The incorporation of gender perspective into Spanish health surveys

Izabella Rohlf, Carme Borrell, Lucia Artazcoz, Vicenta Escribá-Águir

Background: Most studies into social determinants of health conducted in Spain based on data from health surveys have focused on social class inequalities. This paper aims to review the progressive incorporation of gender perspective and sex differences into health surveys in Spain, and to suggest design, data collection and analytical proposals as well as to make policy proposals.

Methods: Changes introduced into health surveys in Spain since 1995 to incorporate gender perspective are examined, and proposals for the future are made, which would permit the analysis of differences in health between women and men as a result of biology or because of gender inequalities.

Results: The introduction of gender perspective in health surveys requires the incorporation of questions related to family setting and reproductive work, workplace and society in general to detect gender differences and inequalities (for example, domestic work, intimate partner violence, discrimination, contract type or working hours). Health indicators reflecting differential morbidity and taking into account the different lifecycle stages must also be incorporated. Analyses ought to be disaggregated by sex and interpretation of results must consider the complex theoretical frameworks explaining the differences in health between men and women based on sex differences and those related to gender.

Conclusions: Analysis of survey data ought to consider the impact of social, political and cultural constructs of each society. Any significant modification in procedures for collection of data relevant to the study of gender will require systematic coordination between institutions generating the data and researchers who are trained in and sensitive to the topic.

Health interview surveys, which provide data about perceived morbidity, lifestyles, living conditions and health service utilisation, as well as revealing attitudes and opinions about specific topics, are useful in health planning. As such they are recommended by the World Health Organization (WHO) as an efficient way of obtaining planning. As such they are recommended by the World Health Organization (WHO) as an efficient way of obtaining planning.

However, these surveys suffer from certain limitations. These include the difficulty of making comparisons between different population settings, the analysis of time trends (since many surveys have changed over time, not only in terms of the variables collected but also in the formulation of questions), the difficulty in comparing data collected for the same concepts by different national and international organisations using different scales and the lack of “objective” instruments (that is, from an empirical or biological viewpoint) in order to permit external validation of the data, as most surveys rely on data based on the subjective perceptions of respondents. Furthermore, surveys frequently ignore social determinants related to the production of health and disease and do not record variables which are required for determining the impact of biological differences and social inequalities that operate differently for men and women. Other health affecting variables or constructs such as subjective perceptions of respondents. Furthermore, surveys frequently ignore social determinants related to the production of health and disease and do not record variables which are required for determining the impact of biological differences and social inequalities that operate differently for men and women. Other health affecting variables or constructs such as subjective perceptions of respondents. Furthermore, surveys frequently ignore social determinants related to the production of health and disease and do not record variables which are required for determining the impact of biological differences and social inequalities that operate differently for men and women. Other health affecting variables or constructs such as subjective perceptions of respondents. 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HEALTH SURVEYS AND THE STUDY OF SOCIAL INEQUALITIES IN HEALTH IN SPAIN

Health surveys have only been widely used in public health in Spain since the 1980s. The first significant study was conducted in Barcelona in 1983 and since then the number of local, regional and national surveys has steadily grown. Almost all the autonomous regions of Spain have now conducted at least one health survey. There have also been seven national health surveys (known in Spanish as Encuesta Nacional de Salud or ENS) conducted in 1987, 1993, 1995, 1997, 2001, 2003 and 2006.

To date, the study of social determinants of health using data from surveys has centred on the analysis of associations between socioeconomic level and health indicators. Unlike other routine sources of health information, health surveys collect data that permit factors such as health status, health service utilisation and lifestyles to be compared with demographic variables making it possible to identify the interviewees’ socioeconomic status and reveal the gradient of related inequalities and lifestyle and service use patterns. Social class, obtained through occupation, and educational level are used as the main variables to study health inequalities in terms of socioeconomic position. However, the incorporation of the study of gender inequalities from health survey data dates back only to the late 1990s and was initially scarce although the study of gender inequalities in Spain does have a longer history. National, regional and local health surveys have progressively begun to incorporate gender perspective into health research.

This greater sensitivity to gender issues and the increase in the number of studies is a result of various factors: (a) international experiences, (b) the exploitation of data from existing surveys, (c) the observation that certain questions formulated to better understand the health of the population and conditioning factors remained unanswered owing to a failure to collect the appropriate explanatory variables, and (d) concerns expressed by advocacy groups which have revealed the need to collect information on emerging and/or little known areas of public health. The first paper to establish the importance of the gender perspective in Spain in all stages of health interview surveys from sample design to question formulation and data analysis was written by the Gender Group of the Spanish Association of Public Health and Health Administration (SESPAS) in 2000. This influential paper also set the standards for future surveys.

Evolution of gender perspective in national health surveys from 1993–2006

Table 1 shows clearly how the Spanish national health surveys have evolved since 1993 and includes all the variables that were recommended by the SESPAS Gender Group paper. As will be observed, the first significant change in the variables was introduced in 2001 and special emphasis was placed in the main ENS report of 2001, published by the Ministry of Health.

Table 1 Progressive introduction of certain variables, which make it possible to conduct gender perspective analyses, into the Spanish national health surveys (ENS), 1993 to 2005–6

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|---------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|
| **Demographic and occupational** | **ENS 93** | **ENS 95** | **ENS 97** | **ENS 01** | **ENS 03** | **ENS 05–6** |
| De facto marital status | X | X | X | X | X | X |
| Living with a partner | X | X | X | X | X | X |
| Social class | X* | X* | X* | X* | X* | X* |
| Educational level | X | X | X | X | X | X |
| Job status | X | X | X | X | X | X |
| Productive work (paid) | X | X | X | X | X | X |
| Occupation | X | X | X | X | X | X |
| Position | X | X | X | X | X | X |
| Type of firm in which you work or worked | X | X | X | X | X | X |
| Activity of the firm where you work or worked | X | X | X | X | X | X |
| Type of contract | X | X | X | X | X | X |
| Full time or part time | X | X | X | X | X | X |
| Number of hours worked per week | X | X | X | X | X | X |
| Reproductive work (unpaid) | X | X | X | X | X | X |
| Family structure (cohabitation) | X | X | X | X | X | X |
| Domestic work | X | X | X | X | X | X |
| Performance of domestic work | X | X | X | X | X | X |
| Sharing of domestic work | X | X | X | X | X | X |
| Care of dependent people | X | X | X | X | X | X |
| Sharing of care of dependants | X | X | X | X | X | X |
| Availability of outside help (family or contracted) to carry out domestic and caring work | X | X | X | X | X | X |
| Number of hours of reproductive work | X | X | X | X | X | X |
| Morbidity, perceived health, quality of life and mental health | X | X | X | X | X | X |
| Perceived health status | X | X | X | X | X | X |
| Mental health and quality of life | X | X | X | X | X | X |
| Chronic conditions | X | X | X | X | X | X |
| Number of hours of sleep per day | X | X | X | X | X | X |
| Social support (existence and type of social network) | X | X | X | X | X | X |
| Network structure (size, density) | X | X | X | X | X | X |
| Functional social support (affectional and confidential) | X | X | X | X | X | X |

*In 1993, 1995 and 1997 a variable called social status was created: well off; medium-high; medium-medium; medium-low; low. Obtained by crossing level of education completed (illiterate; finished school aged 14–15 years; finished school aged 16–19 years; additional non-university studies; university studies; unknown) with occupation of the head of the household (self employed; public or private sector employee; other).

**In 2001, 2003 and 2005–6 social class was obtained through self occupation.

†Age, sex, relationship of cohabiting individuals.

‡Do the shopping, prepare meals, cleaning, ironing, etc.

§Children, elderly, disabled.

*List of the most prevalent conditions or disablements (table 2).
Table 2  Evolution of the list of chronic symptoms or conditions inquired about in the national health surveys (ENS), 1993 to 2005–6

<table>
<thead>
<tr>
<th>Survey</th>
<th>Chronic symptoms or conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENS 93, 95, 97</td>
<td>High blood pressure; raised cholesterol; diabetes; chronic asthma orbronchitis; stomach ulcer; heart disease; allergies</td>
</tr>
<tr>
<td>ENS 2001</td>
<td>Added: depression</td>
</tr>
<tr>
<td>ENS 2003</td>
<td>Added: emphysema (with asthma or bronchitis); other mental illness; headaches, migraines; poor circulation; hernias, arthritis and rheumatic conditions; conditions related to menopause; conditions related to prostate</td>
</tr>
<tr>
<td>ENS 2005–6</td>
<td>Added: myocardial infarction; varicose veins in legs; chronic back pain (neck); chronic back pain (lumbar); duodenal ulcer (with stomach ulcer); urinary incontinence; cataracts; chronic skin conditions; chronic constipation; stroke; piles; malignant tumours; anaemia; thyroid conditions</td>
</tr>
</tbody>
</table>

As we have seen above, health surveys are instruments that need to evolve to encompass new insights into areas of public health concerns and to adapt to social changes. This, however, frequently presents the dilemma as to whether historical series should be maintained in order to allow comparisons between surveys over time.

Analysis with gender perspective

In spite of the progress achieved in the design of health survey questionnaires in Spain, scientific literature in indexed publications still fails to reflect the significant increase in studies carried out to investigate the impact of gender as a determinant of health in women and men. It should also be noted that many studies and reports offering a gender perspective are not published in scientific journals or by commercial publishers but rather form part of what has been called a “grey literature” that is only made available to a limited readership consisting often only of those who have commissioned the work. Despite the fact that the results of these reports and studies may not be widely or publicly known, it is to be expected that they should act as a foundation for the development of public health policies.

One point that stands out from a review of literature in Spain using the words “gender” or “sex” (1995–2005) is that although there has been a notable rise in recent years in papers studying the variables mentioned above as being important for determining the impact of gender relationships on health, many do not perform an in-depth study of gender but only conduct a descriptive analysis disaggregated by sex or, alternatively, fit multivariate models adjusted by sex.

Disaggregation by sex, while constituting one of the first steps in any analysis of gender health inequalities, is not sufficient to understand the full underlying complexity of the situation. The interaction between sex, which unlike gender is a measurable variable, and other variables, social constructs, and biological characteristics can also have an impact on health. These interactions may be additive or multiplicative, and in the multivariate analyses certain factors may counteract the effect of sex. It should also be noted that the direction of certain associations between variables may be different when the analysis is stratified by sex. Data must be analysed with care in order to emphasise the social relationships between the sexes and clearly delineate underlying inequalities in them. In this respect, one of the aspects to be taken into account in analyses incorporating gender perspective is the life cycle, given that biological and social differences that vary depending on the age group can have a significant impact on determining gender patterns.

PROPOSALS AND CONCLUSIONS

In a broad definition of health, the analysis of data from vital statistics and health information, principally from surveys,
needs to consider the impact of the social, political and cultural constructs of each society. For example, as stated before, collecting data on working conditions inside and outside the household is fundamental to understand health outcomes of women and men.

As is detailed in table 3, careful attention to certain aspects of survey design, incorporating a gender perspective into health surveys, and to the correct analysis of the data and the way that it is expressed is essential in order to deepen our understanding of public health inequalities.

The researcher in public health must be aware that there are informational gaps; that it is often impossible to disaggregate data by sex, although it should be borne in mind, as mentioned earlier, that an analysis disaggregated by sex is not sufficient to understand the importance of gender as a determinant of health in women and men. In any case, a critical reading of the findings, which must be discussed within the historical, political and social contextual framework of the society in which men and women live, is absolutely essential.

While improvements and innovations to surveys are often the result of scientific evidence, they may also be introduced in response to the work of advocacy groups, which have revealed the need to collect information on emerging issues, or issues that are not sufficiently studied from a public health perspective. The inclusion of gender perspective in health surveys is an example of modification being made as a result of a combination of both of these reasons.

That there is growing scientific interest and political will regarding the study of gender inequalities in health can be clearly observed. Health surveys in general, and in the case of Spain the ENS, are excellent sources of information for determining these inequalities, and their use not only for research but also for health planning and the formulation of public policy should be actively encouraged.
What this paper adds

- It was found that health surveys often fail to take into account the social determinants related to the production of health and disease. Aspects such as social class, gender and work (reproductive and productive), which affect people’s health, are often not tackled in sufficient depth.
- Furthermore, the variables required to determine the impact of biological differences and social inequalities which operate differently for men and for women are frequently not collected.
- The paper reviews the progressive incorporation of gender perspective into health surveys in Spain and makes proposals for future improvements.

Policy implications

- Taking a broad definition of health, the analysis of data from health surveys ought to consider the impact of social, political and cultural constructs of the population being studied.
- In refining the design of populational health surveys, it is essential that policymakers, social health investigators, epidemiologists and interest groups should contrast their perspectives and pool their knowledge in order to establish national guidelines that overcome shortcomings in the identification of gender and other social inequalities, which result in the failure to address unseen needs.
- The improved resulting data will help in formulating action plans that equitably tackle disadvantaged sectors of society.

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APHORISM OF THE MONTH

“I believe that women-centred, physiologically accurate knowledge of what is normal related to our female bodies, menopause, menstrual cycles and many other aspects of our health does not exist”

Jerilynn C Prior

Jerilynn Prior made this statement during the First Congress on Women, Health, and Work (Barcelona, 1996). She is one of the first researchers who, over 20 years ago, realized that to avoid perceiving women as victims of their bodies or their culture an alternative approach was necessary. She thought it necessary to studying their health while taking biological, psychological and sociocultural factors into account. She also realized that this approach required taking what was “normal” in women’s biology as a starting point. When early in her career Jerilynn Prior had begun researching the role of the healthy menstrual cycle in the entire body’s functions, both during the reproductive period and during the transition towards menopause, she assumed that this “normalcy” was already defined in science, even if it was ignored or not applied. However, what she discovered was that this basic, necessary information simply did not exist. She has been devoted to this task ever since.1-5

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