcomes in the UK are well recognised, but the drivers of these disparities are not fully understood. In *The Lancet Public Health*, Sonali Wayal and colleagues[1] use data from the British National Survey of Sexual Attitudes and Lifestyles (Natsal-3) to explore the extent to which these disparities can be explained by ethnic variations in established risk factors such as socioeconomic status, substance use, depression, and sexual behaviours, and the extent to which disparities persist after adjusting for these factors. Despite adjusting for these risk factors, and for neighbourhood and geographic effects, the authors find persistent ethnic disparities on a range of sexual health measures. This finding points to the possible importance of factors operating at the level of sexual partnerships or sexual networks. Of particular relevance, given the research question, is the racial and ethnic composition of sexual networks.

Similar research in the USA has found that the frequency of assortative mixing by race (as well as rates of sexual concurrency) can explain a substantial portion of residual racial disparities in STI infection.[2] This is because intra-racial partnerships remain more common than inter-racial ones, so STIs in particular tend to occur within relatively closed sexual networks. In the USA, only 10% of existing couples and 17% of newlyweds in 2015 were in mixed race relationships,[3] suggesting that although intra-racial relationships are rapidly becoming more common, the overwhelming majority of sexual partnerships remain racially homogenous. In the UK, the most recent census data[4] suggest that only 9% of co-habiting couples in England and Wales in 2011 were of mixed ethnicity (up from 7% in 2001). Of course, the extent of racial or ethnic homogeneity is not the only relevant characteristic of sexual networks that could contribute to explaining persistent racial disparities in sexual health outcomes, but it does suggest the importance of collecting and analysing demographic data on sexual partners. It also could point to the need for ethnographic work to help develop culturally tailored messages and services based on community-specific sexual cultures.

For example, Wayal and colleagues describe a lower self-reported "sexual competence" at sexual debut among black African women than among white British women. Low sexual competence meant failure to meet at least one of four criteria: contraceptive protection, autonomy of decision, both partners equally willing, and that it happened at the right time.[1] Any of these criteria, but especially those related to timing and consent, might reflect lower control over circumstances of sexual debut, which is often related to coercion. Experiences of coercion and violence by partners are consistently related to women's risk of STI, unplanned pregnancy, and other adverse sexual health outcomes in many settings.[5-7] Research in other settings[8] points to the importance of hegemonic heterosexual gender norms in shaping sexual behaviour, and shows that where such norms emphasise male dominance and control over women, including perceptions of women as targets for male sexual conquest, the risk of acquiring and transmitting STIs increases in men. Understanding how gender and power dynamics in relationships vary across cultural groups in the UK is an important area of future inquiry to understand the reported patterns of sexual health disparities and an important layer to consider under the lens of intersectionality.

Fuller understanding of sexual health disparities also requires interrogating the meaning of sexual health indicators in different communities, and ensuring that we understand the contexts in which certain outcomes occur. For example, should emergency contraception use be considered a contraceptive failure or a success in accessing and using a needed back-up method? Is attendance at a sexual health clinic a signal of sexual ill health or a positive sexual health seeking behaviour? Wayal and colleagues have shown that Black Caribbean and Black African men tend to have more STI diagnoses as well as more clinic use. Is this because a higher prevalence of symptomatic STIs drive greater use of services in these groups, or—given that many STIs are asymptomatic and remain undetected—is it a sign that other groups are underutilising services and might be underdiagnosed?

This study highlights the importance of studying ethnic inequalities in sexual health and service use, to deepen our understanding of the sexual health needs of the population and how best to meet them. However, the analyses presented by Wayal and colleagues,

tantalising as they are, also highlight the need to return to the practice of oversampling ethnic minority populations in future research waves of Natsal data collection. Only through the use of more robust and representative sampling of ethnic minorities can we maximise the value of investing in population-based data collection, and ensure that we have the data necessary to properly inform efforts to eliminate sexual and other health disparities in the UK.

Rachel Jewkes, Kristin Dunkle
Gender & Health Research Unit, South African Medical Research Council, Pretoria 0001, South Africa
rachel.jewkes@mrc.ac.za

We declare no competing interests.

1 Wayal S, Hughes G, Sonnenberg P, et al. Ethnic variations in sexual behaviours and sexual health markers: findings from the third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Lancet Public Health* 2017; **2:** e458–72.
2 Hamilton DT, Morris M. The racial disparities in STI in the U.S.: concurrency, STI prevalence, and heterogeneity in partner selection. *Epidemics* 2015; **11:** 56–61.
3 Livingston G, Brown A. Intermarriage in the U.S. 50 years after Loving v. Virginia, 2017. Washington DC, USA: Pew Research Centre. May 18, 2017.
4 ONS. 2011 Census analysis: what does the 2011 census tell us about inter-ethnic relationships? UK: Office for National Statistics, 2014.
5 Jewkes R. Gender inequities must be addressed in HIV prevention. *Science* 2010; **329:** 145–47.
6 Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet* 2004; **363:** 1415–21.
7 Christofides NJ, Jewkes RK, Dunkle KL, et al. Risk factors for unplanned and unwanted teenage pregnancies occurring over two years of follow-up among a cohort of young South African women. *Glob Health Action* 2014; **7:** 23719.
8 Jewkes R, Morrell R. Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. *J Int AIDS Soc* 2010; **13:** 6.