Check for updates

DOI: 10.1363/psrh.12189

ARTICLE

PERSPECTIVES on Sexual and Reproductive Health

Sex, poverty, and public health: Connections between sexual wellbeing and economic resources among US reproductive health clients

Jenny A. Higgins[1,2] | Renee Kramer[2] | Leigh Senderowicz[1,2] | Bethany Everett[3] | David K. Turok[4] | Jessica N. Sanders[4]

[1]Department of Obstetrics and Gynecology, University of Wisconsin-Madison, Madison, Wisconsin, USA

[2]Collaborative for Reproductive Equity (CORE), University of Wisconsin-Madison, Madison, Wisconsin, USA

[3]Department of Sociology, University of Utah, Salt Lake City, Utah, USA

[4]Department of Obstetrics and Gynecology, University of Utah, Salt Lake City, Utah, USA

Correspondence
Jenny A. Higgins, Department of Obstetrics and Gynecology, University of Wisconsin-Madison.
Email: jenny.a.higgins@wisc.edu

Funding information
Collaborative for Reproductive Equity (CORE) at the University of Wisconsin-Madison, Grant/Award Number: P2C HD047873; Center for Clinical and Translational Sciences, Grant/Award Number: 8UL1TR000105; Building Interdisciplinary Researchers in Women's Health, Grant/Award Number: K12 HD085852; The William and Flora Hewlett Foundation; The Society of Family Planning Research Fund; Eunice Kennedy Shriver National Institute of Child Health and Human Development, Grant/Award Numbers: R01 HD095661, T32HD049302, K24 HD087436, P2C HD047873, K12 HD085852

Abstract

Objective: To document associations between socioeconomics and indicators of sexual wellbeing.

Methods: We obtained our data from the HER Salt Lake Initiative, a large, longitudinal cohort study of family planning clients in the United States who accessed free contraceptive services between March 2016 and March 2017. Baseline socioeconomic measures included Federal Poverty Level, receipt of public assistance, and difficulty paying for housing, food, and other necessities. Sexual wellbeing measures assessed sexual functioning and satisfaction, frequency of orgasm, and current sexlife rating. Among participants who had been sexually active in the last month ($N = 2581$), we used chi-square tests to examine bivariate associations between sexual and socioeconomic measures.

Results: We found strong and consistent relationships between sexual wellbeing and economic resources: those reporting more socioeconomic constraints also reported fewer signs of sexual flourishing.

Conclusions: Financial scarcity appears to constrain sexual wellbeing. To support positive sexual health, the public health field must continue to focus on economic reform, poverty reduction, and dismantling of structural classism as critical aspects of helping people achieve their full health and wellbeing potential.

ClinialTrials.gov Identifier: NCT02734199.

INTRODUCTION

Sexual health is public health. However, sexual wellbeing entails not merely the ability to avoid sexually transmitted infections (STIs), unwanted pregnancy, or sexual violence; it also represents the opportunity for sexual flourishing, including a pleasurable, unstigmatized, and satisfying sex life. The World Health Organization,[1] the American Sexual Health Organization,[2] and major scholarly outlets in public health have all underscored the salience of sexual flourishing and not just prevention of sexual infirmity.[3,4]

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
© 2022 The Authors. *Perspectives on Sexual and Reproductive Health* published by Wiley Periodicals LLC on behalf of University of Ottawa.

Sexual health research still heavily skews toward negative sexual health outcomes. However, a growing body of empirical literature documents social and structural determinants of sexual wellbeing,[5] including disparities in who is most able to flourish in their sexual bodies. Gender is a key factor in this scholarship. For example, research on the orgasm gap indicates that in cisgender, heterosexual relationships, people with penises are much more likely to have orgasms than people with clitorises.[6] Social scientists and social justice champions are also investigating how structures of discrimination such as homophobia, transphobia, and racism constrain sexual flourishing.[7] Human rights advocates in the Global South have integrated "erotic justice" into social and political movements to uplift sexual rights and wellbeing of queer and sexually diverse communities.[8]

However, the scholarship on erotic inequities largely omits poverty and access to financial resources, even though socioeconomics is arguably one of the most significant influences on people's daily experiences. Despite a strong focus on poverty in the study of sexual health outcomes such as STIs, HIV/AIDS, and unwanted pregnancy, little research examines how positive domains of sexuality are shaped by socioeconomic status. This absence needs to be addressed for at least two reasons. First, incomplete understandings of sexual socioeconomic inequities weaken the public health field's commitment to positive sexual health for all. Second, if public health researchers and practitioners continue to focus solely on negative sexual health outcomes among communities experiencing poverty, we risk perpetuating the notion that people living on low incomes are undeserving of the basic human right of sexual wellbeing.

In an attempt to shed light on the understudied relationships between socioeconomics and sexual flourishing, our team examined data from a large cohort of people seeking family planning services. Here we present findings from an exploratory analysis of associations between economic resources and sexual wellbeing.

METHODS

Data derive from the HER Salt Lake Contraceptive Initiative (Contraceptive Trial Registration Number NCT02734199). Between March 2016 and March 2017, family planning clients in this large longitudinal cohort study in Salt Lake Country, Utah received their desired contraceptive method at no cost and could switch or discontinue at any time.[9] At baseline, participants completed socioeconomic and sexual wellbeing measures. We limit this analysis to participants who reported being sexually active in the past 4 weeks ($N = 2853$).

Measures

Economic measures included (a) how often participants had enough money to meet their basic living needs in the past month (all the time, most of the time, some of the time, rarely, or never); (b) current receipt of at least one form of public financial assistance, including welfare, unemployment, Supplemental Nutrition Assistance Program (SNAP), and Women, Infants and Children (WIC); (c) federal poverty level (FPL), in 100% FPL increments; and (d) level of difficulty paying for housing, food, transportation, or medical care in the past 12 months.

Sexual wellbeing measures included (a) the Female Sexual Function Index (FSFI-6),[10] which captures desire, arousal, pain, lubrication, orgasm, and overall sexual satisfaction; (b) the New Sexual Satisfaction Scale (NSSS),[11] which captures individual-level domains (e.g., feeling of letting oneself go), interpersonal domains (e.g., emotional closeness in sex), and behavioral domains (e.g., variety of sexual activity) of sexual satisfaction; (c) the FSFI-6 item on overall satisfaction with sex life (very dissatisfied, moderately dissatisfied, about equally satisfied and dissatisfied, moderately satisfied, or very satisfied); (d) the FSFI-6 item on orgasm frequency (never or almost never, a few times, about half the time, more than half the time, or almost always or always); and (e) current sex life rating on a scale of 1 to 100. After reviewing outcome distributions, we collapsed the lowest two and highest two categories for the overall satisfaction (c) and orgasm (d) items to avoid small cell sizes. We also created quintile variables for the FSFI-6 (a) and NSSS (b) sum scales, as well as current sex life rating (e) to facilitate interpretation of differences between groups.

Analyses

We conducted bivariate associations between our categorical sexual wellbeing and socioeconomic measures and compared socioeconomic groups using chi-square tests. We assessed significance at $\alpha = 0.05$ as well as at the Bonferroni-adjusted $\alpha = 0.0025$ to guard against potential false-positive associations.

RESULTS

Table 1 presents bivariate associations between our sexual wellbeing measures and socioeconomic indicators. We found strong and consistent relationships between sexuality and socioeconomics, all in the same direction—those reporting more socioeconomic constraints also reported signs of sexual flourishing. Out of 20 bivariate analyses between socioeconomic measures and sexual outcomes, three-quarters ($n = 14$) were statistically significant at alpha level 0.05. Here we share some more specific examples not shown in tables.

- Among those who always had enough money to meet their basic needs in the last month, 75% reported that they were either moderately or very satisfied with their sex life (FSFI-6 satisfaction item); their average current sex-life rating was 75 out of 100 (visual analog scale), compared to 56% and 66 out of 100, respectively, of those who did not have enough money ($p < 0.0001$).
- Among those receiving any assistance in the last month, one in three (30%) reported sexual functioning (FSFI-6) scores in the lowest quintile, compared to only one in five (19%) of those who had not received public assistance ($p < 0.0001$).
- Among those who had trouble paying for food, housing, transportation, or medical care in the past 12 months, 26% reported NSSS

TABLE 1 Associations between economic measures and sexual wellbeing measures among 18–44 year-old reproductive health clients, Salt Lake City, Utah, 2016–2017 ($N = 2581–2853$)

	Female sexual function index, quintiles		New sexual satisfaction scale, quintiles		Satisfaction with overall sex life (very dissatisfied to very satisfied)		Frequency of orgasm during sex (never/almost never to always/almost always)		Self-rating of current sex life, quintiles	
	χ^2	*p*-Value	χ^2	*p*-Value	χ^2	*p*-Value	χ^2	*p*-Value	χ^2	*p*-Value
During the past month, often did not have enough money to meet basic living needs	22.6	0.12	28.9	0.03*	30.7	<0.001**	12.8	0.12	35.5	0.003*
Currently receiving at least one form of public financial assistance (welfare, unemployment, food, WIC)	20.6	<0.001**	14.9	0.005*	12.8	0.002**	0.011	0.99	25.3	<0.001**
Federal poverty level	31.1	0.002**	26.5	0.009*	10.8	0.10	11.6	0.07	13.4	0.34
During the past 12 months, has had trouble paying for housing, food, transportation, or medical care	16.8	0.002**	28.0	<0.001**	34.1	<0.001**	15.3	<0.001**	23.7	<0.001**

*$p < 0.05$. **$p < 0.0025$ (the Bonferroni-adjusted *p*-value cutoff).

scores in the lowest quintile, compared to 18% among those who did not ($p < 0.0001$).

DISCUSSION

Results from this analysis suggest that economics are strongly associated with sexual wellbeing, with indications that financial scarcity may reduce sexual satisfaction, orgasm, and overall functioning. These results remind us that structural constraints affect sexual bodies. While findings are cross-sectional, possible pathways to these inequities could include poverty's emotional and physical taxes on bodies and cognition, as well as weathering related to economic stress and discrimination, which are likely to thwart sexual flourishing. To support and promote positive sexual health, the public health field must continue to focus on economic reform and poverty reduction as a critical aspect of helping people achieve their full health and wellbeing potential.

This study focused solely on women. Including cisgender men and gender-expansive individuals in research on economic constraints and sexual flourishing will be paramount. We must also consider socioeconomic status in relationship to race and ethnicity, gender, sexual identity, nationality and nativity, and other inequities with strong influences on sexual bodies. We chose deliberately to examine one axis of inequality here given its absence in prior research, but multilevel studies will be important. On the other hand, drawing from the scholarship of Lisa Bowleg and others, we caution that interaction terms alone will not accurately capture the lived experiences of communities who experience multiple oppressions.[12] We encourage scholars and practitioners to use mixed-methods, community-based, and structurally attuned approaches to both delineate and divert the underlying factors driving inequities in sexual wellbeing.

ACKNOWLEDGMENTS

This analysis was funded by an award (R01 HD095661) from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). Support for the HER Salt Lake Contraceptive Initiative comes from The Society of Family Planning Research Fund, The William and Flora Hewlett Foundation, and a large, anonymous family foundation. The following companies contributed contraceptive products: Bayer Women's Healthcare, Merck & Co Inc, and Teva Pharmaceuticals. The authors also acknowledge support from two NICHD infrastructure grants (P2C HD047873 for the University of Wisconsin-Madison; the Building Interdisciplinary Research in Women's Health K12 HD085852 for the University of Utah). Study data were collected and managed using REDCap (Research Electronic Data Capture) hosted at the University of Utah; this service is supported by Center for Clinical and Translational Sciences grant 8UL1TR000105. Dr. Turok is funded by an NICHD Midcareer Investigator Award (K24 HD087436). Leigh Senderowicz's contribution was supported by the National Institutes of Health under the Ruth L. Kirschstein National Research Service Award (T32HD049302) from the NICHD. Drs. Higgins and Senderowicz receive additional support from a center grant to the Collaborative for Reproductive Equity (CORE) at the University of Wisconsin-Madison. The content is solely the responsibility of the authors and does not necessarily represent the official views of any funding agency.

DISCLOSURES

Dr. Turok reported nonfinancial support from Bayer Pharmaceuticals, Merck, ad Teva Pharmaceuticals (now Copper Surgical), all of which provided contraceptive devices for the HER Salt Lake study. He also reports fees from Merck for the University of Utah Department of Obstetrics & Gynecology to conduct investigator-initiated research of the etonogestrel contraceptive implant outside the submitted work. No other disclosures were reported.

ETHICS STATEMENT

This study was approved by the University of Utah Institutional Review Board.

REFERENCES

1. World Health Organization. Sexual health World Health Organization. https://www.who.int/westernpacific/health-topics/sexual-health
2. American Sexual Health Organization. Homepage. American Sexual Health Organization. https://www.ashasexualhealth.org/
3. Landers S, Kapadia F. The public health of pleasure: going beyond disease prevention. *Am J Public Health*. 2020;110(2):140. doi: 10.2105/AJPH.2019.305495-141.
4. Morabia A. The public health of pleasure. *Am J Public Health*. 2020; 110(2, theme issue):133-160.
5. Boydell V, Wright KQ, Smith RD. A rapid review of sexual pleasure in first sexual experience(s). *J Sex Res*. 2021;19:1. doi:10.1080/00224499.2021.1904810-13.
6. Mahar EA, Mintz LB, Akers BM. Orgasm equality: scientific findings and societal implications. *Curr Sex Health Rep*. 2020;12(1):24. doi: 10.1007/s11930-020-00237-9-32.
7. Kumar P. Introduction to the special theme: erotic marginality and erotic justice. *Explorations*. 2018;2(1):16.
8. Collins D, Talcott M. 'A new language that speaks of change just as it steps toward it': transnationalism, erotic justice and queer human rights praxis. *Sociol Compass*. 2011;5(7):576. doi: 10.1111/j.1751-9020.2011.00386.x-590.
9. Sanders JN, Myers K, Gawron LM, Simmons RG, Turok DK. Contraceptive method use during the community-wide HER Salt Lake contraceptive initiative. *Am J Public Health*. 2018;108(4):550. doi: 10.2105/AJPH.2017.304299-556.
10. Isidori AM, Pozza C, Esposito K, et al. Development and validation of a 6-item version of the female sexual function index (FSFI) as a diagnostic tool for female sexual dysfunction. *J Sex Med*. 2010;7(3):1139. doi:10.1111/j.1743-6109.2009.01635.x-1146.
11. Štulhofer A, Buško V, Brouillard P. Development and bicultural validation of the new sexual satisfaction scale. *J Sex Res*. 2010;47(4): 257. doi:10.1080/00224490903100561-268.
12. Bowleg L. When black + lesbian + woman ≠ black lesbian woman: the methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles*. 2008;59(5):312. doi:10.1007/s11199-008-9400-z-325.

How to cite this article: Higgins JA, Kramer R, Senderowicz L, Everett B, Turok DK, Sanders JN. Sex, poverty, and public health: Connections between sexual wellbeing and economic resources among US reproductive health clients. *Perspect Sex Reprod Health*. 2022;1-4. doi:10.1363/psrh.12189