This report has been prepared by the Observatory on Women's Health. The first in a series, it will assess subsequent achievements as well as those aspects that have to be approached throgh our National Health System, in order to improve the equity as well as the quality of the health care that is offered to men and women.

Health and Gender 2005 Report

Health and Gender 2005 Report

MINISTRY OF HEALTH AND CONSUMERS' AFFAIRS

REPORTS, STUDIES AND RESEARCH 2007
MINISTRY OF HEALTH AND CONSUMERS' AFFAIRS. SPAIN

MINISTERIO
DE SANIDAD
Y CONSUMO

www.msc.es

Health and Gender 2005 Report

MINISTRY OF HEALTH AND CONSUMERS' AFFAIRS. SPAIN

Edita y distribuye:

CENTRO DE PUBLICACIONES
PASEO DEL PRADO, 18, 28014 Madrid

NIPO: 351-07-050-7
Depósito Legal: M-46884-2007

Catálogo general de publicaciones oficiales
http://www.060.es

Health and Gender
2005 Report

MINISTERIO
DE SANIDAD
Y CONSUMO

Plan de Calidad para el Sistema Nacional de Salud

The Observatory on Women's Health (OSM) has been part of the Directorate General of the Ministry of Health and Consumers' Quality Agency, since 2004. It targets health inequalities on account of gender, aiming at promoting their progressive disappearance. It acts in a participative and cooperative manner in order to generate and disseminate the kind of knowledge which may enable analysis from a gender perspective and promote the inclusion of both equity and a gender approach in health policies and systems.

Task force:

Colomer Revuelta, Concepción. Observatory on Women's Health. MHC. Madrid.
Espiga López, Isabel. Observatory on Women's Health. MHC. Madrid.
García Izaguirre, Clara. Observatory on Women's Health. MHC. Madrid.
López Rodríguez, Rosa. Observatory on Women's Health. MHC. Madrid.
Mosquera Tenreiro, Carmen. Observatory on Women's Health. MHC. Madrid.

Collaborations:

Public Health General Directorate.
National Drugs Plan.
Women's Institute.
Healthcare Information Institute.
Lligam Recerca (Consultant).

Thanks for the manuscript revision and contributions, to:

Mercedes Alfaro Latorre. Healthcare Information Institute. MHC. Madrid.
Lucía Artazcoz Lazcano. Barcelona Public Health Agency. Barcelona.
Carme Borrell i Thió. Health and Gender Research Network. Barcelona.
Flora de Pablo Dávila. CSIC Biological Research Centre. Madrid.
Vicenta Escribá-Aguir. Health and Gender Research Network. Valencia.
Esteve Fernández. Healthcare Gazette. Barcelona.
Alberto Infante Campos. Quality Agency DG. MHC. Madrid.
Daniel La Parra Casado. Alicante University. Alicante.
Luis Andrés López Fernández. Andalusian School of Public Health. Granada
Lucía Mazarrasa Alvear. Health and Gender Research Network. Madrid
Consuelo Miqueo Miqueo. Zaragoza University. Zaragoza
Juncal Plazaola. Andalusian School of Public Health. Granada
Isabella Rohlfs Barbosa. Health and Gender Research Network. Girona
Isabel Ruiz Pérez. Health and Gender Research Network. Granada
Andreu Segura i Benedicto. Health Studies Institute. Barcelona
Enrique Terol García. Healthcare Planning and Quality Office. MHC. Madrid
Marian Uría Urraza. Asturias Women's Institute. Oviedo
Carmen Valls Llobet. Health and Gender Research Network. Barcelona
Isabel Yordi. Gender Unit. WHO-Europe Copenhagen.

Summary

Foreword

With a view to adequately address both women and men's health, social determining factors are to be considered amongst others, along with those inequalities that for the sheer fact of being unjust and avoidable must be targets for public authorities' action.

Researching, gathering and disseminating information on health inequalities on account of gender are thus material tasks. This present 2005 Health and Gender Report, in itself one of the 45 measures adopted by the March, 2005 Cabinet Meeting to favour equality between women and men, is intended to serve this very end.

This is the first of a series which will enable the tracking of progress made and aspects to be sequentially addressed in the course of time. It includes those subjects on which there is already evidence of gender inequalities. Such is the case of cardiovascular diseases, AIDS/HIV or the effects on heath of certain types of work. Actions aimed at reducing them are outlined here.

This Report also reflects the need for health authorities to count on more and better information about gender inequalities that surface in relevant matters, as for instance, injuries resulting from traffic accidents, obesity or tobacco, alcohol or illegal drugs consumption. That is why research and study initiatives are set forth in the Report to better and more completely deal with their being addressed in the near future.

I am convinced that this is a line of analysis and proposals that is already proving to be very important, and will be much more so in the future, to improve both equity and quality of the healthcare our National Health System provides to women as well as to men.

Elena Salgado Méndez
Minister of Health and Consumers' Affairs

1. Introduction

This report is the first of its kind issued by the Ministry of Health and Consumers and is aimed at contributing to the reduction of inequalities between women and men.

Women's health is not what is dealt with in here, but rather the association between health and gender, and the how gender is a health determining factor. The Report's starting point is the recognition that gender is not synonymous with sex or women but rather a relational concept.

This Report is not intended to be thorough. It just addresses from a gender perspective those aspects on which the need for action has already been established. Future reports will take care of issues that undoubtedly deserve attention but need further information and deepened analysis before proposals for action can be set forth.

The latest demographic trends for the Spanish population are low fertility, aging, rising immigration and all these factors impact on households structuring and dispensing of official and unofficial care.

Life expectancy improvement has had an impact on the evolution of the burden derived from illnesses and disabilities (different for women and for men). This in turn has had a repercussion on the provision of personal care services within families, which continue to fall on women, hired immigrant women having recently come on stage.

Analysis on health determining factors shows differences and inequalities related to both gender and social class. Broadly speaking, men still lead less healthy lifestyles than women. But the significant and relatively recent incorporation of women to the public sphere, has brought their health determining factors progressively closer to those traditionally ascribed to men (as happens with tobacco and alcohol consumption). On the other hand inequitable distribution of times and care burden between women and men shows up both in the public and in the private sphere as well as access to so called productive jobs. Also, this advening of women to productive work without the counterpart incorporation of men to reproductive work, hinders women's benefiting from free time to devote to physical activity, leisure enjoyment or getting enough sleep.

Incidence and consequences of illnesses differ between women and men in accordance with biological features, and present inequalities due to gender. In the former case, the different types of cancer would be an example and in the latter, gender bias detected in medical care to cardiovascular diseases.

Telling what owes to sex from what owes to gender may prove more complex in some processes than in others as is the case of the change in AIDS/HIV epidemiological pattern or injury due to external causes. It is widely accepted that healthcare services and providers occupy an important role, still to be developed, in promoting gender equity.

The trend in present-day societies towards life medicalizing, has a greater impact in the case of women, partly because they tend to resort to healthcare services earlier and more frequently than men in what their reproductive aspects are concerned. But also due to gender considerations, healthcare policies and services structuring show a penchant for intervening to a greater extent in women's health and for medicalizing their life cycle (giving birth or menopause care, amongst others).

Violence against women is a public health concern in keeping with its magnitude and with its repercussions on their physical, mental and social health. It has proved to be a complex issue in all its dimensions, regarding both its causes (that are social) and the knowledge about its frequency (in which methodological and ethical aspects must be considered when early detection is the matter) as well as its care (that must be comprehensive and coordinated among all sectors involved. Act 1/2004 provides the action framework for its integral tackling; its impact will have to be assessed in the medium and long run.

Conclusions, after inspection of political interventions put into action to address women's health and the gender approach to health matters, from Health and Equality Plans, point to a still existing emphasis on women's reproductive and health aspects and although gender equality is regarded as a general principle, targets and operational measures to make it a reality, are still scarce.

2. Conceptual aspects and definitions

In the United Nations Millennium Declaration as well as in other international agreements, the importance of equal rights between women and men is recognized along with everyone's right to living free from discrimination in all ambits of life, access to healthcare included. Many countries have accepted this and other similar commitments[1], and are in the process of introducing the necessary changes in the healthcare sector.

This Report is intended to abide by the terms of the Agreement of the Cabinet Meeting and published by Order PRE/525/2005, of 7 March, by which measures are adopted to promote equality between women and men. Among them Measure 4.3., by which "Agreement is reached on the drafting of an Annual Report on Health and Gender that shall be submitted to Parliament". It is therefore the Ministry of Health and Consumers' first Annual Report on this subject; it is based on 2005 information and previous years when applicable, and constitutes the reference line for subsequent analysis on gender inequalities in health matters.

The aims of the 2005 Report on Health and Gender are:

- To contribute to understanding gender inequalities in health and the role of the National Health System (NHS) to this respect.
- Initiate a series of Health and Gender Reports that will periodically analyse health and its determining factors from a gender perspective, putting forward actions aimed at promoting equity and quality of the National Health System and at reducing or eliminate gender inequalities.

This Report does not deal with women's health but with the association between health and gender; on how gender is a health determining fac-

[1] United Nations' International Pact on Economic, Social and Cultural Rights, International Pact on Political and Civil Rights, Convention for the Elimination of All Forms of Discrimination against Women (1979), Declaration on the Elimination of Violence against Women (1993), Action Programme of the International Conference on Population and Development (1994), Copenhagen Declaration on Social Development (1995), Beijing Declaration and Platform for Action (1995), Declaration of Commitment on (the fight against) HIV/AIDS, United Nations' General Assembly on HIV/AIDS (2001); Mainstreaming Gender Equity in Health: The Need to Move Forward (Madrid Statement (2001) and European Union Council (2006/C 146/02).

tor. The starting point of the Report is the assumption that gender is not synonymous with either gender or woman. It is a relational concept that targets inequality relations between women and men and the impact this inequality has on people's life as well as on their health.

It should be pointed out that not all differences in health between women and men entail gender inequity; the concept targets those considered to be "unnecessary, avoidable and, moreover, unjust" (Gómez, 2002).

Therefore, achieving full gender equity in health would not necessarily translate into equal mortality and morbidity rates in women and men, but into the wiping out of avoidable differences, when it comes to enjoying good health and not falling ill, to enduring disability or dying of causes that might have been prevented. It should not have to mean forcibly equal share of resources and services for men and women, but a differential assignment and reception of resources in accordance with each person's particular needs and with each socio-economic context.

Gender analysis must be used when examining differences in relations between women and men and their respective roles, as well as the way those differences may affect the aspects below:

- Health and disease social and cultural determining factors
- Protection and risk factors
- Access to resources for promoting and protecting health; information, education, technology and services, among others
- Signs, seriousness, and frequency of illnesses
- Health systems and services responses
- Fresh knowledge production, dissemination and consumption

This Report does not intend to be thorough in its treatment of information on illnesses or health problems and neither does it mean to be on the functioning of the NHS with regard to women and men. It just addresses those aspects upon which there is already evidence of the need for action from a gender approach.

In future Reports other subjects may be discussed that, no wonder, deserve attention but would entail further analysis and information gathering before enabling us to formulate proposals for action.

Glossary on Gender WHO[2]

The term **gender** is used to describe those men and women's traits based upon social factors whereas sex refers to biologically determined characteristics. Individuals are born with feminine or masculine sex but learn to be boys and girls who later become men and women. This learned behaviour makes up gender identity and determines genders roles.

Gender analysis defines, analyses and informs the measures aimed at confronting inequalities deriving from the different roles ascribed to women and men or from unequal power relations between them and the consequences of such inequalities in their lives, their health and well-being. The way in which power is distributed in most societies makes less accessible to women and beyond their control the necessary resources to protect their health and fewer the probabilities of their intervening in decision making. Gender analysis in the healthcare sphere usually reveals the way in which inequalities will result in harm to women's health, limitations they will have to confront to achieve good health and ways to face and overcome such limitations. Gender analysis also highlights the health risks and problems males have to face up as a result of the social playing of their role.

Gender equality is tantamount to absence of sex-based discrimination in terms of opportunities, allocation of resources and benefits or access to services.

Gender equity refers to impartiality and justice in the distribution of benefits and responsibilities between men and women. The concept recognizes that men and women have different needs and enjoy different powers and that such differences must be determined and addressed with a view to correcting the unbalance between sexes.

Gender issues incorporation. United Nations Economic and Social Council Resolution defines incorporation of gender issues as «... the process of evaluating the consequences that any planned action has for men and women, including legislation and policies or programmes in any sector and at all levels. It is a strategy to make women and men's problems and experiences an integrated

[2] WHO POLICY IN GENDER ISSUES. Integration of gender perspectives in WHO activities. Glossary on Gender.. http://www.who.int/gender/mainstreaming/ESPwhole.pdf

dimension of the design, implementation, follow-up and assessment of measures, in all political, economic and social spheres in such a way that women and men result equally benefited and so that inequality is not perpetuated. The ultimate aim is to achieve gender equality». «Incorporation of gender issues is a process both technical and political that demands the introduction of changes in organization cultures and mentalities as well as in objectives, structures and resources allocation… Incorporating gender issues calls for changes at different levels within institutions, at the setting up of programmes, designing of policies, planning, implementation and evaluation. Among the tools available for incorporation purposes stand new practices of personnel assignment and budgets preparation, training programmes, political proceedings and guidelines.»

3. Demographic aspects

The most recent demographic trends among the Spanish population have been low fertility, aging, immigration increase and the impact of all this on how households are structured and on the provision of official and unofficial care. Life expectancy improvement has had an impact on the evolution of the morbidity and disability burden, and the provision of personal care within families, has largely been taken on by immigrant women (Solsona and Viciana, 2004). »

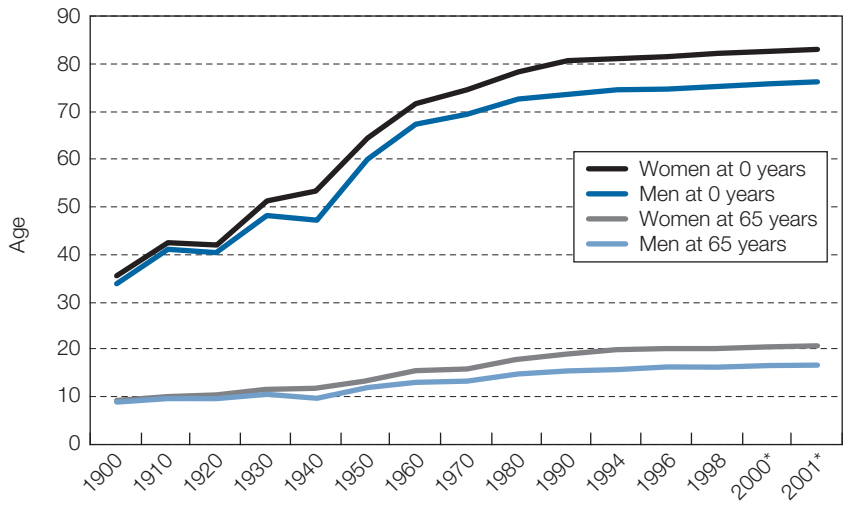
Fertility decrease in Spain throughout the 20th century is in keeping with a reproductive behaviour trend present in all modern societies and is associated with different processes of demographic, social, economic and cultural change (Garrido, 1996; De la Rica, 2003). Especially with women's incorporation to the work market which takes place in more precarious working conditions than those of men and without co-responsibility on their part in the housework and care, which makes it difficult for women to conciliate personal, family and working interests.

Demographic transition in Spain takes place in two phases. The first of these represented by women born in the first half of the century was characterized by a reduction in the number of children per woman (INE, 1999; Bernardi, 2003). In the second phase, the generations of women born in the 50's got further involved in the educational system and work market than preceding generations, and the women of the 60's delayed the age of emancipation from the family home, marrying age and maternity. (Solsona and Viciana, 2004).

Aging of the Spanish population is due on the one hand to a decrease in fertility and on the other to the increase in life expectancy. Life expectancy at birth in Spain is of 77.2 years for men and 83.7 for women in 2003 (OECD, 2005).

The increase in longevity, measured in terms of **Life Expectancy,** is an indicator that reflects both an improved state of health and the higher social, economic and healthcare levels in the country all along the 20th century. This increase of life expectancy in Spain was higher among women, the gap between them and men growing progressively wider, up until the last decade of the century, in which for the first time, life expectancy increased for men more than for women (from 1991 to 2002 it increased 3 years for men and 2.5 for women) (Chart 1). This change could be explained, at least partly, in terms of the significant decrease in men mortality resulting from traffic accidents and liver cirrhosis and a little less from lung cancer, and, to a lesser extent, due to the increase of mortality for this latter reason among women.

Chart 1: Life expectancy at birth qnd at 65 years of age (1900 2001)



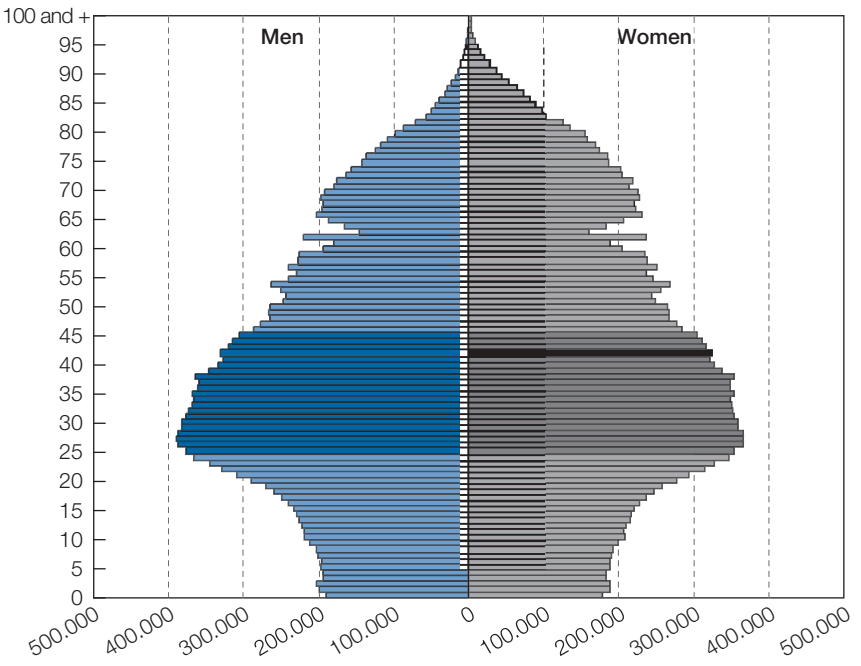
Source: INE. Anuario Estadístico de España, 2005.

In Spain the population group that grows the most in the last decade is that of 80 years and older, whereas the one that decreases the most is the one of youngsters of up to 20 years of age (Chart 2).

However, according to the estimates, negative vegetative balances expected for the beginning of this century, would be delayed until halfway through it, due to the demographic growth resulting from the increase in immigrants that also present a higher fertility rate. The arrival of young adults and the increase in birth figures will postpone though not reverse, the aging process of Spanish population (IMSERSO, 2004) (Chart 3).

In developed countries extended longevity does not necessarily translate into more years of life lived in good health since present-day health problems are characterized by their chronicity and do not imply immediate death. Along this line of thought, in order to assess the state of health of a population it has proved to be essential to measure, not just mortality or morbidity, but also the consequences of the illness. Thus, other useful indicators have started to be used to assess the quality of life or state of health in which such life expectancy is lived.

Chart 2. **Spanish population pyramid by sex and age groups. 2003**



Source: INE, 2004.

Life Expectancy Free of Disability[3] (MHC, 2000) offers information not only on duration but also on quality of life. In Spain at birth it stands at 69 years for men and 72.4 for women, sustaining a rising trend, and higher in both cases than European Union countries' average.

Life Expectancy Free of Chronic Illness[4] (MHC, 2002) in Spain, shows a different behaviour pattern, as men at birth have 41 years compared to the 38 years women have.

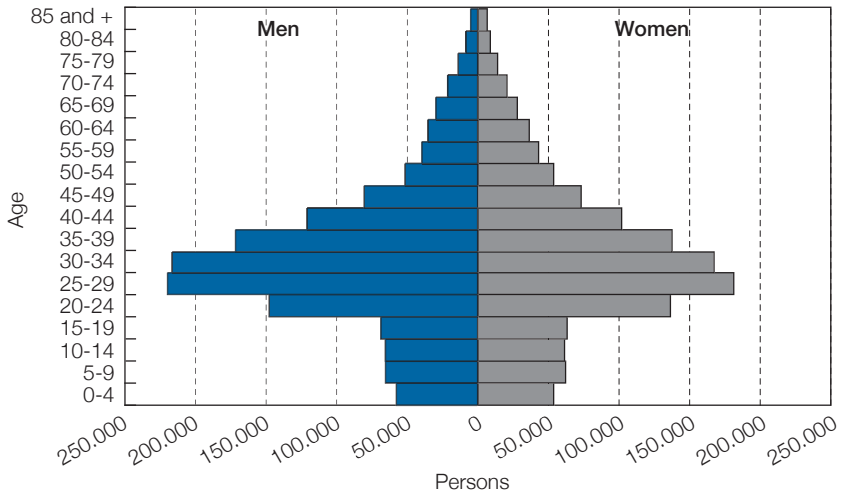
Life Expectancy in Good Health[5] (MHC, 2002) differs from the previous ones in that years to be lived are considered taking the subjective per-

[3] It reflects the average number of years free of disability for a person to enjoy at a given age. It is calculated using mortality and disability data.

[4] It shows the average number of years free of chronic illness for a person to live from thet age until the time of death.

[5] It shows the average number of year for a person to live in good health from a given age until their death.

Chart 3. **Foreign population by sex and age groups**



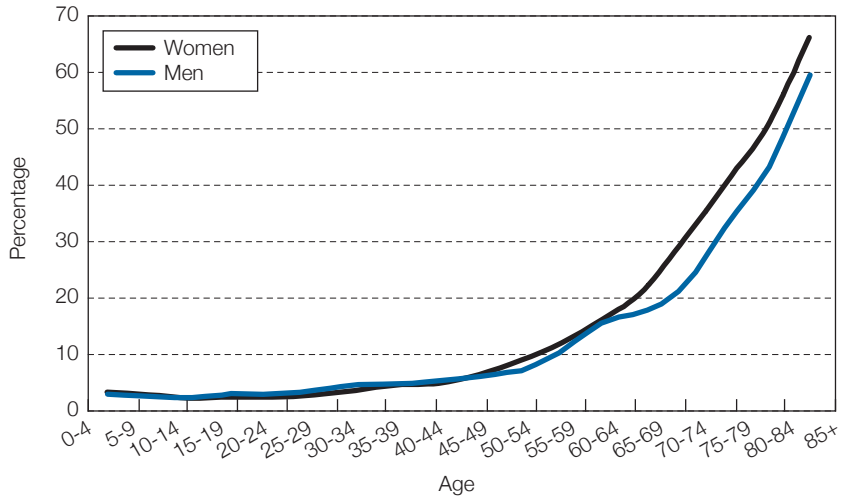
Source: INE: INEBASE: Revision of the Inhabitants Municipal Register - 1st January 2003. INE, 2004.

ception of one person's state of health, instead of considering it in terms of years of disability or chronic illness. In 2002, it meant at birth, 56.3 years for men and 53.9 for women.

We can summarize by saying that women have, when compared with men, a greater life expectancy at birth and at 65, but that their life free of chronic illness and with a good self-perception of one's own health, is shorter than for men. Contrary to what happens with regard to life free of disability where men are more affected.

Disability is to a great extent associated to age. According to the last survey on disabilities and state of health (EDDES, 1999), 59% of people who declare to suffer from it are over 65. Also, and partly related to their greater longevity, 58% of people suffering from disability are women. These present disability global rates and per age group (exception made of the youngest), higher (10.3%) than men (7.7%) this gap, growing wider with age (Chart 4).

Chart 4. Distribution of disability by age and sex



Source: IIMSERSO. Monographic Study. Disability in Spanish Population. 2004.

The most frequently declared disability in women as well as in men is the difficulty to move around (6.8%), followed by limitations to take care of oneself (5.1%) and the incapacity to see (4.3%). In all types of disabilities, frequencies are higher in women than in men.

4. Self-perceived health

Self-perception of one's state of health is a subjective and summary indicator that reflects on physical state, illnesses suffered and, at the same time, social, and economic factors from the person's milieu. Despite its simplicity, it is a good predictor of mortality and useful to make comparisons among different populations (Segovia, Bartlett and Edwards, 1989; Idler and Benyaminy, 1997).

To the above concept, the complexities of historic and socio-cultural dimensions that construct and have an influence on the way the population assess their own state of health, are to be incorporated. The various cultural conceptions on health, their meanings, the way to take care of it and expectations about it, take shape through the articulation of variables of social and cultural nature, in the frame of daily life. One's own experiences in relation with health and illness have an influence in the appraisal on one's own state of health.

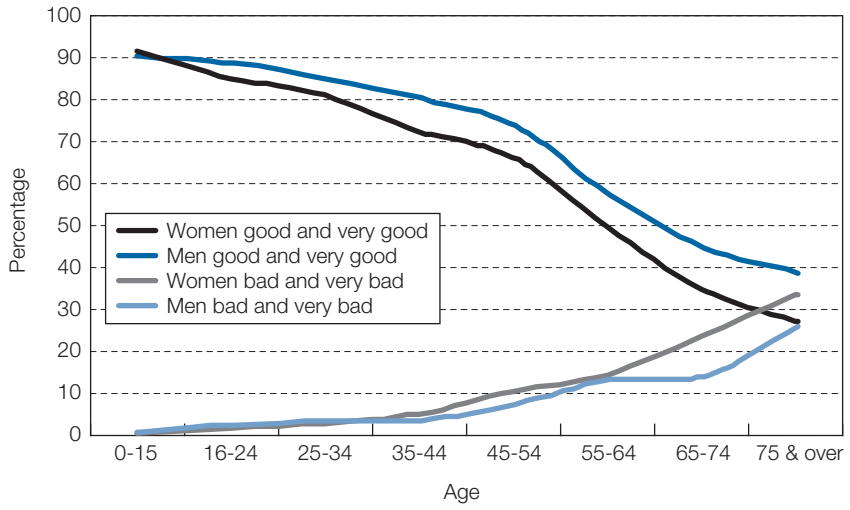
In persons over 16 years of age, the perceived state of their health is worse in women than in men of all social classes (Charts 5 and 6). On the contrary, during childhood, perception of good or bad health (6), is more frequent in girls than in boys. It is important to point out, regarding this information, that it is not gathered directly from children themselves, but from the adult person in their care. The subjective component of self-perception is thus replaced by someone else's perception of the minor subject, which means that other factors take part, including the possible gender bias from whom the assessment is made.

Among the few existing initiatives to gather information straight from minors we can mention the studies conducted using the Child Health and Illness Profile (Starfield, 1995; Rajmil, 2003; Serra-Sutton, 2003). According to its results, among Barcelona teenagers between 12-15 years, girls showed a lower degree of satisfaction and well-being and a better academic performance than boys. In general these results were worse for both sexes in groups with a lower level of family education.

Most women claim to enjoy good health until 54 years of age whereas men perceive it as good until 64. With age, state of health worsens in the whole population, but also the gap between men and women grows wider, a third of women over 75 believe their state of health to be good or very good, though for each one of them there are two men in the same belief.

[6] National Survey on Health for Minors under 16 years, 2001

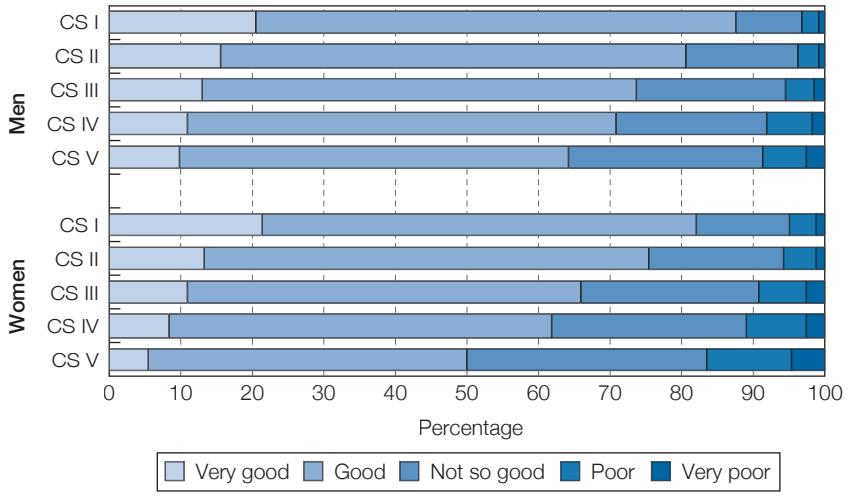
Chart 5. Perception of one's state of health by sex and age



Source: Abellán, 2004.

It is important to point out that state of health is also influenced by the social class one belongs to. (Chart 6). Best health is enjoyed by both women and men of the most privileged classes while, on the contrary, people with handcraft occupations, qualified or not, are those that declare the worst health, especially women with non-qualified jobs. In spite of all this, when considering women of the same social class, those employed have better health than those devoted to non-remunerated housework. Furthermore, this difference becomes more accentuated with age in such a way that, taking social class in a cross section, elderly women having work at home alone, would be, in general terms, the ones in poorest health. Some of the reasons that explain this are discussed in the section dealing with work effects on health.

Chart 6. Self-perceived health and social class (7)



Source: M. Rodríguez-Sanz, 2005.

[7] In the 2003 National Health Survey, occupation is codified in accordance with the National Classification of Occupations; it is grouped according to the proposal of the Spanish Society of Epidemiology and finally social class is obtained through the following categories or groups: SC I: Top businessmen/women, Executives and college professionals; SC II: Small businessmen/women and technical professionals; SC III: Administrative workers, superiors, security workers, SC IV: Qualified and semi-qualified handcraft workers ; SC V: Non-qualified workers.

5. Life Patterns

a) Diet, physical activity and sleep

These are three of the basic components of life patterns that influence people's physical, mental and social health. Body weight, physical fitness and general well-being depend to a great extent on their proper balance and are in turn influenced by genetic and social factors, among them, gender. There exists evidence of gender and social class inequalities in the access to a healthy diet (for reasons of economic or cultural nature or availability of time to spare among others), to the practice of regular and healthy physical activity, either at work (productive and reproductive), or in free time (because of free time availability , access to sport facilities, habits and attitudes) and during sleeping time depending on working timetables and dedication to reproductive work.

Diet and physical activity are, together with genetics, the factors with the most impact on body weight and both overweight and underweight have an influence on people's physical, mental and social health.

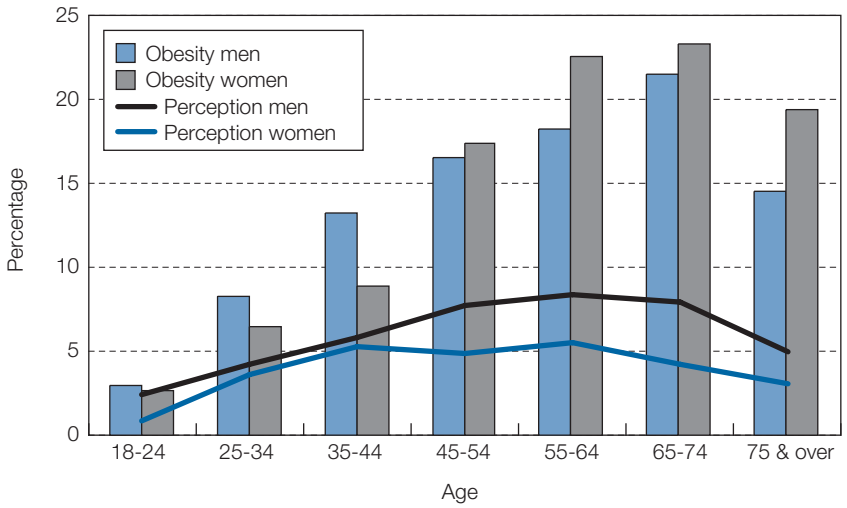
In the National Health Survey, interviewees are asked about their weight and size and from their answers the Body Mass Index[8] is calculated. This index may underestimate overweight as people tend to declare less weight and bigger size than is true. They are also directly asked about the perception they have of their own weight in relation with their size. This way two types of information are obtained: a subjective one and a relatively more objective one, based on the weight and size they declare they have and not on their actual measuring.

According to results yielded by 2003 National Health Survey, overweight frequency is similar for men and women (13.2% and 13.1% respectively) and presented an average increase of three points in the last decade, slightly higher for women. Overweight frequency increases with age for both sexes but is higher for men up until 45 years of age; from that point onwards it is more frequent in women (Chart 7).

Chart 7 shows overweight distribution as per BMI, and category "overweight well beyond normal" from personal weight assessment in relation to size. Comparing both items and assuming that "overweight well beyond normal" means "obesity", it can be observed that though curves trace similar

[8] The **BMI** measures body weight in relation to the size and classifies the results in a gradient that ranges from underweight for a specific size to obesity (>30 Kg. per m2).

Chart 7. Comparison between perception on weight "(well beyond normal") and obesity (BMI>=30) depending on age and sex.



Source: Inhouse, based on NHS 2003.

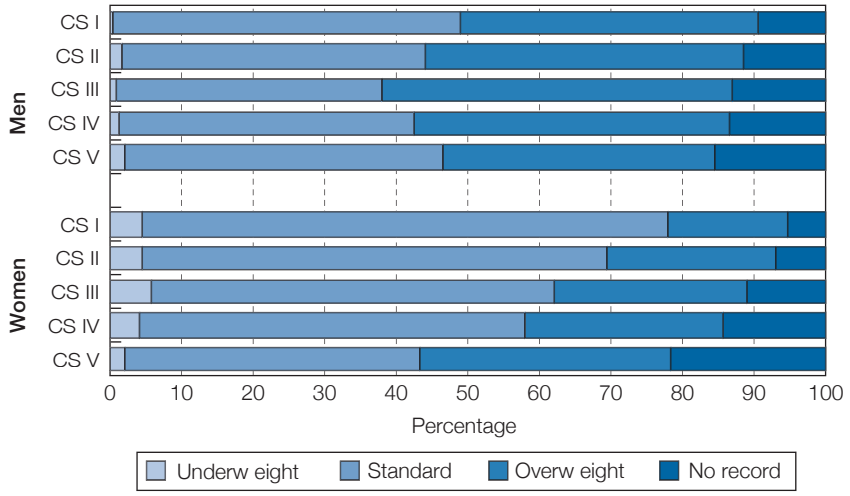
shapes. both women and men show perception of their obesity frequencies below obesity frequencies according to BMI. Women in general show for all ages a perception of obesity beyond that of men, even at ages when frequency is higher in men.
These differences between men and women might mean an increased interest of women about their weight and a lesser concern of men about their health care (Sabo, 1995).

According to 2003 National Health Survey (Chart 8), underprivileged **social classes,** exhibit a greater proportion of **obesity** both in women and men, although for women the class gradient is higher. However, **underweight** is more frequent among women from upper classes and men from lower classes.

Differences between women and men's dietary habits are also noticeable. NHS results show an over 5% prevalence of people that have no breakfast at all most of whom happen to be men. As far as age is concerned data analysis shows that women between 16 and 45 are the ones to have the least breakfast, so much so, that it can be said that one out of ten women have nothing to eat in the morning.

As for **physical activity**, especially that performed during main activity time, men, to a greater extent than women, engage in activities that demand

Chart 8. **Weight distribution in terms of body mass depending on social class, in men and in women, Spain, 2003**



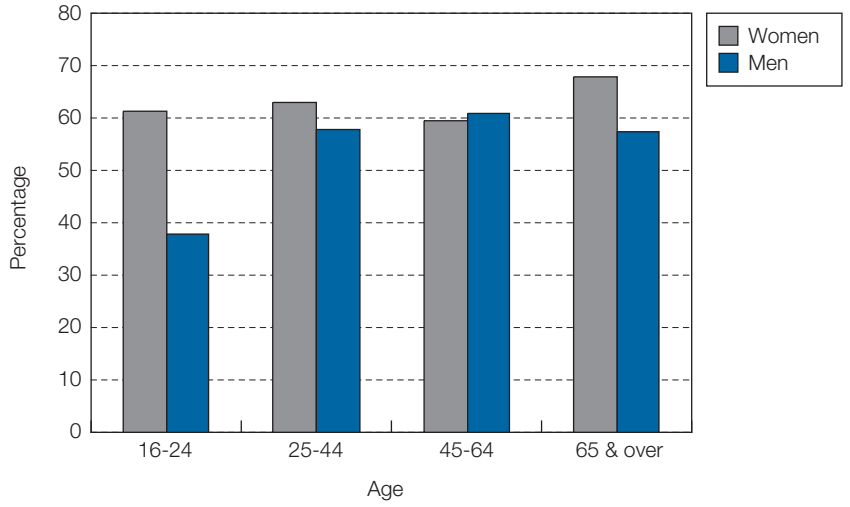
Source: M. Rodríguez-Sanz, 2005.

a greater physical effort and activities requiring to remain seated the most part of the working day. More than one half of women and one third of men devote their time to activities that require to stand most of the day, involving no big efforts or travelling.

Data on **sedentary free time** reveal important differences, above all at extreme **ages** during lifetime and especially among the youngest, where the percentage of she-sedentary lifestyles outnumbers the one of he-sedentary lifestyles (Chart 9). Although in general, the proportion of sedentary people decreases as education level increases, women appear to be more sedentary at all levels (Chart 10).

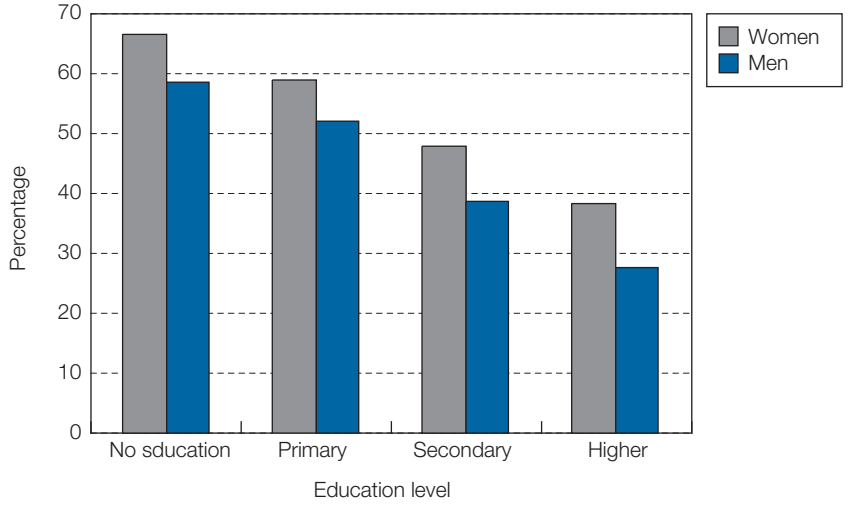
These differences might be reflecting differences in education, –family, school and social–, and in the access to those resources from the social environment that enable the engaging in healthier conducts. Opportunities for playing sports are different for boys and for girls and with a few exceptions, the most popular social sports snapshot is masculine, which means that girls lack models to refer to. On the other hand, and in what concerns adult women, on top of the lack of habits acquired at childhood and maintained through youth, factors relating to a greater dedication of women to upbringing and to productive and reproductive work, limit own time and energy availability for planned physical activities (Artazcoz et al., 2001).

Chart 9. **Sedentary population (%) at free time, by sex, in, 2003.**



Source: Inhouse, based on National Health Survey 2003.

Chart 10. **Sedentary population (%) by sex and education level, Spain 2003.**



Source: Inhouse, based on National Health Survey 2003.

In **childhood,** present-day difficulties for open-air leisure time together with the access to some technologies have made television, computers and videogames the most frequent forms of entertainment. Differences in types of games exist that target girls or boys, and that mostly concern speed, resilience and physical contact where boys is the case, and that stress on more cooperative or static features when it comes to girls.

According to 2003 National Health Survey, **physical exercising** is not that frequent among boys (16%) or girls (13%), differences related to sex increase with age and sport playing increases in keeping with the family level of education.

Watching TV is significantly widespread (90% of boys and 88% of girls) and is a common practice even among children under one year of age, according to the National Health Survey (2004 SESPAS Report). A 2005 "Corporación Multimedia" Survey reveals that over a million boys and girls between 4 and 12 watch TV during prime time[9], which represents a 7% of the audience in Spain. **Television consumption** time during childhood-adolescence is related to family education level, thus, both girls and boys consume more in non-educated homes than in higher education ones.

As regards **videogames** use, 85% of boys and 52% of girls play with them, whereas 15% of minors (3% of girls and 28% of boys) admit to playing with videogames in which interactively situations of violence against women are reproduced ("Protégeles" 2004).

Finally, **sleep** influences people's health. Broadly speaking it can be said that sleeping patterns split by sex are quite alike, though with some differences. Most people who sleep less than 6 hours are women, while men that declare to sleep more than 10 hours a day, slightly outnumber them. By age, women declare to sleep less than men in the range between 25 and 34 and from 44 onwards. After 44 years of age, men who declare to sleep 10 or more hours are a majority. These data might be showing a different dedication to minors upbringing care in such reproductive ages.

b) Affective-sexual health

The concept and experiencing of affection have had different meanings through the various periods of History, with distinct repercussion on present-day women and men subjectivity. (Lagarde, 2005). To understand the

[9] It is the time with the largest TV audience, when advertising slots are most expensive and that depending on the country may range from 20:00 pm to 24:00 pm..

way in which affections are viewed as well as dynamics of communication and social exchange ways, some gender analysis has to be made. Power relations and role reproduction are expressed in relations between men and women and more precisely in couple relations (Sanz, 2004).

As regards sexuality, differences between men and women have become naturalized throughout History. Gender identity and ways to develop sexuality occur jointly (Giddens,1992). This perspective has revealed that any consideration of human sexuality will be incomplete if it ignores the cultural constructions of "masculinity" and "femininity" (OPS, 2000). Regarding this subject, society has lived immersed in a series of prejudices and preconceptions it has not yet entirely shed and that generate effects on subjectivity, influencing individuals' lust, emotions and practices, hindering a full enjoyment of sexuality (Boston Women's Health, 2000).

An array of the various ways to understand and live sexuality, coexist at present, with greater or lesser visibility and acceptance depending on the environment where they occur (Alberdi, 2000). Possibilities regarding desire orientation are diverse: persons who call themselves heterosexuals, homosexuals, bisexuals; even persons that do not wish to be included in any of such categories. With respect to sexual ways and practices, some scenes are more receptive and permeable when it comes to considering different ways of giving and obtaining pleasure, in a context where sexuality is a dynamic variable and in dialectical relation with other life aspects.

Some of these changes reflect on the earlier occurrence of sexual relations in young women, existing a greater resemblance between young men and young women's sexual initiation than there was in previous generations, as is gathered in 2003 Survey on Sexual Health and Habits (MHC, 2004). An early sexual initiation may entail unwanted effects, different for men and for women. Unwanted pregnancies and sexually transmitted diseases are among the most significant. (Voluntary termination of pregnancy and contraceptive methods in youths, MHC, 2006). To this respect, the difficulties women may encounter to protect themselves from risky sexual practices is a significant aspect that has to be considered (Velasco, 2002, 2003).

From the viewpoint of health policies the challenge is to create resources that may enable a greater freedom for citizens to access the various options within the affection and sexuality world. Something to be underlined is the recognition of sexual and reproductive rights of women (Cairo, 1994, Beijing, 1995). Important legislative changes have taken place in recent years in Spain seeking to normalize other options existence (Act 13/2005).

Despite changes, the hegemonic social discourse is still characterized by its maintaining a direct link between sexuality and reproduction; genitality and heterosexuality. This regulatory model conditions both the social

perception of sexuality and the research being conducted as well as the existing programmes and services in terms of sexual health.

In this context of scarcity of studies with a gender perspective, phenomena keep on surfacing that require serene reflection and thorough analysis due to the repercussions they may entail for men and women's health as is the case of sexual matters that end up being labelled as sexual dysfunctions (Ojuel, 2005). Aspects like absence of desire or pain during intercourse may be related to others such as power asymmetries within the couple, vital milestones, malaise and dissatisfaction in other dimensions of existence and self-esteem problems (Fernández-Gaviria, 2006).

To come to understand this situation it is essential to also consider certain sectors' professional or economic interests, as has happened in the case of erectile dysfunction therapy in men (Moynihan, 2002).

Using a gender approach in the analysis and intervention in this subject entails consideration of differences in sexuality patterns for men and women - men's are generally better known than women's (Velasco, 2003) – and the fact that adjustments must be made to enable adequate assessment for each sex as they will constitute the basis for diagnosis bearing in mind that ignoring this gender adjustment might lead to diagnostic errors or to inadequate or unnecessary therapies (Moynihan, 2005). It is central to give women a say in this sphere of existence with the aim of outlining a diversity map which may prevent the risk of appraisal from a "masculine model" taken as the only one.

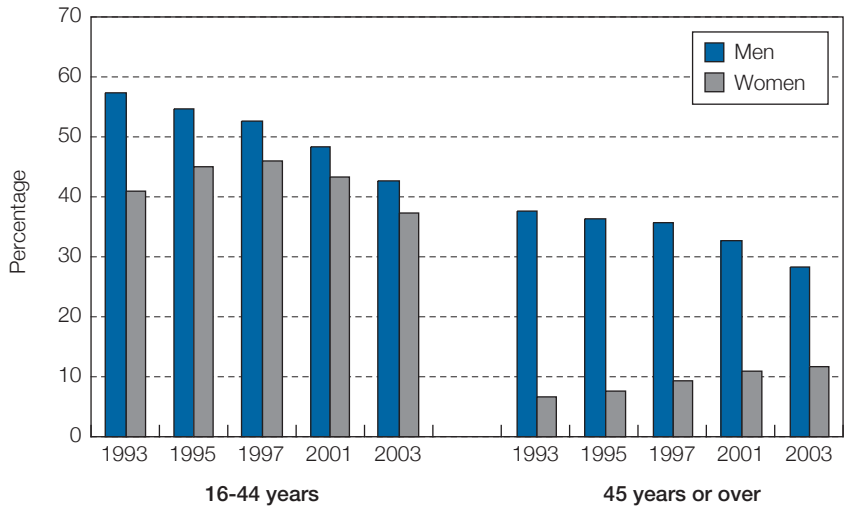
Studies on emotions and sexuality have to incorporate flexible and emergent methodologies that allow entrance into the world of intimacy and help us understand the complexity behind the linking network of attitudes, values, beliefs, practices and conditions of existence men and women live in.

c) Tobacco, alcohol and illegal drugs consumption

Smoking used to be traditionally associated to masculine roles, but at present women as a whole smoke more and more, thus making sex-related smoking patterns converge. Roughly a third of men and one out of five women smoke daily. The age group of 16 to 24 years is the one in which smoking habits are more alike between men and women whereas over 55 is the one in which differences are greater.

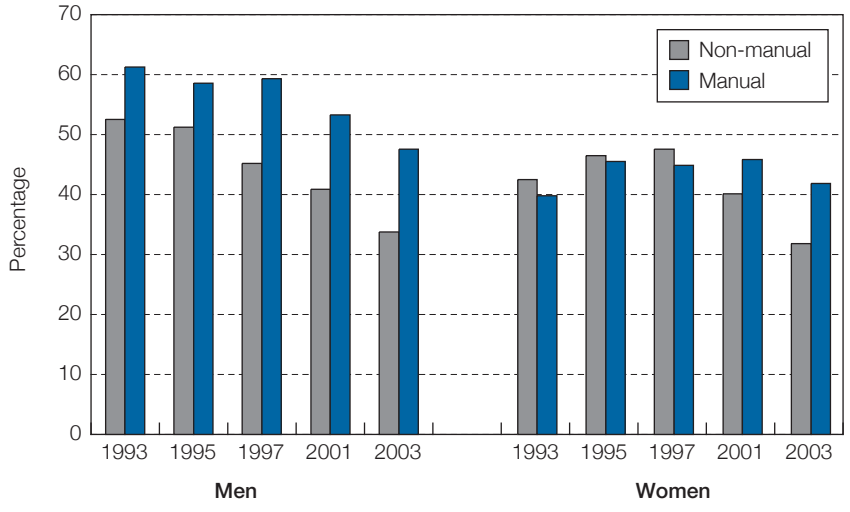
Smoking initiation age has decreased over the years as sex-related smoking patterns have kept changing too. Among today's population over

Chart 11. **Evolution of smoking habit prevalence by sex and age. Spain, 1993-2003**



Source: M. Rodríguez-Sanz, 2005.

Chart 12. **Evolution of smoking habit prevalence by sex and social class within the population group aged16-44. Spain 1993-2003**



74 years of age there used to be a starting age difference of 5 years between men and women-smokers, but in younger groups starting age is earlier and similar for boys and girls.

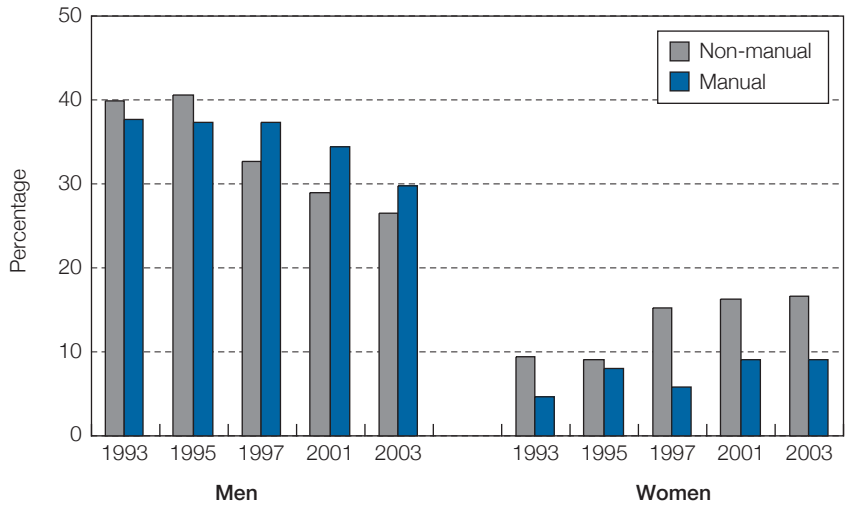
In Chart 11 it can be seen that smoking prevalence since the early 90's has had different evolution as regards sex and age. While the trend for people over 44 years of age has been rising for women and decreasing for men, in the youngest group it went down for both sexes since the mid 90's. In all cases the sex gap has progressively shrunk.

As regards number of cigarettes a day, more than half the male smokers population declare to consume over twenty cigarettes a day whilst two thirds of the female smokers say that they smoke less than twenty.

These changes in sex and age-dependent patterns are not unrelated to the tobacco industry strategies of the last decades, especially aimed at the youngest population, females in particular, targeting the enlargement and the keeping of their market share

When analysing social class effects on smoking habit prevalence, different trends dependent on sex and age are observed. In the 16 to 44 group (Chart 12) a decline in the number of male smokers was registered in all social classes, although in the most privileged ones this decline was steeper.

Chart 13. **Evolution of smoking habit prevalence by sex and social class in the population group aged 45 years or over. Spain 1993-2003**



Source: M. Rodríguez-Sanz, 2005.

In women on the contrary, the prevalence rose up until half way through the period and then also went down. For both sexes social class-related disparities reached their peak at the end of the period under study.
In more adult ages (Chart 13), the effect of social class in men and women trends are completely different and opposed. Men show a declining trend in smoking prevalence, above all in privileged classes, whereas among women the trend is a rising one for all social classes, especially for the most privileged ones.

Hence, the only populational group that does not seem to have benefited either from the existing knowledge on the risk of smoking, or the preventive measures established, is that of women over 44 years of age from privileged social classes. Although this is the group with the lowest prevalence it is the only one to register is a sustained and progressive growth.

The starting point to devise preventive strategies is knowing the various motives to start, smoking patterns and habit persistence or withdrawal, for men and women of different ages and social classes. To this end, studies must be conducted, that take into account all social, psychological and political factors involved. Especially, the reasons why the smoking habit prevalence keeps rising among older women from privileged classes, should be better understood.

To confront this public health concern, a law on healthcare measures to face smoking was prepared during 2005. This law transfers the European Parliament and Council Directive to our legal system, incorporating at the same time the action lines from the Outline Agreement for Smoking Control promoted by the WHO in May 2003 and signed by Spain.
Alcoholic drinks consumption has consequences for physical and mental health and may be connected to social problems and in what concerns personal relations, with work absenteeism and accidents.

According to the 2003 National Health Survey, 48.2% and 17.2% of women declare to be moderate drinkers. Prevalence of risk alcohol consumption is always higher in men than in women, especially in older ages groups.

From **school population** between 14 and 18 years of age (State Survey on Drugs Use during Secondary Education, 2004) 80.6% declares to have consumed alcohol at some time and 64% to have consumed some within the previous thirty days. **Starting age** is 13.7 years and what is rather striking is the increase of the last two years prevalence by ten points for both sexes and in all age groups. A typical teen alcohol consumption pattern is that of mixed drinks and beer, mostly at public places, with friends and at weekends, assuming a leisure time and social relations articulating role, and being alcohol, tobacco and cannabis consumption usually associated in such a way that usage of any of these substances entails a greater possibility of consumption of the others.

It is generally detected, that the population over 35 years of age consumes more alcoholic drinks that the younger population, and that men

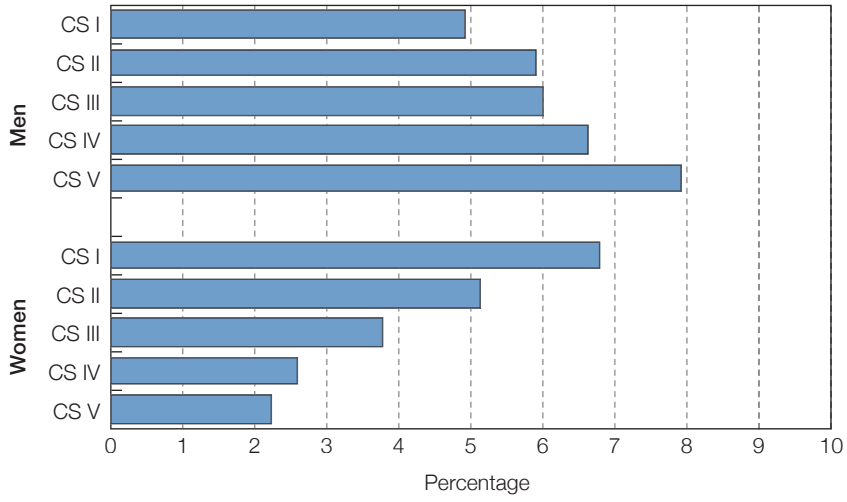
consume to a greater extent than women at all ages (except for binge drinking).

Some data from the Alcohol and Drugs in Spain Home Survey may be of use to inscribe and dimension the problem and to outline the differential traits per sex: more than three quarters of the general population consume alcohol occasionally, 64.6% habitually and 14.9% on a daily basis, being daily consumption 5.4 times higher in men between 15 and 24 years of age than in women.

Alcohol intake increases significantly at weekends: 19.7% of surveyed people got drunk some time during the last year. Drunkenness episodes are more frequent among men (27.2%) than among women (12.0%) and among young people between 15 and 34 years (30.9%) than among older age group (11.3%). Something that stands out is the fact that 5.5% of surveyed people are "risk drinkers"[10] with a higher frequency among men.

Average alcohol consumption initiation age was 16.7 years, with an earlier occurrence among men (15.9) than among women (17.7years).

Chart 14. **Risk alcohol consumption distribution per sex and social class, Spain, 2003**



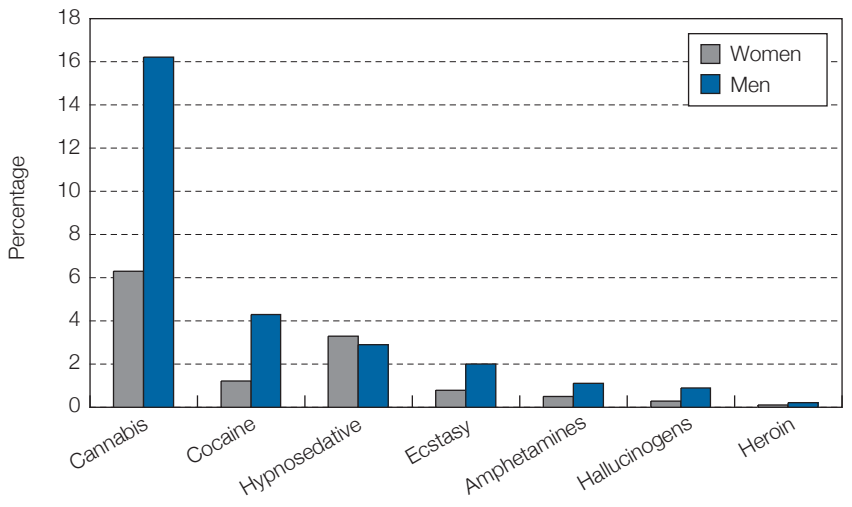
Source: M. Rodríguez-Sanz, 2005.

[10] Risk consumption (Men=50cc/day. Women 30 cc/day)

The pattern per **social class** is differential and reverse according to sex (Chart 14). Men from less privileged classes are those to present a greater prevalence of risk alcohol consumption. On the contrary, women from more privileged classes present higher percentages of risk drinkers, with a higher differential gradient among women.

In the socio-economic and cultural environment in which we live, alcohol consumption is deeply rooted, enjoys social acceptance and a traditional and constant presence in daily life, all of which encourages its initiation and incorporation to lifestyle patterns. Age, sex and social class interact in the creation of such patterns according to which, as is the case with tobacco, women from upper classes would be at present the worst hit. Alcohol consumption occurrence in young populations is closely linked to adult age consumers, transmitters of messages and behavioural models. This practice, as well as other conducts related to health, cannot be considered from an individual or group viewpoint but rather as a whole of interacting factors that integrate social behaviours, all of which involves the need for a better knowledge of the causes and an overall approach that may afford strategies targeting the population as a whole and each of its segments separately.

Chart 15. **Illegal drugs consumption (last 12 months) per sex (%)**



Source: Inhouse, based on Home Survey on Drugs, MHC.

In broad terms, *illegal trade substances consumption* is more widely spread among men than among women (Chart 15), and in younger age groups rather than in groups over 35 years of age. So far, it presents a markedly masculine profile although in recent years consumption among women, especially among the youngest groups, is rising.

The most consumed substances have been cannabis derivatives (11.2%), cocaine (3%) and ecstasy (1.2%).

Cannabis derivatives (hashish, marijuana) were consumed on occasion by 28.6% of Spaniards between 15 and 64 years; and 2% are daily consumers. Consumption prevalence was much higher for men (15.7%) than for women (6.6%) and concentrates in youngest ages.

Powder **cocaine** (excluding the base cocaine or "crack", highly minority use) is the second more extended illegal trade drug in Spain after cannabis. Its use has an occasional character and the proportion of habitual consumers is very low. It is higher in men (4.6% had consumed it in the previous 12 months) than in women (1.3%) and in young people between 15 and 34 years (5.2%) than in older groups (1.3%).

Ecstasy (synthetic drug derived from phenylethylamine shows a more sporadic and higher consumption in men (1.8%) than in women (0.6%).

In the group of 14-18 year-old **students,** the most pronounced difference between sexes is present in the case of heroin consumption over the last 12 months (0.7% in boys and 0.1% in girls) and the least, in the case of cannabis consumption over the last 12 months (39.4% in boys and 33.7% in girls). Drugs that start to be consumed the earliest are: inhaled, volatile (14 years), heroin (14.4 years), cannabis (14.7 years), amphetamines (15.7 years) and cocaine and hallucinogens (15.8 years).

In global terms, the most serious problems related to illegal drugs consumption have decreased, as is the case of directly related deaths and intravenous HIV transmission, all of which probably explains the decline in the importance attached by the general population to the problem that drugs represent. At any rate, serious problems have not yet disappeared, as still, nearly 900 deaths directly related to drugs consumption occur annually in Spain and the expectable significant fall has not yet taken place which leads us to reflect on the extension and nature of interventions performed.

In the last ten years, cannabis consumption in the population group between 15 and 64 years of age, rose both among women (4.4% in 1995 and 6.6% in 2005) and among men (10.7% in 1995 and 15% in 2005).

It is mandatory to bear in mind men and women's different consumption patterns in underway interventions, especially those oriented to prevent initiation among teens and youths, and the study of differential impelling factors behind consumption.

6. Prevalent or serious illnesses

a) Cardiovascular

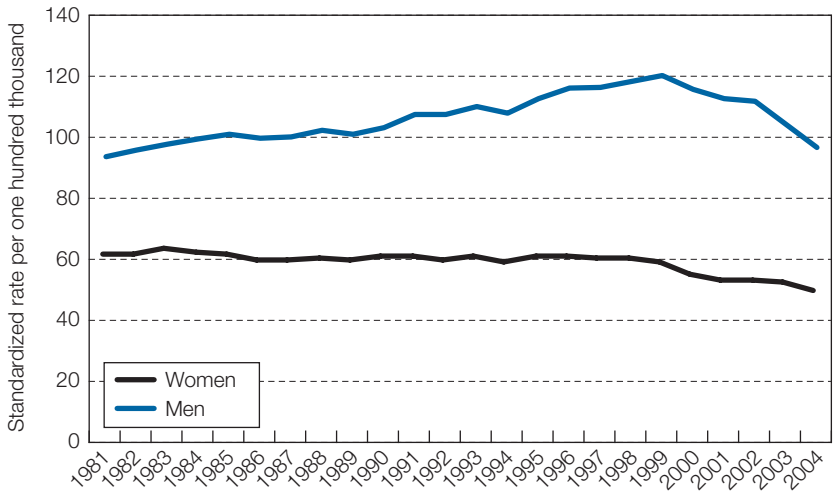
Cardiovascular illnesses represent in present-day Spain the first mortality cause in women (39% of the total) and in men (30%); ischemic cardiopathy and stroke are responsible for 60% of cardiovascular deaths (MHC, 2005) and the first cause for hospital admissions.

In 2004, **ischemic cardiopathy** produced a gross mortality rate of 104 for men and 78 for women and **stroke,** 68 for men and 92 for women.

In the last five decades, mortality due to ischemic cardiopathy (just as mortality due to stroke) has been declining for women and so has for men, in recent years, at an even faster pace (Chart 16).

Acute myocardial infarction is the most frequent of all cardiac ischemic diseases. According to data from local population records (that only include cases of up to 74 years of age) and to specific studies, frequency is higher for man than for women, at all ages.

Chart 16. **Evolution of mortality due to ischemic cardiopathy, by sex, Spain 1981-2004**



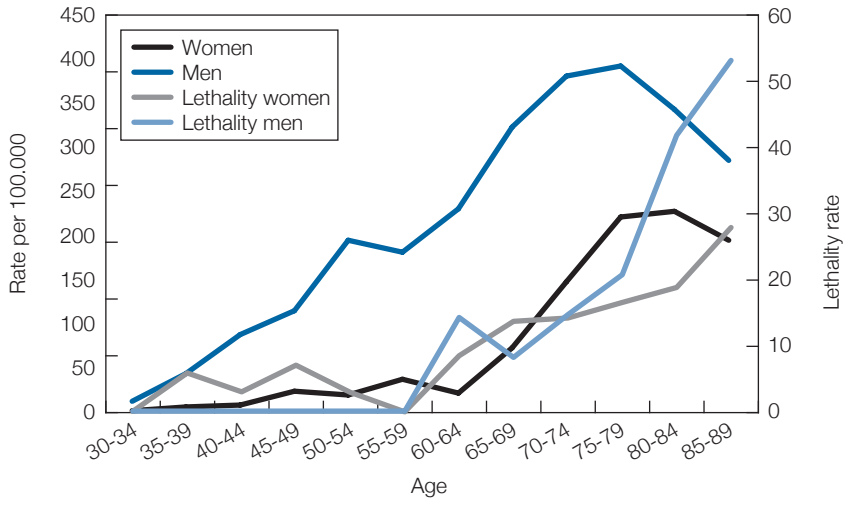
Source: Inhouse, based on MHC. Healthcare Information Institute.

Hospital admissions due to **ischemic cardiopathy** are more frequent in men (from Hospital Morbidity Survey data, in 2003, men hospital discharges totalled 104,880 against 47,246 women). It should be borne in mind that only 60% of AMI are estimated to get to hospital and that such an estimate is not broken down by sex.

This registered higher frequency of diagnosed men is visible in various population studies conducted in Spain such as MONICA, REGICOR or IBERICA. In Chart 17, drawn from RIMAS data (Myocardial Infarction Registry of the Asturias region) in 1998, onset patterns that differ according to age, for women and men, can be seen, as well as the higher lethality (mortality in diagnosed cases) women present after 28 days, compared to that of men (24% and 10%) (Mosquera, 2002a). This is a finding also present in other studies.

However, women present a higher frequency of **angina,** according to the Angina Prevalence Study (PANES) in Spain (Marrugat, 1996); this frequency ranged between 5.3% (men between 45-54 years) and 8,8% (women between 65-74 years). Other European studies, based on the Rose Questionnaire for Angina show similar patterns for age andsex.

Chart 17. Frequency and lethality (%) of Acute Myocardial Infarction by age and sex. Asturias, 1998



Source: RIMAS Study.

In men, infarctions appear at earlier ages than in women. A later appearance in women has been associated, in the absence of specific research on the subject, to oestrogen protection until menopause. However, recent clinical assays related to the effects of hormone replacement therapy have revealed that estrogens alone or combined with progestagens not only do they not protect from either coronary disease or stroke but may, on the contrary, increase risk. (Writing Group for The Women's Health Initiative Investigators, 2002, Million Women Study Collaborators, 2003).

The different pattern of acute myocardial infarction onset for men or for women could be partly explained because of the different distribution of the main **cardiovascular risk factors** described in women (high blood pressure, dyslipemia, diabetes and therapeutic use of hormone compounds) and in men (smoking, hypertension and diabetes) with infarction, and the different age of first exposure to the former. To these risk factors, psychosocial ones should be added as well as lifestyle conditions (subjective construction of illness, work insertion or link handling among others) that have scarcely been studied, especially from a gender approach.

The **delay in receiving treatment** is a key indicator for acute myocardial infarction. In the Asturias Study (Mosquera 2002a and 2002b) it was concluded that women suffering infarction get to hospital one hour later in average, which endangers their lives and the attention received. There is hardly any research conducted in our healthcare services to get to know the causes for this delay.

This higher **lethality** in women than in men suffering infarction, regardless of their age, has been the object of research during the last decades (Marrugat, 1994, 1998 and 2004; Watanabe, 2001; Mosquera, 2002a and 2002b; Griffith, 2005), which is an indicator of the concern this subject raises, and which has contributed to identify relevant and useful aspects that may help correct gender inequities in the care given to myocardial infarction.

Until recently, acute myocardial infarction has been described as a typically "masculine" pathology; It was among this subpopulation where research for its treatment was conducted and for which an illness development pattern was defined, with a typical symptomatology. This lack of knowledge regarding the clinical onset of acute myocardial infarction in women, that became evident many years ago (Healy, 1991) might well be the origin of delayed diagnosis underdiagnosis or even misdiagnosis made by the healthcare system (as when acute myocardial infarction is taken for a digestive problem, for instance). (DeVon, 2002; Kyker, 2002; Bello, 2004; Mosca, 1997; Chrysohoou, 2003; Rohlfs, 2004; Wenger, 2002). So, women, misinformed and under the influence of this a-scientific and erroneous learning, turn for help, late, to healthcare services or do not turn to them at all, when they suffer from ischemic manifestations (be it infarction or angina).

The gender role, on account of which women take care of the family health in the first place, and of their own in the last, may also contribute to this delay which entails a diagnostic and therapeutic slowdown that, just as the incurred by the healthcare system, calls into question the effectiveness of thrombolytic therapy in the first hours of the infarction process, worsening prognosis and survival for women. (Lefler, 2004).

The third concern focus on the **medical care** received when faced to a diagnosis of acute myocardial infarction; in other words, whether the therapeutic, complete diagnosis, treatment and rehabilitation endeavours, are equally adequate in women as in men. (Raine, 2002; Vodopiutz, 2002; Nilsson, 2003; Ettinger, 2003; Haglund, 2004; Norris, 2004; Bongard, 2004; Chandola, 2004; Ruiz-Cantero, 2004).

b) Cancer

Cancer, together with cardiovascular diseases, is one of the main causes of death, for men and for women alike,. Both the type of cancer and its incidence present different patterns as shown in Chart 18:

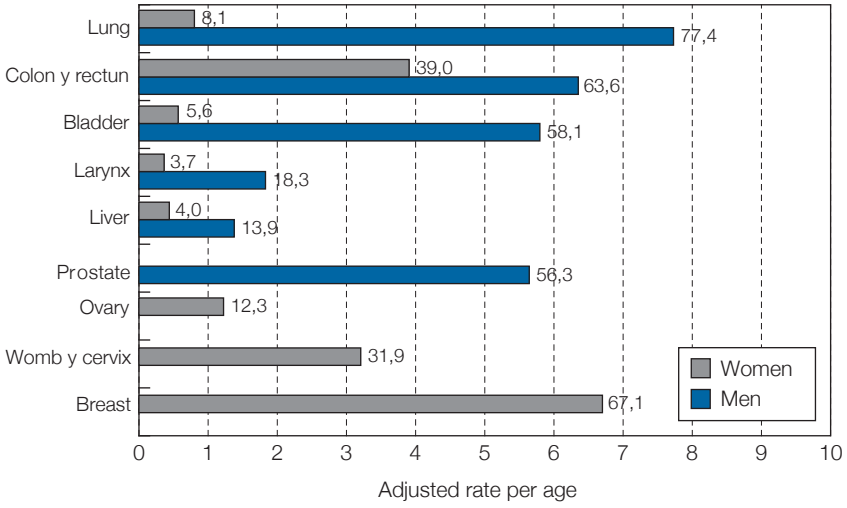
In men, the most important in terms of mortality is **lung cancer**. On the contrary this type of cancer is less frequent in women (one case in women out of 11 in men), although survival is very low for both men and women. Since 1994 mortality due to this kind of tumour has been shrinking (0.35% per year) in men, while going up in women (2.4% per year) since 1990 as a consequence of women joining in the tobacco epidemics in the 70's.

Colorectal cancer is second in importance, in terms of both mortality and incidence figures, for men (after lung) as well as for women (after breast). Five-year survival rates range from 53% for men to 55% for women. This higher mortality and incidence in men suggests lesser healthy eating habits and lesser attention paid to one's health care (Sabo, 1995).

Breast cancer is the primary cause of death and the one causing the highest loss of potential life years to women in their middle ages (35-64). Currently, survival from breast cancer ranges around 75% after 5 years from diagnosis. Mortality has been declining since 1995 (Chart 19) just as it has in other European countries. Mortality decline is habitually associated to improvements in treatments and to the putting into action of screening programmes that became widespread in Spain by the end of the 90's. In recent years some authors (Olsen, 2005) have engaged in a debate on the effects of screening on mortality decline, which will have to be taken further.

As regards breast cancer treatment, it has to be said and considered that radical mastectomy may entail physical problems and body image alteration, and that in many cases it may affect women self-esteem, social relations and sexuality.

Chart 18. **Cancer estimated annual incidende (rate per 100,000) by sex and type of cancer, Spain, 1997-2000**

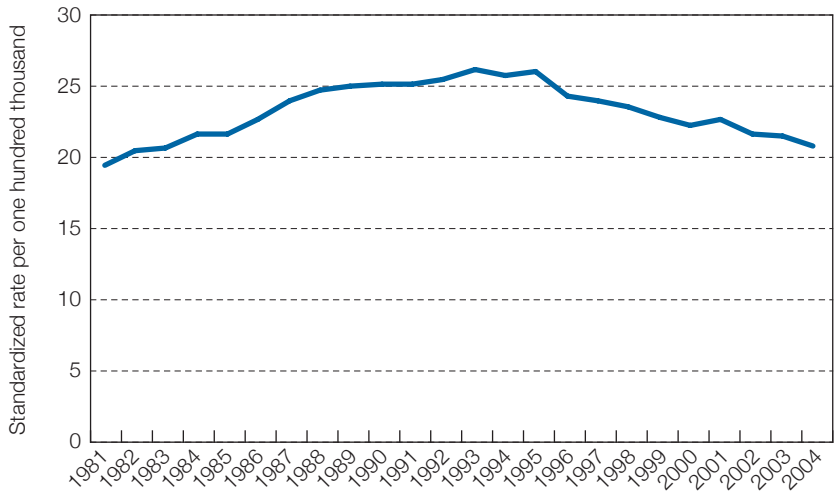


Source: Inhouse. Cancer situation in Spain, MHC.

Just as in nearby countries in recent years, although mortality has come down, cancer incidence has gone up. Many factors of the socio-demographic type (later first pregnancy, lesser number of children and breastfeeding pattern) might have had a contribution, although further research should have to be conducted to analyse a possible impact, on the one hand, of hormone replacement therapy in the number of cases increase, and on the other hand the effect of false positives or overdiagnosing of cases that would never have been detected, had it not been for the existence of screening programmes.

With regard to the potential harmful effects of hormone replacement therapy (HRT), some recent studies (Million Women Study Collaborators, 2003; Writing Group for the Women´s Health Initiative Investigators, 2002) have quantified the related risk of breast cancer. According to them, exposure time is related to an increased risk and so is, the use or not, of a combined therapy (estrogen and progestagens). The "Agencia Española del Medicamento" (Spanish Drug Agency), published an estimate of the risks in 2004, taking the results of both studies into consideration. A different study (Mosquera, 2002c) concluded that in 2000 a 15% of Spanish women aged 45-54 were using hormone replacement therapy and were thus, subjected to

Chart 19. **Evolution of women mortality due to breast cancer. Spain. 1981-2004**



Source: Inhouse. Ministry of Health and Consumers.

risks derived from such hormone compounds. This would mean, in absolute terms, that around 400,000 women all over Spain would have been exposed that year. Applying the Spanish Drug Agency's risks estimate to this population, would result in 3,000 to 7,000 breast cancer additional cases, which would mean that between 20 and 40% of that year cases would have been related to hormone replacement therapy.

As regards the effects of screening programmes on the incidence of breast cancer, there are studies in other countries that suggest a connection with overdiagnosing of cases (Per-Henrik, 2004; Barrat, 2005) and related therapeutic interventions (Gotzsche, 2005).

Prostate cancer, just as in other countries of the European Union, has gained relevance in the last few years, and has come to be the third most important cancer both in terms of incidence as in mortality among men. In most cases, it appears at 50 years of age and onwards, 90% of cases being the population group aged 65 and over, and causing death over 75 years of age. Estimated five-year-relative survival for Spain is 65%. The possibility of establishing PSA (prostatic-specific antigen) screening test programmes is raising controversy, but in the absence of sufficient scientific evidence, its implementation is not yet recommended (Barry, 2001).

Womb and ovary tumours hold the third and fourth position in mortality due to cancer. Tumour of the cervix account for a low mortality and incidence and for an estimated five-year survival of 69%. Underway screening operations must be appraised in terms of streamlining, periodicity and adequacy and so must other possible actions like papilloma virus vaccination campaign, with a view to establishing its need, effectiveness and costs, before they become widespread.

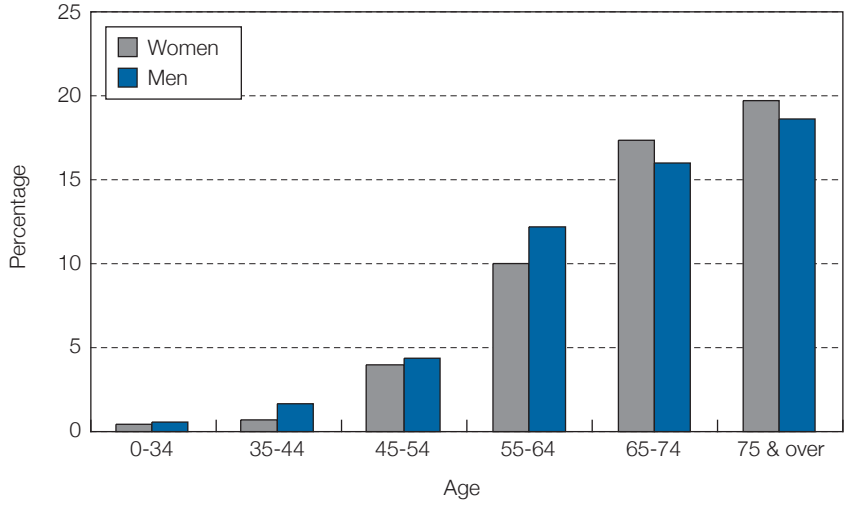
c) Diabetes

Diabetes is one of the most prevalent chronic health problems. It is an illness that evolutes progressively, that may have serious and costly complications, among which cardiovascular diseases, kidney failure, amputations and blindness are the most significant.

Mortality rate due to diabetes was, in 2003, 28.5 for women and 19.4 for men, although mortality underestimates the real magnitude of this chronic disease. (Ruiz-Ramos, 2006).

According to data from 2003 Spain National Health Survey, **self-declared prevalence** of diagnosed diabetes is 5.6% in men and 6.2% in women,

Chart 20. **Diagnosed diabetes frequency, by age and sex. Spain, 2003**



Source: Inhouse, based on the National Health Survey, 2003.

but while in men is more frequent until 65 years of age, in women it is so from that age onwards (Chart 20). Whether or not this difference is due to a different exposure to the risk of developing the illness, or to a greater diagnostic possibility for men during their productive stage at companies prevention services, is something that has to be investigated.
Even though diabetes prevalence is similar for men and women, the risk of suffering acute myocardial infarction is higher for diabetic women with respect to diabetic men and their prognosis is worse (Rohlfs, 2004; Huxley, 2006).

Women also endure additional risk factors; those related to pregnancy and delivery. Gestational diabetes occurs in 6 to 8% of all pregnancies but clears up after delivery. However, a number of studies describe a higher risk of developing diabetes type 2 at later ages, for women having suffered gestational diabetes (Pallardo, 1999; Fernández-Pascual 2006).

Healthy habits and self-care must be integrated in the prevention and treatment of diabetes, in a kind of setting in which gender roles and stereotypes play a central part. Some study claims to have found that care given to women afflicted by diabetes in general practice consultations is of a lesser quality than that given to men (Hippisley, 2004). When it comes to designing programmes and when providing healthcare, the incorporation of all perspectives and needs women and men have with regard to addressing diabetes on a daily life basis, (Bolaños, 2001) is something to abide by. Further studies have to be developed that may allow to better know men and women's differences and disparities related to the disease epidemiology and the healthcare they are given.

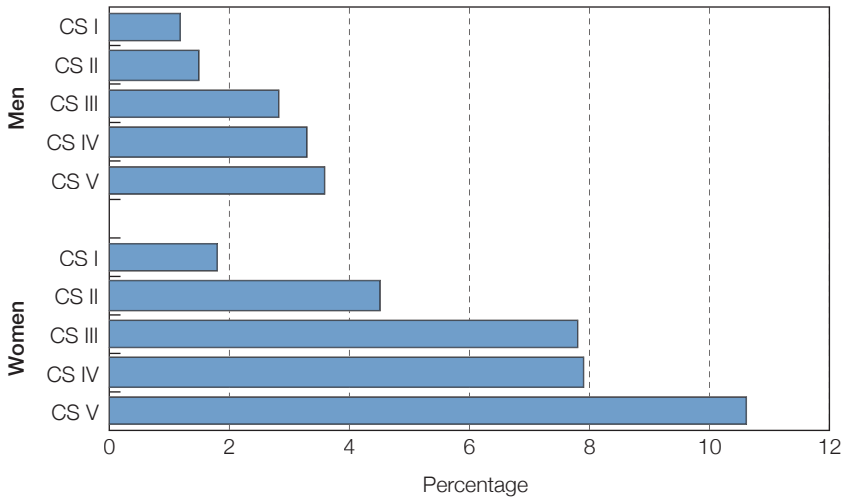
d) Mental Disorders

Mental health is conditioned by a number of factors, biological factors among others (genetic or physiological according to sex), of an individual character (personal experiences), social and family-related (the fact of relying on social support), economic and environmental (social category and lifestyle conditions) and construction of identities and gender commands.

Today it is currently accepted that human psychological development presents differential particularities related to gender; also, that the psychological perception of reproduction, paternity or maternity differs for women and men, and that the psycho-pathological profile and that of psychiatric morbidity present differences, both qualitative and quantitative, between sexes. (Montero, 2004).

Prevalence of **depression** has been found to be consistently higher in women than in men, in epidemiological as well as in clinical studies (Ussall

Chart 21. **Depression prevalence by sex and social class. Spain 2003**



Source: M. Rodríguez-Sanz, 2005.

i Rodié, 2001). A controversial aspect of these studies raises the question of whether the higher prevalence found in women is due to the greater frequency with which women seek help or to the existence of a diagnostic bias tending to diagnose women as suffering from depression more frequently than men (Coryell, 1992) and hence to medicate them.

As regards the alleged effect of sexual hormones on depression, there does not seem to be an association between their use and a greater risk of depression, according to controlled studies conducted with hormone contraceptives currently prescribed. No increased risk of depression has either been found at the peri-menopausal stage (Panay 1996, Alder 2000, Montero 1999).

What has indeed been described is depression prevalence in association with social class, both in men as in women (Chart 21), a lower prevalence having been found in more privileged classes, as well as greater gender inequality among less privileged classes.

An example of the effect of social changes operated in women in the western world is the increasing difference in suicide rates since the 70's with a shortening of the gap between suicide attempts frequency for each sex. Two factors seem to have contributed to its decline: less lethal modern antidepressants, (common way of committing suicide among women) and

an improved detection of depression as a result of their rising trend to ask for help.

In Spain, suicide mortality rate in 2002 was of 13 per 100,000 men and of 4 per 100,000 women. Spain is the fifth country of the European Union with lower mortality due to suicide, with a rate a 40% below average.

There are also gender differences in **seeking help patterns** to have a psychological disorder treated. It is more common for women to express malaise and suffering at primary care services, while it is more probable for men to request assistance in mental health services and to be admitted in hospital.

Gender stereotypes pointing at women being prone to emotional disorders and men to consumption of addictive substances, stand as a barrier to achieve adequate identification and treatment of psychological disorders.

Studies show that three main factors can prevent onset of mental disorders, especially depression, to a great extent:

- To be self-sufficient enough as to be somehow in control of responses when facing serious events.
- To count on material means, that make the various options, available to chose among, when the moment comes to confront serious events.
- Psychological support supplied by family, friends or healthcare providers is powerfully effective.

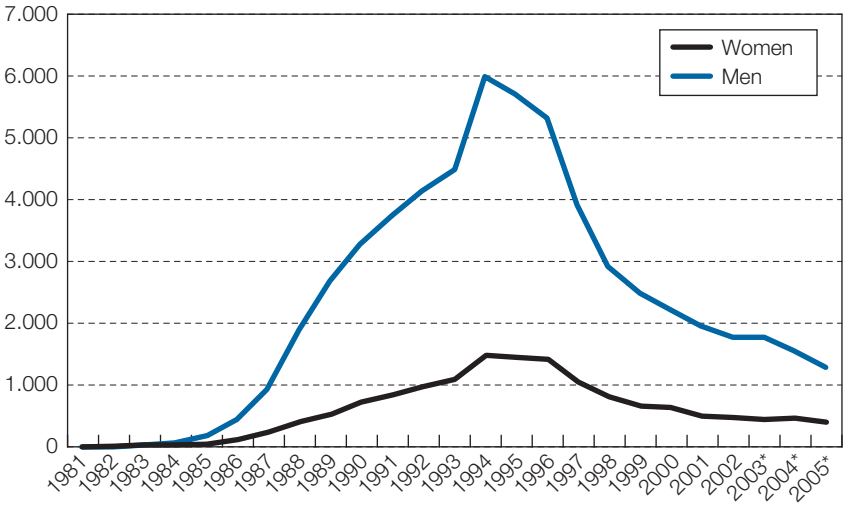
All of them occur differently among men and women, being generally frequent for men to have a greater degree of self-sufficiency and better access to material resources and for women to count on better social support resources due to their closer links within social and family networks.

e) HIV / AIDS

According to the National AIDS Registry at the National Centre of Epidemiology, 1,649 cases of AIDS were diagnosed in Spain in 2005, of which 76.7% were men. With respect to 2004 figures, there was an estimated decline of 17.5% of AIDS cases in men and of 17.7% in women (Chart 22).

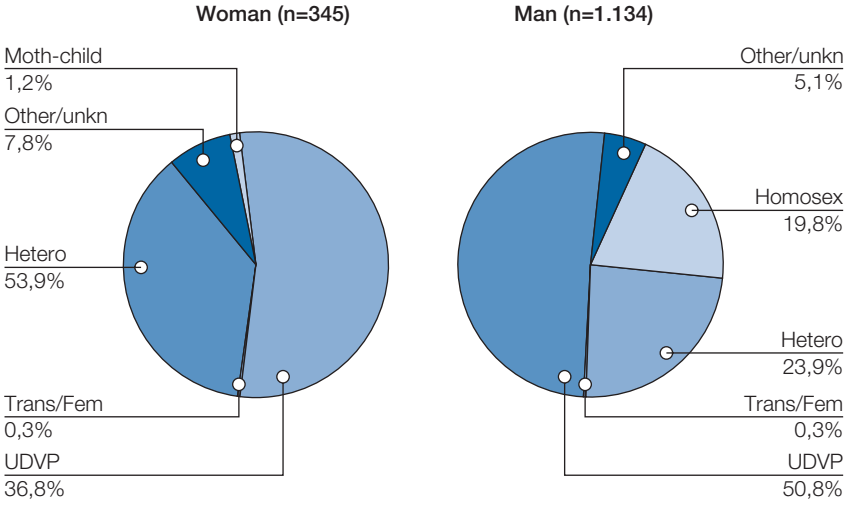
Percentages of AIDS cases on account of **heterosexual transmission** have been increasing progressively from 8.1% in 1990 to 30.9% in 2005. The most frequent form of transmission among men is still parenteral when consuming drugs (50.7%), transmission by way of non-protected heterosexual

Chart 22. AIDS Frequency (cases) in Spain, by sex



Source: National AIDS Registry. Updated 30 June 2006.

Chart 23. AIDS cases distribution expressed by transmission categories. Spain, 2005



Source: AIDS National Registry. Updated at 30 June, 2006.

practice (23.9%) and by way of non protected homo-/bisexual practice (19.8%). Yet, transmission cases in women attributed to heterosexual transmission reach 53.9% (Chart 23).

The White Paper being drafted on the disease and its future in Spain, warns that the **incidence** of the infection by HIV will rise in all autonomous communities, and that most of the new cases will be women.

Differences and inequalities among men and women when it comes to getting protected against infection by HIV/AIDS and confronting its consequences, are significant. Women are more vulnerable to transmission during heterosexual intercourse, as the vaginal mucous membrane presents a greater frailty than the rest of membranes, and semen has a higher infective capacity than vaginal fluids. But apart from biological aspects, relations are marked by gender constructions that assign different roles and stereotypes to men and women, and that influence attitudes, emotions and experiences linked to health and sexual relations.

Gender conditioning factors determine the invisibilizing of the effects connected with women's sexual activity, as is the case of exposure to HIV heterosexual transmission (Velasco 2003).

In addition, women have some difficulty at perceiving their own vulnerability regarding sexually transmitted infections and HIV (Velasco, 2002, 2001). Gender identity repercussions when experiencing health and sexuality are easily detectable in the course of risk relationships, women accept, when faced with the difficulty of negotiating with their partners sexual practices and usage of protective methods. The influence of the romantic love model. and the equality mirage reigning in the most developed societies, that make invisible domination/ submission interaction (Jónasdóttir, 1995) which still today governs relations between men and women, promote vulnerability to infection by HIV/AIDS among women and translate into unequal access to resources which in turn enable decision making concerning their body and their health (WHO, 2003). Violence perpetrated against women is an added risk factor to be considered, since it may entail coercion to engage in risk, health endangering, sexual practices (Campbell, 1999).

Preliminary data contained in the White Paper also point to an increase of HIV among **foreigners** and among people involved in **prostitution.** It has to be borne in mind that some cultural traditions that put in jeopardy women's integrity, such as genital mutilation, and some sexual practices like dry coitus, may add to the possibility of HIV infection erupting among these women. To this respect, efforts must be redoubled to obtain sensitive information conducive to taking socio-culturally adapted actions, that may accommodate, from a gender perspective, the specificity of targeted human groups and that may provide for the ever-changing diversity, both within immigrant population as well as in the prostitution sphere.

It is important to note that stigma associated to HIV/AIDS may also delay the moment of diagnosis for fear of receiving a seropositive result and endure not just physical problems, but socio-work and family rejection and for fear of rejection by the partner.

f) Injury derived from external causes

Injury derived from external causes contribute significantly to **mortality** with respect to the total of other health problems; its sex and age-related different behaviour being something that does not pass unnoticed and that is definitely more relevant among men than among women.

What is currently defined as injury, used to and has traditionally been called "accidents". This modification intends to progress toward a conceptualization of this important health problem through a prevention approach. The contradiction that entails assuming in the traditional definition, that something occurred "accidentally" might be prevented and avoided, is thus eliminated.

A percentage of 4.6 of all deceases registered in Spain in 2004, were due to external causes, this being especially relevant for its occurrence in early ages; namely 40% of deaths were of people under 45 years of age. For each one death attributable to external causes as a whole, among women, 2.3 occurred among men.

Injury due to external causes is the primary cause of decease, among men, up to 39 years old, and in women, it is the first cause of death up until 34 years of age, except for the 5 to 9 years group.

In 2004, a 45% of deaths due to external causes were caused by **traffic injuries,** which amounts to 1.4% of the total deaths (16% among the population between 15 and 44 years).

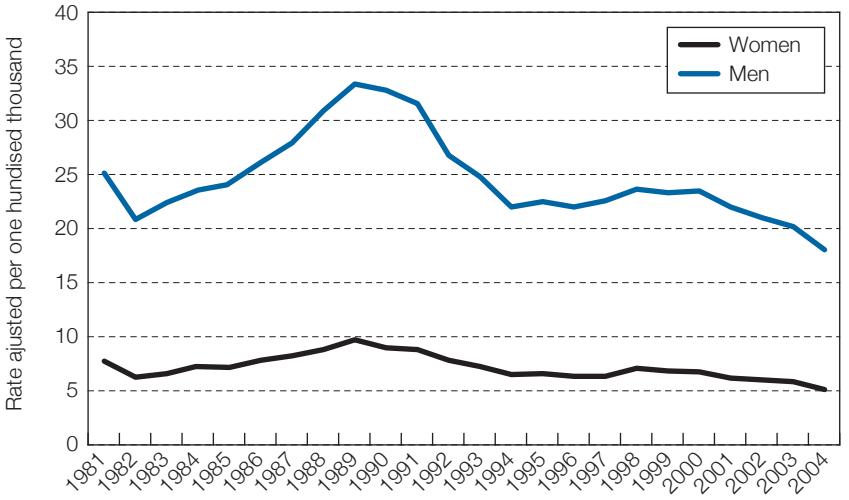
Also traffic injuries present differences sexwise, mortality being much more frequent in men than in women (Chart 24). In 2004, for each one death among women, 3.4 deaths occurred in men.

Since the beginning of the 90's, evolution of mortality due to traffic injury, for both sexes sustains a decreasing trend, and a significant difference between men and women is kept all along.

The masculinity charge detected in this phenomenon is associated to factors linked to sex, such as perception of the risk and attitude while driving, (speed, alcohol consumption) (Sabo 2000). It is worth mentioning that the progressive incorporation of women to driving did not entail an increase in accidents.

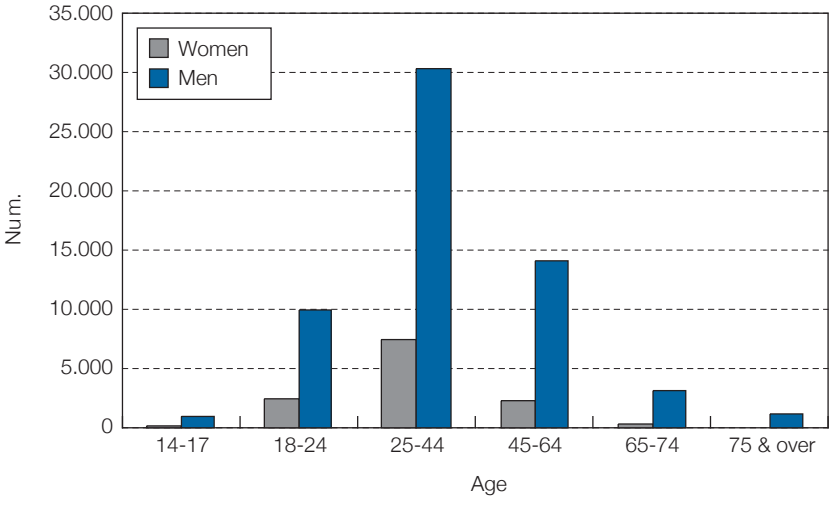
In data shown in Chart 25, the different pattern between women and men can be seen, the overall relation of "accidents with victims" both in metropolitan areas and roads, being of 1 women to every 4 men.

Chart 24. Evolution of mortality due to traffic injuries for men and women. Spain 1981-2004.



Source: Inhouse, based on Health Indicators MHC.

Chart 25. Number of traffic collisions with victims, by age and sex of driver



Source: Inhouse, based on Traffic General Directorate. 2004. Accidents Yearbook.

No specific rates per sex can be extracted, as no denominators related to drivers' sex are available, something that would be advisable to rectify for future statistics so as to obtain reliable information that would enable the adoption of specific prevention measures from a gender perspective.

According to the latest information from CMBDAH 2001 (acronym from the Spanish equivalent of "Minimum Basic Data Collection at Discharge from Hospital"), 40,174 hospital discharges were recorded in Spain for this motive that year. 70% of those injured people and 73% of people deceased while in hospital, were men. Women in both groups were older than men. Injured women averaged 34 years of age (men averaged 28) and deceased women were aged 58 on average (men were 45). Men presented a higher proportion of more serious injuries (Peiró-Pérez, 2006).

What is also really serious about this type of injuries is that most of them entail permanent **disability.** Hence, around 4% of current disabilities among Spanish population aged 6 - 64 are caused by injuries resulting from traffic accidents. (Table 1).

Table 1. Mortality resulting from traffic and leisure-domestic injury, by age groups, sex and importance order, in Spain. 2004

	0-14	15-29	30-44	45-59	60-74	= + 74
Women	Trafic 62	Trafic 299	Trafic 201	Trafic 215	Leisurep-domestic 341	Leisurep-domestic 1.781
	Leisurep-domestic 39	Leisurep-domestic 63	Leisurep-domestic 118	Leisurep-domestic 137	Trafic 213	Trafic 210
Men	Leisurep-domestic 102	Trafic 1.265	Trafic 1.091	Trafic 680	Leisurep-domestic 715	Leisurep-domestic 1.392
	Trafic 84	Leisurep-domestic 446	Leisurep-domestic 617	Leisurep-domestic 622	Trafic 579	Trafic 388

Source: Inhouse. National Institute of Statistics. Deceases by cause of death, 2004.

Mortality resulting from **leisure and domestic injury** (falls, burns, drowning, etc.) get an important share of the whole of injuries due to external causes. It is the first cause of mortality among boys from group aged 0 – 14 years, and from 60 years onwards it outnumbers traffic injury.

In broad lines, we can conclude that the magnitude of leisure and domestic injury is not as well known as to allow development of specific actions for its prevention. As regards traffic injury, whilst mortality and morbidity are both known, the sex factor should be systematically gleaned, to allow gender analysis and to facilitate analysis of differences in accidentality for this cause, with the aim of implementing the necessary actions.

g) Signs and symptoms that are addressed as diseases among women

There is an array of health-related subjects that either are not nosologic entities or do not emerge with the frequency or seriousness that might justify specific action, or else, there is not sufficient scientific evidence to envisage diagnostic of therapeutic interventions, but may appear listed in some political agendas for various reasons. The importance of providing citizens and healthcare personnel with reliable information about them, has determined us to, routinely, approach them in these reports. This one on 2005, only addresses osteoporosis, fibromyalgia and chronic fatigue, leaving for future ones, subjects such as endometriosis and sexual dysfunction among others.

Osteoporosis[11]

From a healthcare viewpoint, osteoporosis owes its importance to its being a risk factor for bone fractures. But there are also other risk factors associated to bone fractures, as is the case of physical environment factors, activities performed, accompanying morbidity, benzodiazepine treatments and other therapeutic drugs, as well as previous fractures medical history. Given the diversity of causing factors, fractures prevention needs a comprehensive approach, with special regard to prevention of falls among population at

[11] Information extracted from an "ad hoc" report issued by the Spanish Agency of Technologies Assessment (2006).

risk and not just detection and treatment of osteoporosis. In fact, the value of bone density measuring, when performed alone, is considered to be limited, as the greatest incidence of hip fracture occurs in women with low bone density but with more than five of the rest of risk factors.

In addition, knowing the results of bone density tests might work negatively against prevention. In some cases a diagnosis of osteoporosis might entail restriction of the activity for fear of possible fractures, when activity is most advisable in terms of prevention. On the contrary, a normal bone density test result, might give rise to the misapprehension that no other prevention measures are needed.

Currently available drugs for the treatment of osteoporosis, have shown a moderate to good performance. Daily intake of Calcium and D Vitamin has proved to reduce hip fracture by 50% in hospitalized women, and peripheral fracture in men and women over 65, by 20%.

Biphosphonates increase efficacy of Calcium and Vitamin D. Hormone Replacement Therapy (HRP) to all pre-menopausal women is no longer a valid option after having come to light the risks it entails.

Fibromyalgia and chronic fatigue

Pain and tiredness are first causes for seeking medical advice in primary care and rheumathology. Chronic pain is the first cause of chronically restricted activity in industrialized countries, Spain and various autonomies and cities (Valls, 2003).

Fibromyalgia is characterized by widespread pain along spine and limbs, muscles being the most affected. Other common symptoms are tiredness, restless sleep, overall morning or after-rest stiffness, subjective sensation of swelling, skin burning, sharp pains.

Its estimated **prevalence** ranges between 2% and 5% of the total population with a greater incidence among women who account for 80-90% of affected people (González de Chávez, 2003).

Fibromyalgia etiology is still the object of controversy (Hazemeijer, 2003). Biological, psychosocial and cultural aspects are influence factors. Correlation has been found in some studies, with psychic conflicts and with some living conditions of women, such as violence by partner (Plazaola-Castaño, 2004).

There also seem to be, in patients affected by fibromyalgia, pain modulation disorders that entail lowering of the perception threshold and hence hypersensitivity to pain (Price 2005).

It is necessary to rely on quality information about the pain and its causes, its impact on the daily life of affected persons and the existing stra-

tegies to confront it. To this end, a better knowledge of the pain afflicting men and, above all, women, is essential, the latter being the most affected, as both their clinical symptoms and the care they are given seem to be different from men's. For instance, men suffering from fibromyalgia seem to have a worse health perception than women, they seek medical advice from more specialists before being diagnosed and are prescribed pharmacological treatments different from women's. Yet, 70% of men are granted permanent disability because of this disease, versus only 42.6% of women (Ruiz Pérez, 2006).

Another problem that has been surfacing in recent times is the one called **chronic fatigue syndrome.** It is a complex and chronic clinical manifestation in which prevails a deep and overwhelming fatigue, that rest cannot relieve and that may worsen with physical and mental activity. It is accompanied by other symptoms which make it a multi-systemic and disabling condition. Chronic fatigue syndrome prevalence among women, outnumbers men's by threefold. (Fernández Solá, 2002).

Gender bias in women's pain circuit, surfaces in diagnostic errors, where psychological causes are claimed, where there are organic diseases and contrariwise, all of which brings about erroneous treatments that may cause iatrogenicity, if incorrectly prescribed. Studies have to be conducted that enable the understanding of these illnesses causes and risk factors, as well as their accompanying emotional components (Valls, 2003).

7. Use of and satisfaction with health services

In order to know the use women and men make of healthcare services, studies have to be conducted to enable a better knowledge of the factors that influence their decisions and those of healthcare providers. An essential aspect is to always identify in healthcare services use statistics, those processes related to reproduction, which explain, at least partly a greater use by women in reproductive age (contraception, pregnancy, delivery and puerperium). It is also necessary to cast more light on the different conducts of men and women when they sicken, the roles gender stereotypes play in healthcare services decision making, or the differential impact that the use of companies' work healthcare services may have on the frequenting of primary care consultations. It is worth mentioning, on the other hand, the scarcity of studies approaching the use of health services by young populations and gender-related possible differences.

According to 2003 National Health Survey, 17% of women and 12% of men had sought medical advice during the two weeks prior to the moment of being surveyed and a 37 and 29% respectively had done it during the three previous months.

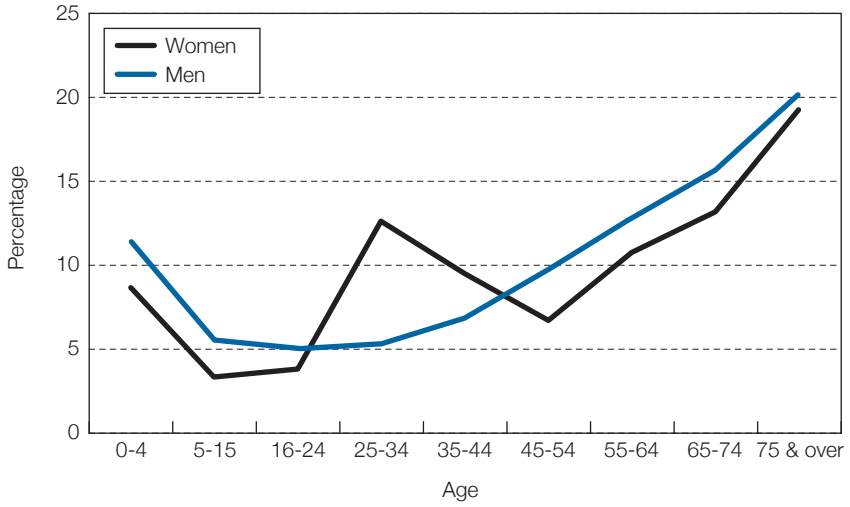
This could be interpreted as differences between men and women in their state of health or between their consultation habits or both. Relations between supply and demand of services, according to gender, would also have to be assessed, or the impact, the fact that prevention programmes targeting women are more numerous (childbirth preparation courses, menopause), may have on the higher or lower use of services by women. Or, if what occurs may be regarded as an excessive use of services by women or as an under-use by men. There are also studies that show differences in healthcare practice depending on healthcare providers, and on persons cared for, being men or women (Delgado, 2002; Arrizabalaga, 2005; Ortiz, 2001).

As regards admissions, they are more frequent for men during childhood and adolescence and in adults up to 65 years of age, exception made of the group aged 25-34 when they are more frequent in women due to pregnancies and deliveries (Chart 26).

There is, in general, a therapeutic and preventive medicalization of women's health, which has an influence on the use of services and on their own health (Pérez-Fernández, 1999).

Excess use of episiotomies and cesarean sections (c-sections) are a good example of this, as well as use of HRT. Even generally accepted secon-

Chart 26. **Population admitted to hospital in last 12 months**



Source: MHC, National Health Survey , 2003.

dary prevention programmes like the ones targeting cervix or breast cancer, are effected without informing women of potential risks and benefits and without informed consent (Segura, 2006).

Delivery care in Spain is mostly provided at hospitals, with results indicators in terms of mortality and morbidity, similar to those of neighbouring countries. Nevertheless, both professional societies and women organizations express the need for some aspects to be improved. Actually, this would involve banning routine performing of some unnecessary procedures (perineum shaving, episiotomy, enema) and controlling progressive increase of C-sections that, according to data from 2004 CMBD, (Minimum Basic Data Collection) would have been performed with a frequency of 21% in public centres and of 35% in private centres.

To explain this different use of services, some studies point at a greater medicalization of women's health or to more frequent risk conducts in men, above all at early ages. It seems that masculine socializing of men (Moyniham, 1998) would make it difficult for them to accept disease, and so would to express their fears and needs, feeling that they have to accept disease with courage, without complaints and alone. This promotes their reluctance to seek medical advice when a health problem arises, rendering equally difficult for them to receive health promoting and illness prevention messages (Doyal, 2001).

With respect to **medicaments consumption,** it is important to differentiate between prescribed medicines, which reflect decisions made by medical personnel once faced with each case, and self-medication that shows persons' own initiatives as a self-care response to their health problems (Table 2).

Consumption of painkillers and antipyretics is remarkably high for both sexes, but even higher for women. Consumption of tranquillizers, antidepressants, stimulants and tonics is twice as high among women. For all those groups of medicines and for both sexes, prescription consumption is higher than self-medication. Through available data, it cannot be inferred whether this higher consumption in women owes to their suffering from pathologies more frequently, or to the health system inclination to prescribe them more medicaments, or to other reasons. In addition, the group of medicaments used at 2003 National Health Survey does not allow us to better know differentiated consumption of the said medicines, or group them by similar effects.

Table 2. Types of medicaments consumed in the last two weeks, by sex and prescription type (consumption % over the total of the Spanish population)

	Women		Men	
	Prescribed	Self-medication	Prescribed	Self-medication
Remedies for the cold, flu, throat and brnchi	3,2	2,1	3,3	2,5
Painkillers and/or medicines to redece temperature	7,3	4,3	4,0	2,8
Tonics (vitamins, minerals, restoratives)	2,5	0,9	0,7	0,7
Tranquillizers, relaxants, sleeping pills	4,5	0,5	1,7	0,2
Medicaments for the allergy	1,4	0,2	1,4	0,2
Medicaments for rheumatism	2,0	0,02	0,7	0,04
Medicaments for the heart	2,2	0,05	2,1	0,04
Medicaments for high blood presure	6,5	0,1	4,4	0,2
Medicines for digestive aliments	2,2	0,3	1,6	0,5
Antidepressants stimulants	1,8	0,08	0,6	0,05
Pills to avoid pregnancies	0,8	0,5	0	0
Replacement hormone therapies	0,8	0,1	0	0
Medicaments for diabete	2,2	0,02	2	0,02

Source: Inhouse, based on National Health Survey 2003

Data from last Healthcare Barometer (MFHC, 2005) show that **satisfaction with the healthcare system** is greater in men than in women, the latter being the ones who use it most. Even so, it is a majority of both men and women who think that the healthcare system works well, although changes would have to be made. To this respect, women in Asturias, in the course of qualitative studies conducted there (Uría, 2004) have shown interest in a greater effort to be made by healthcare authorities, regarding health problems prevention, above all, in which concerns nutrition and physical exercising.

The use of health services is more habitual for people over 64 years of age, than for the rest of the population. According to the NHS, 2003, 38% of people over 64 had been to the doctor's in the previous two weeks compared to 21% of the rest of the population. There are also some health expenses for which elderly people are a majority, and that are related to specific problems of those ages such as urinary incontinence, for both men and women, although the latter have a higher probability of suffering from it due to alterations of the pelvic ground, derived from pregnancies and deliveries. Frequency of urinary incontinence would explain a 97.5% of absorbents being used by the elderly.

In spite of the fact that women are, broadly speaking, the ones to suffer from chronic diseases to a greater extent, (Table 3) adult men, above all from 65 years onwards, yield a greater rate of hospital admissions and hence a higher healthcare expense. (Urbanos, 2002). Meanwhile, women, especially over 65, resort more frequently to emergency services (59% of men versus 72% of women at those ages, according to the NHS, 2003), more frequently visit healthcare centres, and are prescribed more medicaments (Urbanos 2002), their expense per head in terms of prescriptions being, thus, higher (Chart 27).

In general, the most readily available information regarding health and gender is the one referring to state of health; information analysing healthcare system procedures from the gender viewpoint, is rather scarce; in many of those statistics, sex is not even included as a variable, which renders the said information unfit to be used for **gender analysis** purposes.

It is, thus, necessary to count on information which may enable the devising of **indicators** aimed at organizing resources in an equitable and rational way, for a differential allocation of services in accordance with purchasing power and specific needs of women and men, taking into account age, and socio-economic and cultural context.

Aspects such as accessibility, efficacy and security, training, continuity, efficiency and sustainability, are important when it comes to assessing the healthcare system, in what concerns its objectives for gender equity.

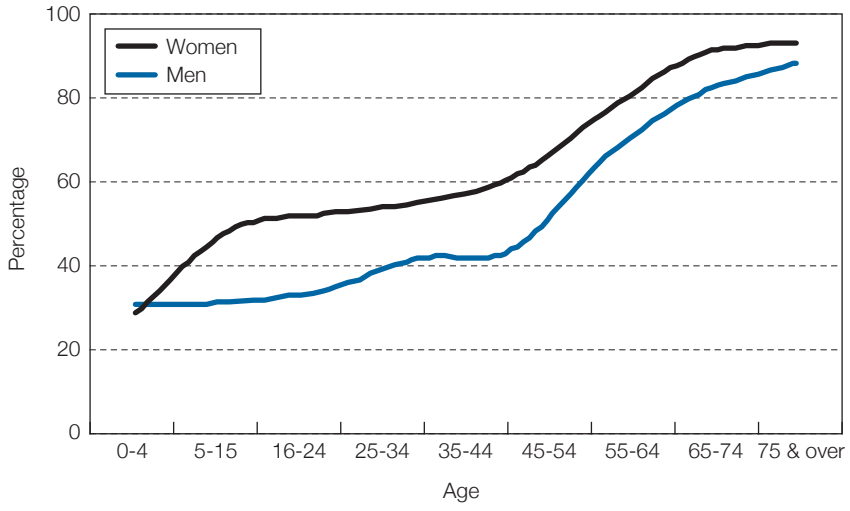
Some examples of this kind of indicators of equity, quality and participation, are: waiting time before receiving health care, percentage of vacci-

Table 3. Distribution of self-claimed chronic diseases, by sex and among the population over 15 years (percentages)

	Women	Men	Total
High blood pressure	16,5	12,4	14,5
Cholesterol	11,3	9,6	10,5
Diabetes	6,2	5,6	5,9
Asthma, emphysema or bronchitis	5,3	5,7	5,5
Allergy	10,9	8,7	9,8
Depression	7,7	2,9	5,4
Heart Conditions	5,9	5,9	5,8

Source: Abellán, 2004.

Chart 27. Medicaments consumption by age and sex, Spain, 2003



Fuente: Abellán, 2004.

nated population, access to, and financing schemes for voluntary termination of pregnancy, contraceptive methods and family planning resources, coverage of care to pregnancy, care given to pregnancy and delivery by trained personnel, proportion of births by c-section, percentage of women or women's associations that participate in decision making processes.

Another field in which progress should be made, with a view to improving gender equity, is in the analysis of how public healthcare budgets are distributed.

Another relevant information in need of analysis broken down by sex is the one concerning **new medicaments,** resulting from clinic assays, their strength, pharmaco-kynetics and pharmaco-dynamics in women and men, authorization and prescription processes, and follow-up of adverse side effects in women and men.

8. Life and working conditions

Social representation associated to differences between men and women has been sustained for a long time upon a separation pattern according to which men were granted the **productive sphere** (within the professional, political, intellectual, cultural and religious fields) and women the reproductive one (in the domestic and family fields) which translates into different access to material resources and to the public and power spheres (Solé y Parella, 2004).

Although women have always worked, their work has been socially invisible and barely considered as an object of reflection and study up until some decades ago; that is why there are hardly any studies going into the binomial women's work-health,in any depth

Women's work activity in Spain has increased considerably. Currently, work is for women the key factor in their search for individual independence and for the construction of an identity (Tobio, 2006). Yet, Spanish **women's occupation rates** (61.1%) are still below the European average (Table 4) and Spanish men rates (87.2%).

A second transformation in women's employment, shows how a major part of today's women do not leave the work market as often as they used to, staying in it even when they decide to set up a family.

Table 4. Occupation, unemployment and fertility rates, in the EU, 2006

	Rate Occupation		Rate Unemployment		Rate Fertility
	Women	Men	Women	Men	Women
Germany	69,1	79,8	9,6	10,4	1,31
Austria	76,7	90,1	4,7	3,9	1,40
Belgium	71,8	87,2	7,6	6,4	1,62
Denmark	80,3	88,2	5,1	4,2	1,72
España	61,1	87,2	14,4	7,2	1,25
Finland	77,7	84,2	8,2	7,3	1,72
France	73,4	86,4	9,0	6,8	1,89
Greece	58,1	86,1	15,1	5,7	1,25
Holland	75,8	90,3	4,5	3,8	1,73
Irland	67,7	88,9	3,5	4,6	1,97
Italy	59,6	86,9	9,1	5,4	1,26

Source: Fundación Encuentro and Eurostat. htpp://epp.eurostat.ec.europa.eu/).

In order to understand women's rising presence in the work market, **education** is something to be taken into account. In Europe as a whole, the overall level of education of women has gone up so significantly that, in some cases, it has come to surpass that of men. While in Spain in the sixties, higher education was reserved for a limited number of men and a negligible number of women, in 2005, the number of women that reached university level education at 1s and 2nd stages was, according to EPA data, of 2.7 million; 200,000 women more than men.

This improving in education and qualification seems to be the necessary step for men and women to gain access to the work market, in equal conditions. Yet, this theoretical assumption does not always materialise into a reality.

In fact, higher qualification in women does not translate into an equalitarian position with respect to their colleagues in the work market. There exist invisible and "invisibilized" barriers which constitute what is called double segregation: a horizontal segregation that directs men and women towards specific occupations, and a vertical segregation that hinders women's work promotion (Artazcoz et al, 2004 and 2005).

With respect to this **horizontal segregation,** it is claimed that occupations conventionally define those tasks befitting one or the other sex, bringing into force again that form of segregation that considers some paid jobs especially suited for women while others are unfit for them.

This jobs are not the least hard to do, but are similar to those activities that women have been developing for years in the domestic sphere; jobs associated to spaces and activities that are symbolically identified as home extensions: domestic service, clothing industry, teaching and nursing are a good example (Artazcoz et al, 2004 and 2005).

A result of this particular distribution are the different **work risks** related to different socio-working positions. The EPA (Spanish Acronym for Active Population Survey) 2005 reveals that women account for 84% of the services sector while men's share in the same sector would be 50%, and a further 30% in the industrial and construction sectors.

This differentiated concentration entails, according to data from the V National Survey on Working Conditions (CES, 2005) that the most frequent working risks for women be of the ergonomic kind: women usually undertake the type of job that requires maintaining the same position and performing repetitive tasks and movements; and the psychosocial kind: they are forced to assume excessive workloads, fast working rhythms and emotionally highly demanding jobs (teaching, health…).

Men, for their part, assume more frequently physical risks: exposure to loud noise, to vibrations and toxics as well as to powder inhalation, fumes and gases.

Regarding **mental health,** and according to some studies, the best situation seems to be that of men with non-manual jobs, followed by men with manual jobs, women with non-manual jobs and women with manual jobs.

Among these women, and in terms of type of contract, the ones with worst mental health are those with no contract, followed by temporarily hired ones for manual jobs and the ones hired on a fix basis for manual jobs. But in terms of working timetable, the worst mental health is endured by women with manual jobs and irregular timetable, followed by those doing manual job with no-break working day. Among men, the worst situation in terms of mental health would be the association between manual work and nightly shift. (Cortés et al, 2004).

Another aspect related to horizontal segregation is that of work **accidents.** According to data issued by the Economic and Social Council in 2004, 79.6% of accidents were suffered by men. This is mostly due to horizontal segregation and the types of work they take on, although, according to some research on virility, to the fact that the prevalent model of manliness gives rise to men reluctance to protect and care for themselves (Bonino, 2002).

Conforming with this model, concerning oneself with self-care or protection appears as a weakness, which worsens the already scarce culture of prevention within companies, also exhibited by male and female workers, especially manual jobs. This reveals itself as important, when it comes to planning preventive actions, which will also have to pay special attention to the relation between virility and morbidity and must try to avoid the strengthening of the said manliness pattern (Moynihan, 1998).

With regard to **vertical segregation,** the V National Survey on Working Conditions (2005), points at the absence of working promotion at their jobs, as the most frequent working risk among women, something that have not been observed among men. This psychosocial risk appears to be linked to the unequal position women occupy in the work market which entails frustration for them when they see their aspirations to hold jobs with greater responsibility, hampered (Fortino, 1999).

Although present reality in today's western world may be different, the belief that men are the **heads of the family,** the ones providing financial support that allows the subsistence of the members of the family, is still present amidst the collective imaginary.

This belief that may seem outdated, underlies some of the present-day work market articulating dynamics. For instance, the consideration of women's work as secondary. The semanticizing of women's work as "help" leads to the consideration of women professional activitity as "secondary": feminine professions that help masculine ones; women's work salaries as "help" to the household income. If the head of the family or breadwinner is always the man and the woman's work is considered to be simply help, it is

only logical that this help be not worth the same in economic terms as the main job (Gómez, 2001; Pateman, 1995).

Part-time jobs, may represent an a priori satisfactory work measure that allows the combining of a job with the reproduction work. However, this measure is not that effective when applied directly to women and not to men (part-time occupied women amount to 23.3% and men to 4.40%). Allocation of part time to women redefines an initiative which no longer is a family measure to be adopted by men and women, but promotes women to be the ones to assume reproduction work (Torns, 2002). Part time work also entails lower salaries, lowering of the professional career ceiling and a reduction of retirement pensions.

The previously mentioned **reproduction work**[12] refers to a type of activity needed for society's proper functioning, which incorporates those activities aimed at taking care of household and family; a job someone has to take on.

This kind of work is developed within the confines of the family environment and thus have no social repercussion whatsoever, which in turn entails its becoming invisibilized and devalued even to the eyes of the very people who perform it. Excluded from the work market, it is a non wage-earning activity unless carried out by someone external to the family. As women have progressively integrated into the work market, the **family pattern,** bread-winner man-housewife, has also progressively faded away in the real world, although it has not yet disappeared from the collective imaginary, and a new pattern has been making its way that tends to consolidate: men maintain their role almost intact but the traditional housewife figure tends to redefine itself.

Women groups in central ages (24 to 40 years) are actually the ones experiencing a most relevant growth in their **occupation rate.** Thus, 69% of these women were active in 2005, although if we break down this activity by marital status, there is a substantial difference between single and married women or those living in with a partner.

According to related bibliography, employed women would enjoy better health that those who work full time as housewives. This difference would result from the benefits, employment entails and reproductive work lacks, and are, among others: economic autonomy, opportunities to develop self-esteem, social support and autonomy to make decisions.

In addition, reproductive work, when compared with productive one, happens to be more monotonous and routine-like, exposes to a considera-

[12] "It is called reproduction work to differentiate it from production work (of goods and services) not denying this activity the recognition of work, using the motto reproduction work instead of domestic work to underline that its activities and physical and symbolic space are not limited exclusively to the home or domestic sphere. (Carrasquer y cols, 1998).

ble physical load and to risks of injury derived from domestic accidents and exposure to toxic substances and is less rewarding both internally (lesser possibility of training, of personal development) and externally.

Structural transformations resulting in men and women coexistence in the work market, have not meant really important modifications, at the time of men's taking on reproductive work. While most of them carry on with their professional activity, women do not give up their tasks as caretakers and household managers, but assume a double role: family and work. Reconciling these two activities brings about repercussions on their physical and mental health. For some of them, both roles are incompatible, thus they give up the productive one, women being those to chiefly request maternity/paternity **leaves** (99%) and **extended leaves of absence** to look after child (96%)

Reproductive work is the activity most women total or partially assume along their vital cycle, but this dedication is not identical for all women and varies in accordance with the different moments of their vital cycle and with the social class they belong to.

In general, women with a well paid job are better able to confront this double work load or double presence, as they count on the necessary resources to be capable of externalising part of the reproductive work: the care of dependent persons (children or elderly persons) and housework, which is undertaken by poorer women and, in our country to a progressively greater extent, by immigrant women. On their part, less qualified Spanish women have to resort to the near social network: family and female friends.

Women's incorporation to work in Spain has been very fast, while the change in policies for the conciliation of family and work lives has been slower. Two out of three Spanish working mothers resort to family to be able to conciliate work and family life (Tobío, 2006). Forty percent of this help is provided by grandmothers (Fernández, 2005) and in spite of being an altruistic kind of help, most of the actors consider this situation as unsustainable in the medium and long run (Salido 2006). The rest of women make use of such resources as closeness to the work place or school, short or more flexible timetable and only one out of ten women resort to domestic paid help.

The so called ideology of **intensive maternity,** referring to a traditional model of mother devoted full time to the care of her children, would be incompatible with the time and dedication work entails, which would translate into feelings of guilt experienced by these women. Ideologies that promote "ideal" or "normal" couple, maternal or other relations may endanger through pernicious effects, the mental and physical health of those women that cannot or do not wish to adapt to them (Solé y Parella, 2004).

Tasks characterising the **double presence/absence,** include attendance and care to dependant persons (children, but also elderly and disabled people) and the so called housework (cleaning, cooking, etc. Table 5).
Health care family services account for 80% of the care provided to elderly people, while formal care –old people's homes, day centres, house call– would only represent 3% of the total. Decrease in the number of inactive women has not reflected in a giving up of these tasks, and neither has it in the incorporation of men to the said tasks; on the contrary, women are basically who still perform them.

Table 5. Distribution of activities between women and men in an average day (hours)

Main activities	Women	Men
Children care	18,6	11,2
Help to adult members of the household	4,5	2,5

Source: Inhouse, based on Time Use Survey 2002-2003, INE.

Caregiving is a continual activity, the same as housewife: you are a caregiver all day long. It is a task chiefly assumed by women: in the recent survey on Care to the Elderly In the Spanish Home, published by the Institute of the Elderly and Social Services, female caretakers of the elderly were over 83%, and a fourth of them had a paid job independent of their caregiving tasks.

From a gender perspective, it is also worth mentioning that growing to be a man hinders the development of men's emotional potential and the opportunity of exploring their possibilities as caregivers.

According to the Survey on Care to the Elderly in the Spanish Home, the majority of **caregivers** are daughters, wives or partners of the person they care for. It is even the case that many more women look after their parents in law, than men do after their own parents (Table 6). This reveals that more than family bonds, it would be differentiated gender roles which would allow for this situation to continue. Although to a lesser extent, the same could be said about the care for the disabled, and even for children, which as follows from the Use of Time Survey, are reported to be essentially womanly tasks.
Women over 55, whose daughters have been or at present are mothers, are the care generation, also known as the **sandwich generation:** They have looked after their parents and possibly after their parents in law, persons, all

of them who will have had a greater life expectancy than their respective parents, and surely more chronic diseases. They have looked after their children, many of them while holding, at the same time, a paid job, extending this care for their children to limits, unthinkable some time ago: beyond thirty years of age while emancipation time is lingering on. Eventually, they are looking after their grandchildren, so that they may help their daughters and daughters in law to confront the conciliation between a paid work facet, more and more widespread among women, and reproductive work. A positive aspect of this new caring scene is the change operated in gender roles at maturity: Grandfathers are taking on roles they never played while they were fathers (Radl, 2003; García-Calvente, 2004). There is another phenomenon of shifting of the responsibility for providing care, that has made easy the conciliation of remunerated working life and reproductive work, although the burden is still on women's shoulders, in this case, the least privileged ones.

It is none other than **migrated women** from less privileged countries, that look after the dependent population, on a salary basis, but in an unofficial way. This unofficial quality has come to reproduce the patterns of family care which may turn out to produce on these women's health, effects similar to those observed in family caregivers: exhaustion, frustration, stress, etc. although in a different context, in which there is a salary but not the presence of a family bond and everything it entails. It is important to point out that these women often leave their children behind in their countries, in other people's care (grandmothers mostly) at the emotional cost that involves (Berjano, 2005).

Sandwich generation women's health, as abundant research has revealed, is worse, and will still have to worsen, falling down to a lesser quality of life, during their old age.

Table 6. Bonds that link the caregiver to the person cared for (percentages)

	Child	Espouse/ or Partner	Daughter / So in law
Women	49,6	11,8	8,6
Men	7,6	5,0	1,5

Source: Inhouse, based on Use of Time Survey 2002-2003, INE.

Some of the changes undergone by family structure do not herald a better future: for instance, the reduction in the number of children that a priori translates into less people willing to provide care in the future; in addition, a greater demand of mobility in the working scope, prompts a distancing from the home, which will prevent care from being given the way we currently know; finally a greater probability of divorce, that theoretically would do away with the possibility of looking after the ex-partner, let alone the ex-mother in law (Lehr, 2003) .

The caregiving role has obvious **effects on the health** of the person providing the said care, especially on their mental health. While children care can vitalize their caregivers, elderly people care can, as we will see, have negative effects on care providers' health. Caregivers aged between 50 and 64, the ones from less privileged classes and jobless ones, are those who present a higher probability of developing a worsened state of health, especially if they are in charge of people with mental disorders (García-Calvente, 2004) .

Many studies find **psychic malaise** in caregivers: anxiety (from 32 to 80% of caregivers, depression (between 16 and 60% of interviewed people) and high degrees of effort (from 11.6 to 60% depending on the study). This detected psychic malaise is usually associated to the ill person's degree of physical disability, time devoted to their care, to chronic illness of the caregiver themselves and to lack of support. On the other hand, the presence of anxiety and depression is correlated to help availability, kinship degree with the sick person, and existence of effort made by the caregiver (Moral, 2003). Likewise the load of unofficial care worsens at the least privileged homes (La Parra, 2001; Artaso, 2003).

In this kind of situation, it is important to analyse and orient the healthcare system response, in order not to strengthen gender roles, inducing and making women responsible for the care of other people within the family kernel and excluding or not involving men in their roles of father, son, brother of the dependent person. In short, strengthen the aspects of manly responsibility in the care of their own health and their kins'

The increase in the population over 65 years and particularly over 74 years, issues new challenges to the social protection system, public and family budgets, and health systems. In Spain, as well as in the rest of Mediterranean countries, families and more specifically their women, have been in charge of providing for nearly 80% of the need for long term care to dependent elders. But demographic and social changes make this solution no longer feasible and care to dependence falls more and more on public or private care providing sectors. For all the above, the government has promoted the drafting of a Bill on Dependence envisaging the creation of a National System of care to persons and families enduring this problem.

9. Violence against women

During 1995, Fourth World Conference, United Nations accepted a definition according to which violence against women is understood as "…any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life". (Velzeboer, 2003).

We can see it is an extensive definition, an acceptance intending to encompass all types of violence endured by all women in the world, whatever the context in which they occur. Far from ignoring the seriousness of these other types of violence, we are focusing in this chapter, on **violence occurring within the couple or with the ex-partner,** for its being the one with the greatest incidence in our country and for its being considered the most serious, given its chronicity and the context it is inscribed in (Plazaola-Castaño, 2004). According to the Women's Institute, from the total of 2005 mortal women victims, partners or ex-partners were responsible for 61, some family member: father, son…(other than partner or ex-partner) for 12, and aggressors non-related to the victim accounted for 6 other cases.

Violence also includes psychological or sexual maltreatment, by isolation or social control, that usually go unnoticed to a greater extent than physical maltreatment (Blanco, 2004). The Women's Institute conducted in 1999 and 2002 a Macro-Survey on Violence against Women, results of which show that while the percentage of women classified as maltreated according to technical criteria is 11.1%, the one of women self-classified as such is only 4%. This difference might be related to the fact that behaviours such as humiliation, contempt or control over women are not considered to be violence, either by themselves or by the rest of society.

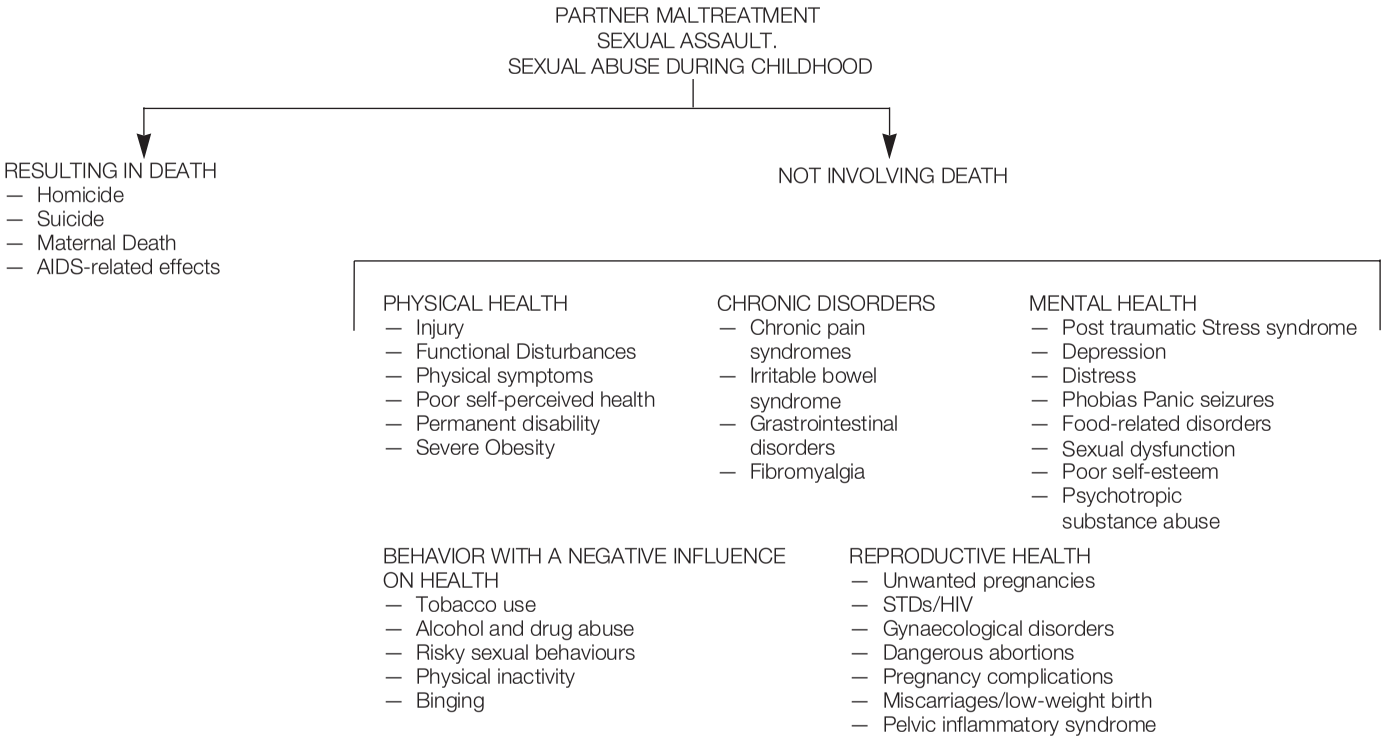
Injury, fear and stress associated to maltreatment, Plazaola- Castaño y Ruiz (2004) point out, may give rise to chronic health conditions. Such conditions range from osteoarticular pain, to cardiovascular impairment and include recurrent neurological symptoms.

The chart that follows (Chart 28) shows repercussions on health, resulting from male violence against women (Velzeboer, 2003).

Violence against women is considered a public health concern by the WHO, both because of its **magnitude** (number of affected women) as well as for its repercussions on women's physical and mental health

Getting to know the **problem exact dimensions** is difficult, due to the nature of the problem itself, and to the comparableness of research initiati-

Chart 28. Men violence effects on women's health



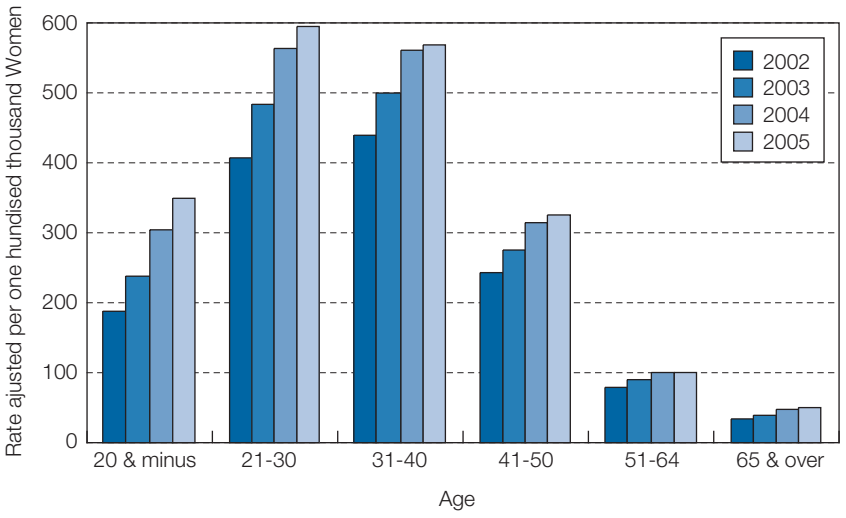
Source: Velzeboer, 2003.

ves. Although studies on the prevalence of gender violence in our country already exist (Mata, 2002; Ruiz, 2004; Plazaola, 2004; Polo, 2001; Raya, 2004); their results vary in accordance with the type of violence being researched (physical, sexual or psychological) and to the methodology used.

As regards number of **formal complaints**, as an approximation to knowing the problem occurrence frequency, increases have been registered for all age groups, above all among the youngest (86%). The total reporting for "partner" maltreatment has experienced a rise, from 43,313 in 2002, to 59,758 in 2005. This reporting is considered to be just a tiny part (5%) of the reality of violence perpetration by men against women (Chart 29).

As regards resulting **mortality**, tracing the number of cases is difficult, as there is no specific register, and available data do not include cases of death resulting from physical violence having needed hospital admission with a "serious" prognosis, where decease did not take place immediately but some time after (Chart 30).

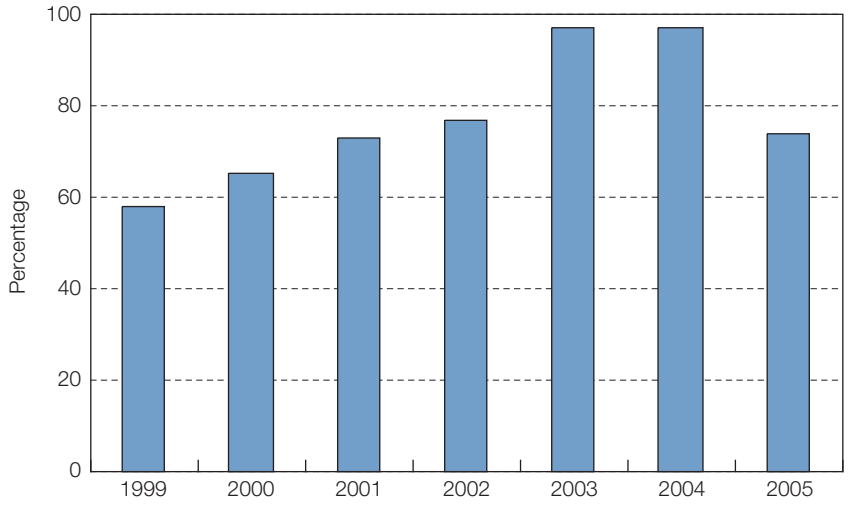
Chart 29. **Frecuency of women reporting maltreatment by partner, by age. Spain 2002-2005**



Source: Instituto de la Mujer (Women's Institute). Inhouse.

To better analyse the evolution of mortality for this cause, some research is being conducted on the part of Public Health, covering, for instance, development of the Epidemic Index on Intimate Partner Violence (IPV)[13]. This index, similar to the ones habitually used for the control and surveillan-

Chart 30. **Deaths of women, caused by partners or ex-partners, Spain 1999-2005**



Source: Women's Institute. Inhouse.

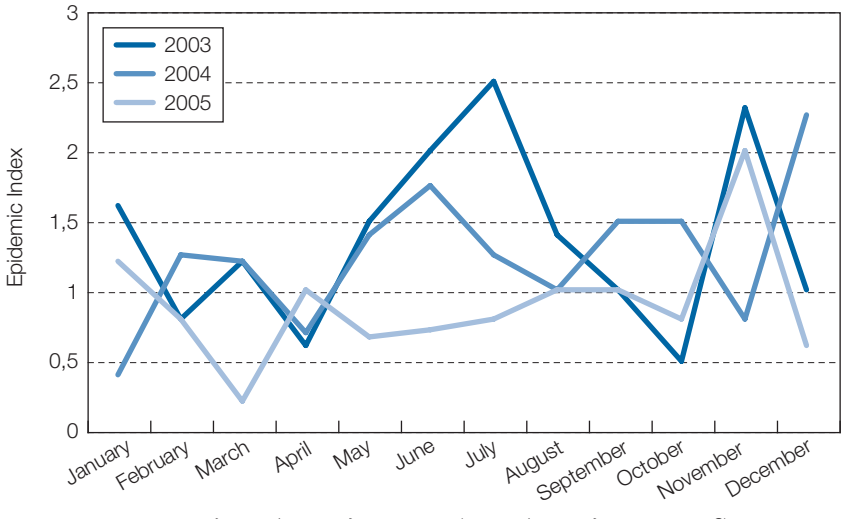
ce of public health issues (Vives, 2005; Vives, 2004), allows controlling of cases, taking occurrence of previous years as a reference. According to it, during 2005, only November presented a higher risk value for this epidemic index on intimate partner violence (Chart 31). Interpreting of this data is effected from the assumption that violence against women should not exist and that it is intolerable at any rate.

Persistence of gender violence deserves deep reflection on the mechanisms intervening in the hegemonic model of virility, and the way in which hundreds of men exercise it with the complicity of an important part of their fellow citizens.

Gender violence is a complex issue when it comes to dealing with its causes (that are social), when its frequency has to be established (from

[13] The index is calculated from data of women murdered by their partners, gathered at the electronic web site of the Separated and Divorced Women's Federation. From these data results the ratio between registered cases in a specific month and the average number of deaths of corresponding months 5 years back. For a correct interpretation of the index, three levels of risk are considered: up to 0.74 (basic), between 0.75 and 1.24 (medium) and >1.24 (high or epidemical).

Chart 31. **Monthly Epidemic Index of intimate parthner violence**



methodological and ethical aspects in relation with its early detection) and regarding its being tackled (comprehensive and co-ordinately among all sectors involved). Act1/2004 provides the frame to address it with an integrated approach, its impact having to be assessed in the medium and long run. In the Healthcare sector, the Commission against Gender Violence of the Interterritorial Council has been created; within it, four work groups have been set in motion to develop a protocol and common indicators, to address the ethical, legal and assessing aspects of actions conducted within the National Health System.

10. Health Plans and Equality Plans

Public policies are the instrument which articulate values, decisions and actions that are devised and implemented from the State, to give response to needs, to participate in social processes and their problematic and to rationalize diverse interests – most times opposed – ultimately targeting common welfare.

Health, as common knowledge has it, comes determined by various factors. Competences to address many of them lie in sectors different from healthcare (education, transport, town planning, housing or agriculture among others). Also, gender equality issues from transversal work, which should pervade any political action. Two are the operative fields, promotion and protection of health and promotion and protection of gender equity, that, to be effective need intersectorial and participative approaches, which lend them considerable complexity[14].

The magnitude of public policies approaching health inequalities due to gender will be dealt with in this chapter from the recognition of that complexity influencing effective action, and the interaction between health and gender: Health Plans and Autonomous Communities' Plans for Equal Opportunities. Firstly, the way gender equity is envisaged within health plans will be discussed in this chapter, and secondly, health aspects included in Plans for Equal Opportunities.

The 1986 General Health Law established the principles for the formulation of Autonomous Communities Healthcare Policy, through health plans. The latter become the health policy articulating mechanisms, and incorporate principles, values, aims and actions to be developed while they are in force, defining what are considered health concerns and what the priorities should be.

Studies conducted to analyse gender equity in Health Plans are scarce and refer only to formulation and not to implementation or assessment. Within this frame of knowledge, it can be said that Autonomous Communities health plans show important differences in what concerns gender awareness and that the inclusion of general objectives of gender equity are not often

[14] "If John Snow today wanted to eliminate the transmitting source of cholera, he would have to work with the community leaders, interact with government, write a report on environmental impact and obtain approval from a human research committee" (Illona Kickbuch).

accompanied by the development of specific operative actions. Although presenting the information broken down by sex is frequent when diagnosing the situation of health issues, gender awareness declines when it comes to formulating actions and supportive targets for the developing of plans, such as interventions in environments where power structures are reproduced, or in information, training or research systems, in order to introduce the gender perspective in the treatment of health. However, health plans usually contain a specific chapter on reproductive health, in women's most traditional sense, the inclusion of men in such subjects, being exceptional, or the latter having a gender approach (Peiró, 2004)

Policies on equal opportunities are, on the other hand, responses issued from governments to address inequalities between women and men. Their initial steps were taken, back in 1983, with the creation of the Women's Institute and the drafting of the First Plan on Equal Opportunities for Women and Men. From 1988, impulse was given to the creation of autonomic institutions for equality. These institutions are entrusted with the managing of equal opportunities plans or positive actions for women plans. Currently, all Autonomous Communities rely on equality mechanisms that are complemented on a State level by the 2003-2006 Fourth Plan for Equal Opportunities between Women and Men.

In Equality Plans, different aspects are approached, such as women's rights, conciliation of work and family lives, participation in economic, social and political lives, education, gender violence and health.

Health, in plans for equal opportunities, is defined as a comprehensive process that envisages women's emotional, social and physical well being along their whole vital cycle (Women's Institute, 2005).

Plans for equal opportunities in the health sphere, are addressed to women's population in general, although taking their diversity into consideration at the time of their practical application. They target especially some specific population groups, such as adolescents, elderly or disabled women or at risk of social exclusion. They propose the use of healthcare resources for improving information and health care through education and health promotion programmes in all fields –social, cultural, political and educational among others– promoting self-knowledge and autonomy for women when making their own decisions. They also propose the promoting of recognition of women and women's associations' learnings and experiences in what concerns health issues.

Especially relevant is the need to train healthcare personnel on gender subjects, coordination and experiences exchange, and good practice in women's health.

Broadly speaking, plans for equal opportunities include, just as health plans do, the caring for women's needs in terms of reproductive health, pro-

posing interventions for improving guidance, information and education in the scopes of pregnancy, delivery, puerperium and menopause; the spreading of healthy habits; and the promotion of access to services, prevention of, and support when facing unwanted pregnancies and sexually transmitted diseases. Also healthy habits are addressed, both relating to nutrition as well as to alcohol, tobacco and drugs use.

Studies of work risks for pregnant women, and in womanized environments, as well as when performing non-paid or domestic work, and men violence against women, are other subjects commonly included.

In general, equality institutions are not responsible for implementing these plans; it usually is a matter of transversal action strategies, which allocate the responsibility for the execution of most of their actions to different departmental units. The lack of a clear executory authority defined in those plans leaves implementation of proposed actions in the hands of the awareness and good will of the different governmental departments involved in their application. In addition to the equality institutions' lack of capacity to impose fines for not complying with plans, the majority of the latter do not include budgetary allotment funds to enable their implementation (Bustelo, 2004; Arranz, 2000).

Broadness is a stumbling block for the implementation and subsequent assessment of certain targets or proposed actions, and in many aspects relates to moral values, attitudes and social relations, difficult to be quantified numerically, and in the scope of which, changes occur from a comprehensive, inter-sectorial perspective and occur in the long run, this being a trait that makes measuring and analysis difficult while plans are in force. Exception made of legislative reforms, it is difficult to assess on the impact such public policies have on health, or on any other sphere.

Both in health plans and in equality ones, special importance is given to the reproductive dimension of women's health, which encourages preservation of the reproductive and caregiving roles allocated to women (Esteban, 2000). It also seems that recognition of the promoting, catalyzing, mediating, caregiving and educational roles of women in the health sphere, proposed in equality plans, would reinforce the traditional feminine role, with direct consequences on their physical and mental health, mostly due to the burden this entails (Izquierdo, 2001).

Finally, we must point at the absence in health and equality plans of positive actions aimed at modifying men's role in education, assistance, or caregiving, or in other spaces related to health, where gender inequalities become ingrained and reproduce.

11. Conclusions

1. Processes and resulting health and disease, and their handling at health services, are to a great extent different for women and men. When these differences are unjust and avoidable, they become inequalities. The majority of them cannot be explained by differences linked to biological sex, but are related to gender roles and stereotypes. Social class has also an influence, interacting in many ways with gender. Other aspects, on which available information is still scarce, like being an immigrant or disabled, also interact with gender influencing the way men and women get sick and relate to health services.
2. Women have a higher life expectancy at birth and at 65 years but their healthy, chronic illness-free life is shorter than that of men. On the contrary, men live less years but with better health, although they suffer disabilities from earlier ages, many of them arising from accidents.
3. Life patterns present a clear distribution by sex. In general, men engage in less healthy conducts as regards use of addictive substances (tobacco, alcohol, illegal drugs) –although this is changing among the youngest population where female youngsters are adopting these same habits–. But on the contrary they do more sport and sleep more hours than women. The former would be related to greater risk practices, adopted following traditional manliness models. The latter would result from the lack of equality in the distribution of productive and reproductive work, leisure and rest times.
4. In the reproductive work, horizontal and vertical segregations give rise to exposure of men and women to different physical and psychosocial risks and also to their obtaining different salaries. With respect to reproductive work, the present situation of inequity in the share of times devoted to work and caregiving –both in the private and the public spheres– translates into a physical and emotional overload, and an impact on women's health, still main caregivers.
5. Obesity prevalence presents important differences when considered by sex, age and social class, with changing patterns in the interrelation among these variables. It is more frequent in men under 50 years and in women after that age. It increases with age until old age. It is more frequent in less privileged social classes, being the class gradient higher in women. On the contrary, insufficient weight is more frequent in upper classes women and in lower classes men.
6. Existing information on some important aspects of people's health, like affective-sexual health is very scarce and when available, it refers chiefly

to the most biological aspects of sexuality and reproduction. This lack of information on the rest of aspects leads to undertaking the medicalizing of situations that might just be sheer variations of traditional sexuality patterns.

7. Diseases that yield the highest mortality rates among men and women are cardiovascular conditions and cancer, which present different prevalence according to sex. Both the existing information and the attention paid to them are in general insufficient to analyse them deeply enough from a gender perspective. In some cases, as is ischemic cardiopathy, plenty of information exists as to propose actions aimed at improving gender equity as far as care is concerned. Broadly speaking, further gender-oriented studies about these issues need to be conducted applying both a gender approach and scientific evidence, to preventive and welfare practices.
8. Other important health problems from the morbidity point of view, such as diabetes, mental disorders, HIV/AIDS, injury due to external causes, osteoporosis or fibromyalgia, need, to be effectively addressed from healthcare services, a gender analysis of their causes and consequences to be conducted.
9. Violence, a cause for social disturbance, presents a clear gender pattern. It is a component of the dominant manliness that influences negatively men's health, causing them injuries and disabilities. But it also influences women's health. Gender violence, because of both its magnitude and its impact on mental and physical health of affected women and their children, is considered to be a public health priority concern. In the healthcare field, development of such tools as the common protocol for comprehensive care, is hence suggested, and so is the need to evaluate in the medium and the long run, Act 1/2004 impact.
10. Faced with the health needs of men and women, society responds by establishing health policies and offering services. Even in those cases in which health policies and services are apparently offered to men and women on equal terms, they are not used in the same way by those ones or these others. Women and men seek medical advice and emergency care for different motives and with different frequencies. They are also admitted to hospital and are prescribed medicaments differently.
11. Gender equality is approached in Autonomous Communities Health Plans, but principally at discourse level, but scarcely being to the point in terms of operative targets and instrumental measures. Practically all of them include disaggregation by sex when analysing health problems, but neither do they include their own gender analysis, nor specific actions with a gender perspective. Inclusion of some chapter on reproductive health with references to women's health, is customary.

12. Plans for Equal Opportunities generally include women's health among their targets (reproductive health, life styles and most frequent or serious diseases). The main problem detected is one of implementation as, being as they are, transversal measures, with no exclusive executor body in charge, their operativeness is complex

12. Proposals for action

In view of the available information on existing links between gender and health, the Ministry of Health and Consumers intends to incorporate a gender approach in all facets of its activity scope and ensure that all kinds of research, policies, projects, programmes and initiatives in which it might be involved, incorporate gender concerns. This will cooperate in the increasing of the coverage, efficacy, effectiveness and, ultimately, on the impact of healthcare interventions, for both women and men, helping, at the same time, to enforce the principle of equality.

The inclusion of this gender approach from the Ministry of Health and Consumers is proposed, to contribute to:

- Provide qualitative and quantitative information on the influence gender has on health and care given to it.
- Promote equity and equal opportunities in achieving men and women's health all along their whole lives.
- Increase coverage and usefulness of health interventions.
- Support Autonomous Communities in achieving the planning, implementing and assessment of policies, programmes and projects that take into consideration gender issues.

Actions promoting gender equity in health must be aimed at modifying the causes for inequity. To this end, from the scope of its competences and counting on the cooperation from other Ministries, autonomic institutions and public and private organizations, the Ministry of Health and Consumers envisages the following actions:

1. Promote, together with the "Carlos III" Institute of Health and the Ministry of Science and Education, the inclusion of a gender approach in all kinds of research, as well as the development of specific investigation on gender inequalities and inequities in health, paying special attention to cardiovascular diseases, cancer, diabetes, mental health, injury resulting from external causes and affective-sexual health, among others.
2. Develop, in cooperation with the Agencies for Technologies Evaluation and for Evaluation of Medicaments, a work schedule for revising and updating available information on care to cardiovascular diseases, breast cancer screening programmes, womb cervix and

colon and rectal cancer prevention, prevention and treatment of osteoporosis, and also addressing fibromyalgia and chronic fatigue.

3. Conduct a study on the effect of gender stereotypes on the healthcare dispensed by the National Health System and on healthcare personnel's attitudes when confronting gender inequalities, with the aim of identifying difficulties and opportunities to effect the necessary changes.
4. Carry out, in cooperation with the Spanish Agency for Food Safety, a study on gender and obesity to acquire a better understanding of its causes, and the effectiveness of preventive measures and treatments.
5. Conduct a study on the practice of c-sections in the NHS, in order to know the circumstances in which they are performed and the role of professionals and users in decision making.
6. Conduct a survey on sexuality, based on previous qualitative studies, permitting to know the aspects which relate to women and men's affective-sexual health.
7. Revise, from a gender perspective, all aspects of work health, especially the instruments for assessment of risk, and the list of work diseases, in cooperation with the Ministry of Work and Social Affairs, trade unions and other agents involved.
8. Revise, jointly with the governmental institutions involved in the battle against gender violence, the sources of healthcare information with the aim of knowing its frequency and features, as well as the existing protocols for its comprehensive care, and thus propose common criteria.
9. Develop, at the website of the MHC Quality Plan, an area providing quality information on health and gender key issues, in a way accessible to the general population.
10. Produce a guide, with Autonomous Communities and scientific and professional societies, for the inclusion of the gender approach to strategies, plans and health programmes.

13. References

Whenever possible, and apart from surnames, we have included the first names of women and men who sign the works listed in the Bibliography,. We wish, this way, to make their contributions "visible".

Abellán García, Antonio. *Las personas mayores en España.* Madrid: CSC; 2004. CSIC.

Agencia Española del Medicamento. R*estricción de las indicaciones terapéuticas de la Terapia Hormonal de Sustitución.* Madrid: Agencia Española del Medicamento; 2004.

Alberdi, Inés; Escario, Pilar; Matas, Natalia. *Las mujeres jóvenes en España.* Barcelona: Fundación La Caixa; 2000.

Alberdi, Inés; Matas, Natalia. *La violencia doméstica. Informe sobre los malos tratos a mujeres en España.* Barcelona: Fundación La Caixa; 2002.

Alder, Beth. *The Perimenopause. At: Mood disorders in women.* Steiner M, Yonkers KA, Eriksson E, pubs. London: Martin Dunitz; 2000.

American College of Obstetricians and Gynaecologists. *Urinary incontinence in women. Obstet Gynecol 2005;* 105(6): 1533-45.

Anteproyecto de *Ley Orgánica de Igualdad entre Mujeres y Hombres. 2006.* Available at: http://www.la-moncloa.es/ ActualidadHome/030306-Leyigualdad.htm.

Arranz, Fátima. Algunas notas tecnológicas sobre los planes de igualdad de oportunidades en el marco de las políticas públicas dirigidas hacia las mujeres: el caso español. *At: Las políticas Públicas a favor de las mujeres.* Arranz F ed. Madrid: Instituto de Investigaciones Feministas. Universidad Complutense de Madrid; 2000.

Arrizabalaga, Pilar; Valls-Llobet, Carme. *Mujeres médicas: de la incorporación a la discriminación.* Med Clin (Barc) 2005; 125 (3): 103-7.

Artaso Begoña, Goñi Adriana, Biurrun Ana. *Cuidados informales en la demencia: predicción de sobrecarga en cuidadoras familiares.* Revista Española de Geriatría y Gerontología 2003; 38(4): 212-8.

Artazcoz, Lucía; Borrell, Carme; Benach, Joan. *Gender inequalities in health among workers: the relation with family demands.* J Epidemiol Community Health 2001; 55: 639-47.

Artazcoz, Lucía; Escribá-Agüir, Vicenta; Cortès, Inmaculada. *Género, trabajos y salud en España.* Gac Sanit 2004; 18(supl 2.): 24-35.

Badià, Xavier; Lara N, Roset M. *Calidad de vida, tiempo de dedicación y carga percibida por el cuidador principal informal del enfermo de Alzheimer.* Aten Prim 2004; 34(4): 170-7.

Barrat, Alexandra; Howard, Kirsten; Irwig, Les et al. *Model of outcomes of screening mammography: information to support informed choices.* BMJ 2005; 330: 936-38.

Barry Michael. *Measurement of prostate-specific antigen in serum as a screening test for prostate cancer.* N Engl J Med 1991; 324: 1156-61.

Barry Michael. Clinical practice. *Prostate-specific-antigen testing for early diagnosis of prostate cancer.* N Engl J Med. 2001; 344(18): 1373-7.

Bello, Natalie; Mosca, Lori. *Epidemiology of coronary heart disease in women.* Prog Cardiovasc Dis. 2004; 46(4): 287-95.

Borjano, Enrique; Simó, Carles; Ariño, Antonio (eds). *Cuidado a la Dependencia e Inmigración.* Madrid: Ministry of Work and Social Affairs; 2005.

Bernardi, Fabricio; Requena, Miguel. *La caída de la fecundidad y el déficit de natalidad en España.* Revista Española de investigaciones sociológicas 2003; 3: 29-49.

Blanco, Pilar; Ruiz, Consuelo; García de Vinuesa, Leonor et al. *La violencia de pareja y la salud de las mujeres.* Gac Sanit 2004; 18(supl.1): 182-8.

Bodoque, Yolanda. *Tiempo biológico y tiempo social. Aproximación al análisis del ciclo de vida de las mujeres.* Gaceta de Antropología 2001; num. 17.

Boletín Oficial el Estado. Ley 13/2005 de 1 de julio por la que se modifica el Código Civil en materia de derecho a contraer matrimonio. Boletín Oficial del Estado 157 of 02/07/2005.

Bolaños, Eva; Sarríà, Antonio. *Perspectiva de las personas con diabetes tipo 2: un estudio cualitativo.* Madrid: Agencia de Evaluación de Tecnologías Sanitarias; 2001.

Bongard, Vanina; Grenier, Olivier; Ferrieres, Jean et al. *Drug prescriptions and referral to cardiac rehabilitation after acute coronary events: comparison between men and women in the French PREVENIR Survey.* Int J Cardiol. 2004; 93(2-3): 217-23.

Bonino, Luis. *Masculinidad, salud y sistema sanitario.* At: Seminario sobre Mainstreaming de Género en las políticas de salud en Europa. Madrid: Instituto de la Mujer; 2002.

Bonino, Luis. *Obstáculos a la comprensión e intervenciones sobre la violencia (masculina) contra las mujeres.* Available at www.sepv.org/ensayos/bonino [downloaded 4 April, 2006].

Bustelo, María. *La evaluación de las políticas de género en España.* Madrid: Los libros de la catarata; 2004.

Campbell J, Soeken K. *Forced sex and intimate partner violence: Effects on women´s risk and women health. Violence against Women 1999,* 5: 1017-35.

Campo, Mª Jesús. *El apoyo informal a las personas mayores y el papel de la mujer cuidadora.* Madrid: Centro de Investigaciones Sociológicas; 2000.

Carmona L, et al. *Evaluación de la densitometría de rayos X de falange como método de cribado de osteoporosis. 2003.* Proyecto convocatoria evaluación de tecnologías sanitarias del ISCIII 2001.

Carrasquer, Pilar; Tejero, Elisabet; Romero, Alfonso et al. *El trabajo reproductivo.,* Papers 1998; 55: 95-114.

Castells, Manuel. *El fin del patriarcado: movimientos sociales, familia y sexualidad en la era de la información. At: La era de la información. Economía, sociedad y cultura. Vol.2. El poder de la identidad. Chap. 4.* Madrid: Alianza; 1997.

Centro Nacional de Epidemiología. *Vigilancia Epidemiológica del SIDA.* Registro Nacional de Sida: Informe semestral; 2006. Available at: www.isciii.es, downloaded 24 November 2006.

CES. *Panorama socio laboral de la mujer en España.* Madrid: CES; 2005, num.42, 4º trimes.

Chandola T, Kuper H, Singh-Manoux A et al. *The effect of control at home on CHD events in the Whitehall II study: Gender differences in psychosocial domestic pathways to social inequalities in CHD.* Soc Sci Med 2004; 58(8): 1501-9.

Chrysohoou C, Panagiotakos DB, Pitsavos C et al. *Gender differences on the risk evaluation of acute coronary syndromes: the CARDIO2000 study.* Prev Cardiol 2003; 6(2): 71-7.

Comisión de las Comunidades Europeas. *Mejora de la salud mental de la población. Hacia una Estrategia de la UE en materia de salud mental.* Libro Verde. Brussels: Comisión de las Comunidades Europeas; 2005. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_es.pdf.

Comisión de las Comunidades Europeas. *100 palabras para la igualdad. Glosario de términos relativos a la igualdad entre hombres y mujeres.* Brussels: Comisión de las Comunidades Europeas; 1998. Available at: http: //www.europarl.eu.int/transl_es/plataforma/pagina/celter/glosario_genero.htm.

Comisión de las Comunidades Europeas. *Informe sobre la situación sanitaria de la mujer en la Comunidad Europea.* Bruselas: Comisión de las Comunidades Europeas; 1997. Available at: http://europa.eu.int/eur-lex/ lexUriServ/LexUriServ.do?uri=CELEX:31997Y1230 (01).

Fourth World Conference on Women. Beijing; 1995.

United Nations International Conference on Population and Development. (ICPD) Cairo: United Nations; 1994

Consensus Development Conference: *diagnosis, prophylaxis and treatment of osteoporosis.* Am J Med 1993; 94:646-50.

Convención sobre la eliminación de todas las formas de discriminación contra la mujer. 1979.

Available at: www.unhchr.ch/spanish/html/menu3/b/e1cedaw_sp.htm.
Cortés, Inmaculada; Artazcoz, Lucía; Borrell, Carme et al. *Desigualdades en la salud mental de la población ocupada.* Gac Sanit 2004;18(5): 351-9.
Coryell W, Endicott J, Kéller M. *Major depression in a non-clinical sample.* Arch Gen Psychiatry 1992; 49: 117-25.
Cummings, Steven; Black, Dennis; Nevitt, Michael et al. *Bone density at various sites for prediction of hip fractures.* Lancet 1993; 341: 72-5.
Dafra MG, Lapolla A, Masin M, et al. *Antepartum and early postpartum predictors of type 2 diabetes development in women with gestacional diabetes.* Diabetes Med 2001; 27: 675-80.
Declaración Universal de los Derechos Humanos. París; 1948. Available at: http://www.un.org/ spanish/aboutun/hrights.htm.
Delgado, Ana; López, Luis Andrés; Luna JD. *Ser médico o médica marca diferencias en la práctica asistencial.* Aten Prim 2001; 28 (4): 219-26.
DeVon, Holli; Zerwic, Julie. *Symptoms of acute coronary syndromes: are there gender differences?* A review of the literature. Heart Lung 2002; 31(4): 235-45.
Doyal, Leslye. *Sex, gender, and health: the need for a new approach.* BMJ 2001; 323(7320): 1061-3.
Espallargues, Mireia; Estrada, M Dolors; Sampietro-Colom, Laura et al. *Guía para la indicación de la densitometría ósea en la valoración del riesgo de fractura.* Barcelona: Agència d'Avaluació de Tecnologia Mèdica. Servei Català de la Salut. Departament de Sanitat i Seguretat Social. Generalitat de Catalunya. 1999.
Esteban, Mari Luz. *El análisis y la intervención en relación a la salud. At: Las políticas Públicas a favor de las mujeres.* Arranz, Fátima (ed). Madrid: Instituto de Investigaciones Feministas. Universidad Complutense de Madrid; 2000.
Esteban, Mari Luz. *El género como categoría analítica. Revisiones y aplicaciones a la salud.* At: Perspectivas de género en salud. Fundamentos científicos y socioprofesionales de diferencias sexuales no previstas. Miqueo, Consuelo; Tomás, Concepción; Tejero, Cruz et al (eds). Madrid: Minerva; 2001.
Ettinger, Steven. *Myocardial infarction and unstable angina: gender differences in therapy and outcomes.* Curr Womens Health Rep. 2003; 3(2): 140-8.
Fernández, Isabel; Pascual de la Pisa, Beatriz. *Valor predictivo del síndrome metabólico en la gestación para el desarrollo de diabetes mellitus.* Aten Prim 2006; 37: 517-21.
Fernández, Joaquín. *El síndrome de fatiga crónica.* Med Integr 2002; 40: 56-63.
Fernández, Marta; Gaviria María N; Muñoz, Francisca et al. *Sexualidad en las mujeres mayores.* Aten Prim 2006; 37(9): 504-9.

Fernández–Cordón, Juan Antonio; Tobío, Constanza. *Conciliar las responsabilidades laborales y familiares: políticas y prácticas sociales.* Madrid: Fundación Alternativas; 2005. Documento de trabajo 79/2005.

Fortino, Sabine. *De la ségrégation sexuelle des postes à la mixité au travail: étude d'un processus.* Sociologie du travail 1999: 41(4):363-84.

Frías, Antonio; Escudero, María; Prieto, Mª Angeles et al. *Vivencias, expectativas y demandas de cuidadoras informales de pacientes en procesos de enfermedad de larga duración.* Enferm Clín 2005; 15(4): 220-6.

Fuentes i Pujol, Mercé. *Salud reproductiva y salud integral de las mujeres. Reflexiones desde la práctica en Asistencia Primaria.* At: Perspectivas de género en salud. Fundamentos científicos y socioprofesionales de diferencias sexuales no previstas. Miqueo, Consuelo; Tomás, Concepción; Tejero, Cruz et al (eds) Madrid: Minerva 2001.

García, Maria del Mar; Mateo-Rodríguez, Inmaculada; Eguiguren, Ana. *El sistema informal de cuidados en clave de desigualdad.* Gac Sanit 2004; 18(sup.1): 132-139.

García, Maria del Mar; Mateo-Rodríguez, Inmaculada; Maroto-Navarro, Gracia. *El impacto de cuidar en la salud y la calidad de vida de las mujeres.* Gac Sanit 2004; 18(2): 83-92.

García-Sánchez, Inés. Diferencias de género en el VIH /SIDA. Gac Sanit 2004; 18(Supl 2): 47-54.

Garrido, Luis. La Revolución reproductiva. At: *Salud, dinero y amor. Cómo viven las mujeres españolas de hoy.* Castaño C, Palacios S eds. Madrid: Alianza; 1996; pp. 157-80.

Gascón, Stephanie. Estrés por desempleo y salud. *Cuadernos de Medicina psicosomática y psiquiatría de enlace 2003;* 66: 9-18.

Giddens, Anthony. Sociología. Madrid: Alianza Universidad; 1992.

Goetzsche PC. *Outcomes of screening mamography.* BMJ 2005; 331: 350-1

Gómez, Carmuca. Mujeres y trabajo: principales ejes de análisis. Papers 2001; 63/64: 123-40.

Gómez, Elsa. *Género, equidad y acceso a los servicios de salud: una aproximación empírica.* Revista Panamericana de Salud Pública 2002; 11: 5.

González de Chávez, María Asunción. *La fibromialgia. Su relación con la condición de las mujeres.* At: La salud de las mujeres. IV Jornadas de la Red de Médicas y Profesionales de la Salud. Madrid: Instituto de la mujer; 2003.

Griffith D, Hamilton K, Norrie J et al. *Early an late mortality after myocardial infarction in men and women: prospective observational study.* Heart 2005; 91: 305-7.

Habiba M, Kaminski M, Da Frè M. *Caesarean section on request: a comparison of obstetricians' attitudes in eight European countries.* BJOG 2006; 113: 647.

Haglund, Bengt; Koster, Max; Nilsson, Tage et al. *Inequality in access to coronary revascularization in Sweden.* Scand Cardiovasc J 2004; 38(6): 334-9.
Hazemeijer I, Rasker JJ. *Fibromyalgia and the therapeutic domain. A philosophical study on the origins of fibromyalgia in a specific social setting.* Rheumatology 2003; 42: 507-15.
Healy, Bernardine. *The Yentl syndrome.* N Engl J Med 1991; 325: 221-5.
Hippisley-Cox, Julia; O'Hanlon, Shaun; Coupland, Carol. *Association of deprivation, ethnicity, and sex with quality indicators for diabetes: population based survey of 53 000 patients in primary care.* BMJ 2004; 329: 1267-9.
Huxley, Rachel; Barzi, Federica; Woodward, Mark. *Excess risk of fatal coronary heart disease associated with diabetes in men and women: meta-analysis of 37 prospective cohort studies.* BMJ 2006; 332: 73-78.
Idler EL, Benyamini Y. *Self-rated health and mortality: a review of twenty-seven community studies.* J Health Soc Behav 1997; 38: 21-37.
IMSERSO. *Las personas mayores en España.* Madrid: IMSERSO; 2004.
Instituto de la Mujer: *Estudio comparativo de los planes de igualdad de oportunidades entre hombres y mujeres autonómicos y nacional.* Madrid: Instituto de la Mujer; 2005.
Instituto de la Mujer. *Estudio sobre la conciliación laboral y familiar.* Madrid: Instituto de la Mujer; 2005.
Instituto Nacional de Estadística: *Encuesta de empleo del tiempo.* Madrid: INE; 2004. Available at: http://www.ine.es/inebase [downloaded 16 February 2005].
Instituto Nacional de Estadística. *Encuesta sobre Discapacidades, Deficiencias y Estado de Salud.* Madrid: INE; 1999.
Instituto Nacional de Estadística. *Anuario Estadístico de España.* Madrid: INE; 2005.
Instituto Nacional de Estadística. Defunciones según la causa de muerte. Madrid: INE; 2004.
Instituto Nacional de Estadística. *Defunciones según la causa de muerte.* Madrid: INE; 2003.
Instituto Nacional de Estadística. *Encuesta sobre Discapacidades y Estado de Salud.* Madrid: INE; 1999.
Instituto Sindical de Trabajo, Ambiente y Salud. *Análisis de las tareas y las percepciones de los delegados y delegadas de prevención en España.* Madrid: ISTAS; 2005.
Izquierdo, María Jesús. Sin vuelta de hoja. *Sexismo: poder, placer y trabajo.* Barcelona: Ediciones Bellaterra; 2001.
Izquierdo, María Jesús. *Los órdenes de la violencia: especie, sexo y género.* At: El sexo de la violencia. Género y cultura de la violencia. Fisas V ed. Barcelona: Icaria Antrazyt; 1998.

Krieger, Nancy. *Genders, sexes and health: what are the connections—and why does it matter?*. Int J Epidemiol 2003; 32(4): 652-7.
Kyker KA, Limacher MC. *Gender differences in the presentation and symptoms of coronary artery disease*. Curr Womens Health Rep 2002; 2(2): 115-9.
La Parra, Daniel. *Contribución de las mujeres y los hogares más pobres a la producción de cuidados de salud informales.* Gac Sanit 2001; 15(6): 498-505.
Fondo de Población de las Naciones Unidas. *La promesa de igualdad: Equidad de Género, Salud Reproductiva y Objetivos de Desarrollo del Milenio.* Estado de la Población Mundial. New York: Fondo de Población de las Naciones Unidas; 2005.
Lagarde, Marcela. *Para mis socias de la vida.* Madrid: Horas y horas; 2005
Lefler, Leanne; Bondy, Kathleen. *Women's delay in seeking treatment with myocardial infarction: a meta synthesis.* J Cardiovascular Nursing 2004; 19(4): 251-68.
Lehr, Ursula. Altern in Europa im 21. Jahrhundert. *Eine Herausforderung für das Individuum un die Gesellschaft.* Pliegos de Yuste: revista de cultura y pensamiento europeos 2003; 1: 29-40.
Lynch, John; Davey, George; Kaplan, George et al. *Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions.* BMJ 2000; 320: 1200-4.
Malterud, Kristie. *Symptoms as a source of medical knowledge: understanding medically unexplained disorders in women.* Fam Med 2000; 32(9): 603-11.
Marrugat, Jaume; Antó, Josep María; Sala, Joan et al: *Influence of gender in acute and long term cardiac mortality alter a first myocardial infarction.* J Clin Epidemiol 1994; 47 (2): 111-8.
Marrugat, Jaume; Cosín, Juan; Cabadés, Adolfo et al. Estudio PANES. Rev Esp Cardiol 1996; 49 (supl 3): 113.
Marrugat, Jaume; Garcia, María; Elosua, Roberto et al: IBERICA Investigators; PRÍAMO Investigators; RESCATE Investigators; PEPA Investigators; REGICOR Investigators: Short-term (28 days) prognosis between genders according to the type of coronary event (Q-wave versus non-Q-wave acute myocardial infarction versus unstable angina pectoris). Am J Cardiol. 2004; 94(9): 1161-5.
Marrugat, Jaume; Sala, Joan; Masiá, Rafael et al: *Mortality differences between men and women following first myocardial infarction.* JAMA 1998; 280 (16): 1405-9.
Marshall, Deborah; Johnell, Olof; Wedel, Hans. *Meta-analysis of how well measures of bone mineral density predict occurrence of osteoporotic fractures.* BMJ 1996; 312:1254-9. (a)
Maruani, Margaret. Introducción. At: *Las nuevas fronteras de la desigual-*

dad: hombres y mujeres en el mercado de trabajo. Maruani M, Rogerat Ch, Torns T ed. Barcelona: Icaria Antrazyt; 2000.
Mata, Nelva; Ruiz, Isabel. *Detección de violencia doméstica en mujeres que acuden a un centro de Atención Primaria.* [Tesina]. Granada: Escuela Andaluza de Salud Pública; 2002.
Million Women Study Collaborators. *Breast cancer and hormone-replacement therapy in the Million Women Study.* Lancet, 2003; 362: 419-27.
Ming Chan, Kai; Anderson, Mary; Lau, Edith. *Exercise interventions: defusing the world´s osteoporosis time bomb.* Bulletin of the World Health Organization 2003; 81-827-830.
Ministerio de Sanidad y Consumo. *Encuesta de Salud y Hábitos Sexuales.* Madrid: Ministerio de Sanidad y Consumo; 2003.
Ministerio de Sanidad y Consumo. *Encuesta Nacional de Salud.* Madrid: Ministerio de Sanidad y Consumo; 2003.
Ministerio de Sanidad y Consumo: *La Esperanza de Vida Libre de Incapacidad: un indicador estructural,* Madrid: Ministerio de Sanidad y Consumo; 2004. Available at: http://www.msc.es/estadEstudios/estadisticas/docs/Informe EVLI.pdf].
Ministerio de Sanidad y Consumo. Estadística de Establecimientos Sanitarios con Régimen de Internado. Madrid: Ministerio de Sanidad y Consumo; 1997-2002.
Ministerio de Sanidad y Consumo. *La Interrupción Voluntaria del Embarazo y los métodos anticonceptivos en jóvenes.* Madrid: Ministerio de Sanidad y Consumo; 2006. Available at: http://www.msc.es.
Ministerio de Sanidad y Consumo. *La salud de la población española en el contexto europeo y del Sistema Nacional de Salud. Indicadores de Salud.* Madrid: Ministerio de Sanidad y Consumo; 2005.
Ministerio de Sanidad y Consumo. *Encuesta Domiciliaria sobre Abuso de Drogas 2005.* Madrid: Ministerio de Sanidad y Consumo-Delegación del Gobierno para el Plan de Drogas; 2006.
Ministerio de Sanidad y Consumo: *Encuesta Estatal sobre uso de Drogas en Enseñanzas Secundarias 2004.* Madrid: Ministerio de Sanidad y Consumo-Delegación del Gobierno para el Plan de Drogas; 2005.
Ministerio de Sanidad y Consumo. *La situación del cáncer en España.* Madrid: Ministerio de Sanidad y Consumo; 2005.
Ministerio de Trabajo y Asuntos Sociales. *Cuidado a la Dependencia e Inmigración.* Borjano E, Simó C, Ariño A eds. Madrid: Ministerio de Trabajo y Asuntos Sociales; 2005,
Ministerio de Trabajo y Asuntos Sociales. *Encuesta sobre Cuidados a las Personas Mayores en los Hogares Españoles.* Madrid: Ministerio de Trabajo y Asuntos Sociales-Instituto de Mayores y Servicios Sociales; 2005.
Ministerio de Trabajo y Asuntos Sociales. *IV Plan de Oportunidades entre*

Mujeres y Hombres 2003-2006. Madrid: Ministerio de Trabajo y Asuntos Sociales; 2006. Available at: http://www.mtas.es/uafse/equal/ descargas/IV_Plan_Igualdad_Hombre_Mujeres_2003-2006.pdf.

Montero, Isabel; Aparicio D, Gómez-Beneyto, Manuel et al. *Género y salud mental en un mundo cambiante.* Gac Sanit 2004; 18(1): 175-81.

Montero, Isabel; Ruiz, Isabel. *Depresión y menopausia. At: Trastornos depresivos en la mujer.* Leal C ed. Barcelona: Masson SA; 1999.

Moral M, Ortega J, López M et al. *Perfil y riesgo de morbilidad psíquica en cuidadores de pacientes ingresados en su domicilio.* Aten Prim 2003; 32(2): 77-83.

Mosca, Lori ; Manson, JoAnn ; Sutherland, Susan et al. *Cardiovascular Disease in Women. Statement for Healthcare Professionals From the American Heart Association.* Circulation 1997; 96: 2468-82.

Mosquera, Carmen; De la Hera, Jesús; Barriales, Vicente. Grupo de Estudio RIMAS: *El infarto ¿Por qué la sobremortalidad en mujeres?* Gac Sanit 2002 b; 16(Supl 1): 60.

Mosquera, Carmen. La enfermedad coronaria. At: *La Salud de las mujeres en Asturias. Oviedo:* Consejería de Salud y Servicios Sanitarios; 2002.

Mosquera, Carmen. *La salud en la menopausia.* At: *La salud de las mujeres* en Asturias. Oviedo: Consejería de Salud y Servicios Sanitarios; 2002.

Moynihan, Clare. *Theories of masculinity.,* BMJ 1998; 317(7165): 1072-5.

Moynihan, Ray; Heath, Iona; Henry, David et al. *Selling sickness: The pharmaceutical industry an disease mongering.* BMJ 2002; 324(7342): 886-91.

Moynihan, Ray. *The marketing of a disease: female sexual dysfunction.* BMJ 2005; 330: 192-4.

NIH Consensus Development Panel on Osteoporosis Prevention, Diagnosis, and Therapy. *Osteoporosis prevention, diagnosis, and therapy.* JAMA 2001; 285:785-795.

NIH State-of-Science Panel. *National Institutes of Health State-of-the-Science Conference.* Management of Menopause-Related Symptoms. Annals Int Med 2005; 142: 1003-13.

Nilsson P, Brandstrom H, Lingfors H et al. *Gender differences in secondary prevention of coronary heart disease: reasons to worry or not? Scand* J Prim Health Care 2003; 21(1): 37-42.

Norris CM, Ghali WA, Galbraith PD et al: *Women with coronary artery disease report worse health-related quality of life outcomes compared to men.* Health Qual Life Outcomes 2004; 2: 21.

OECD. *Health at a glance.* 2005 Indicators. OECD; 2005.

Oliveira Mercedes. *La educación sentimental.* Madrid: Icaria; 1998.

Olsen, Ole; Gøtzsche, Meter. *Cribaje (screening) con mamografía para el cáncer de mama (translated Revision Cochrane).* At: La Biblioteca Cochrane Plus, number 4. Oxford: Update Software Ltd; 2005.

OMS. Integración de las perspectivas de género en la labor de la OMS. Glosario sobre el género. Available at: www.who.int/gender/mainstreming/ESPwhole.pdf. Geneva: WHO;

OPS. Promoción de la salud sexual. *Recomendaciones para la acción.* Washington DC: OPS; 2000.

Oluel, Julia; Fuentes Mercé; Mayolas Emma. *Disfunción sexual femenina.* AMF. 2005: 86-93.

Orencia A, Bailey K, Yaawn B et al: E*ffect of gender on long-term outcome of angina pectoris and myocardial infarction / sudden unexpected death.* JAMA 1993, 269(18): 2392-7.

Ortiz Gómez, Teresa. *El género, organizador de profesiones sanitarias.* At: *Perspectivas de género en salud. Fundamentos científicos y socioprofesionales de diferencias sexuales no previstas.* Consuelo; Tomas, Concepción; Tejero, Cruz (eds). Madrid: Minerva; 2001.

Pallardo F, Herranz L, García T et al. *Early postpartum metabolic assessment in women with prior gestacional diabetes.* Diabetes Care. 1999; 22: 1053-8.

Panay N, Studd JWW: *Menopause and the central nervous system.* Eur Menopause J 1996; 3: 242-9.

Pateman, Carol. *El contrato sexual,* Barcelona: Anthropos; 1995. p.240.

Peiró, Rosana; Álvarez-Dardet, Carlos; Ramón, Nieves et al: *Sensibilidad de género en la formulación de planes de salud en España: lo que pudo ser y no fue.* Gac Sanit 2004; 18(Supl 2): 36-46.

Peiró, Rosana; Seguí-Gómez, María; Pérez-González, Catherine et al: *Lesiones por tráfico, de ocio y domésticas y laborales. Descripción de la situación en España.* Gac Sanit 2006; 20(Supl 1): 32-40.

Per-Henrik, Zahl; Strand BH, Maehlen J et al. *Incidence of breast cancer in Norway and Sweden during introduction of nationwide screening: prospective cohort study.* BMJ 2004; 328: 921-24.

Pérez M, Gervas J. *Encarnizamiento diagnóstico y terapéutico con las mujeres.* SEMERGEN 1999; 25: 239-48

Philpott, Sue; Boynton, Petra; Feder, Gene et al. *Gender differences in descriptions of angina symptoms and health problems immediately prior to angiography: the ACRE study. Apropriateness of Coronary Revascularisation study.* Soc Sci Med. 2001; 52(10): 1565-75.

Plazaola-Castaño, Juncal; Ruiz, Isabel. *Violencia contra la mujer en la pareja y consecuencias en la salud física y psíquica.* Med Clín (Barc) 2004; 122: 461-7.

Polo, Cristina. *Maltrato a la mujer en la relación de pareja. Factores relacionados implicados.* [Tesis Doctoral]. Alcalá de Henares: Universidad de Alcalá; 2001.

Population and Development Studies. Publicación ocasional, num. 4. 1995.

Price, Donald; Staud, Roland. *Neurobiology of fibromyalgia syndrome.* J Rheumatol Suppl. 2005; 75: 22-8

Protégeles y Civértice. *Videojuegos, menores y responsabilidad de los padres.* Availableat:http://usuarios.lycos.es/atarifa/estudio%20videojuegos.pdf

Radl, Rita. *Transformaciones en el comportamiento en función del género en la vejez: el caso de las relaciones familiares actuales entre abuelas, abuelos y nietas y nietos.* Papers 2003; 70: 117-34.

Raine RA, Black NA, Bowker TJ et al. *Gender differences in the management and outcome of patients with acute coronary artery disease. J Epidemiol Community Health*. 2002; 56(10): 791-7.

Rajmil, Luis; Serra-Sutton, Victoria; Alonso, Jordi. *The Spanish version of the Child Health and Illness Profile Adolescent Edition (CHIP-AE): reliability and preliminary validity.* Qual Life Res 2003, 12: 303-13.

Raya, Lourdes; Ruiz, Isabel; Plazaola-Castaño, Juncal et al. *La violencia contra la mujer en la pareja como factor asociado a una mala salud física y psíquica.* Aten Prim 2004; 34: 117-27.

Rodríguez-Sanz, Maica; Carrillo, Paloma; Borrell, Carme. *Desigualdades sociales en la salud, los estilos de vida y la utilización de servicios sanitarios en las CC. AA.* 1993-2003. Madrid: Observatory on Women's Health and on the NHS, Ministry of Health and Consumers; 2005.

Rohlfs, Isabella; García, Mª Mar; Gavalda, Laura et al. *Género y cardiopatía isquémica.* Gac Sanit 2004; 18: 55-64.

Ruiz, Isabel; Blanco, Pilar; Vives, Carmen. *Violencia contra la mujer en la pareja. Violencia de género.* Gac Sanit 2004; Supl 1 (monographic).

Ruiz, Isabel; Ubago MC, Bermejo MJ et al. *Differences in sociodemographic, clinical, psychosocial and health care characteristics between women and men diagnosed with fibromyalgia,* (at the press).

Ruiz, María Teresa; Verdú, María. *Sesgo de género en el esfuerzo terapéutico.* Gac Sanit 2004; 18 (supl.1): 118-25.

Ruiz, María Teresa. *Igualdad de oportunidades en los servicios sanitarios: sesgo de género como determinantes de la estructura de salud de la Comunidad.* At: *Perspectivas de género en salud. Fundamentos científicos y socioprofesionales de diferencias sexuales no previstas.* Miqueo, Consuelo; Tomás, Concepción; Tejero, Cruz (eds). Madrid: Minerva 2001.

Ruiz-Ramos, Miguel; Escolar, Antonio; Mayoral-Sánchez, Eduardo et al. *La diabetes mellitus en España: mortalidad, prevalencia, incidencia, costes económicos y desigualdades.* Gac Sanit 2006; 20 (Supl 1): 15-24.

Sabo, Don. *Comprender la Salud de los hombres.* Un enfoque relacional sensible al género. Organización Panamericana de la Salud y Harvard Center for Population and Development Studies. Publicación Ocasional, num. 4. 1995.

Salido, Olga. *La participación laboral de las mujeres en España: cifras para un debate.* Working Paper 02-15. Unidad de políticas comparadas. Madrid: CSIC; 2004.

Salido, Olga. *La participación laboral de las mujeres: reto para el bienestar social.* Working Paper 06-09. Unidad de políticas comparadas. Madrid: CSIC; 2006.

Sanz, Fina. Del mal trato al buen trato. At: *La violencia contra las mujeres.* Ruiz Jarabo C, Blanco P ed. Madrid: Díaz de Santos; 2004.

Segovia J, Bartlett RF, Edwards AC. *An empirical analysis of the dimensions of health status measures.* Soc Sci Med 1989; 29: 761-8.

Segura, Josep; Bastida, Nuria; Martí, Nuria et al. *Los enfermos crónicos domiciliarios y su repercusión en los cuidadores principales.* Aten Prim 1998; 21(4): 431-6.

Segura, Andreu. *Inducción sanitaria de los cribados. Informe SESPAS 2006.* Gac Sanit 2006; 20 (supl1): 88-95.

Serra-Sutton, Victoria; Rajmil, Luis; Alonso, Jordi. *Valores poblacionales de referencia del perfil de salud CHIP-AE a partir de una muestra representativa de adolescentes escolarizados.* Gac Sanit 2003, 17: 181-9.

Solé, Carlota; Parella, Sonia. *Nuevas expresiones de la maternidad. Las madres con carreras profesionales "exitosas".* Rev Esp Invest Sociol 2004; 4: 67-92.

Solsona, Montse; Viciana, Francisca. *Claves de la evolución demográfica en el cambio de milenio.* Gac Sanit 2004; 18(Supl 1): 8-15

Starfield, Barbara; Riley, Anne; Green, Bert et al. *The adolescent Child Health and Illness Profile: a population-based measure of health.* Med Care 1995, 33: 553-66.

Thornton, Hazel. Screening without evidence of efficacy: Screening uncertainties concern evidence, efficacy, decisions. BMJ 2004; 328: 521.

Tobío, Constanza. *Madres que trabajan: Dilemas y estrategias.* Madrid: Cátedra. Colección Feminismos; 2005.

Urbanos R. *Impacto del envejecimiento en el gasto público sanitario y sociosanitario para el período 2000-2050.* Documento de Trabajo del Ministerio de Sanidad y Consumo. Madrid: Ministerio de Trabajo, 2003.

Uría, Marian. *La Salud de las mujeres en Asturias.* Gobierno del Principado de Asturias. Oviedo: Consejería de Salud y Servicios Sanitarios; 2004.

Usall i Rodié, Judith. *Diferencias de género en los trastornos del estado de ánimo: una revisión de la literatura.* Actas Españolas de Psiquiatría 2001; 29(4): 269-74.

Vallés M, Gutiérrez V, Luquin A et al. *Problemas de salud y sociales de los cuidadores de los pacientes con demencia.* Aten Prim 1998; 22(8): 481-4.

Valls, Carme. *El estado de la investigación en género y salud.* At: Perspectivas de género en salud. Fundamentos científicos y socio-profesionales

de diferencias sexuales no previstas. Miqueo, Consuelo; Tomás, Concepción; Tejero, Cruz (eds). Madrid: Minerva; 2001.
Valls, Carme. *Dolor crónico y fatiga crónica: una asignatura pendiente.* Med Clin (Barc). 2003; 121: 412-3.
Velasco, Sara. *La prevención de la transmisión heterosexual del VIH/ sida en las mujeres.* Madrid: Instituto de la mujer; 2001.
Velasco, Sara. *Relaciones de género y subjetividad. Método para programas de prevención.* Madrid: Instituto de la mujer; 2002.
Velasco, Sara. *La transmisión heterosexual del VIH /sida en España.* Madrid: Instituto de la mujer; 2003.
Velzeboer M. *La violencia contra las mujeres. Responde el sector de la salud.* Washington: Organización Panamericana de la Salud; 2003.
Vives-Cases, Carmen; Álvarez-Dardet, Carlos; Colomer, Concha et al. *Una experiencia de defensa de la salud en violencia contra las mujeres. Gac Sanit 2005;* 19(9): 262:4.
Vives-Cases, Carmen; Caballero, Pablo; Álvarez-Dardet, Carlos. *Análisis temporal de la mortalidad por violencia del compañero íntimo en España.* Gac Sanit 2004; 18(5): 346-50.
Vodopiutz J, Poller S, Schneider B et al. *Chest pain in hospitalized patients: cause-specific and gender-specific differences.* J Womens Health 2002; 11(8): 719-27.
Watanabe CT, Maynard C, Ritchie JL. *Comparison of short-term outcomes following coronary artery stenting in men versus women.* Am J Cardiol. 2001; 88 (8): 848-52.
Weber T, Auer J, Berent R et al. *Gender differences in recurrent coronary events.* The FINMONICA MI register. Eur Heart J. 2001; 22(21): 2026.
Wenger NK. *Clinical characteristics of coronary heart disease in women: emphasis on gender differences. Cardiovasc Res 2002;* 53: 558-67.
WHO. *Gender and HIV/ AIDS.* Geneva: WHO; 2003.
WHO. *Gender, Health and tobacco.* Geneva: WHO; 2003.
WHO. *Gender and Mental Health.* Geneva: WHO; 2002.
WHO. *Gender and Road Traffic Injuries.* Geneva: WHO; 2002.
WHO: *Gender disparities in mental health.*
Available at: http://www.who.int/mental_health/media/en/242.pdf.
World Health Organization Study Group. *Assessment of fracture risk and its application to screening for postenopausal osteoporosis.* Geneva: World Health Organization; 1994. Technical Reports Series, Nº 843.
Women's Health in Europe: *Facts and Figures across the European Union. Dublin: European Institute of Women's Health; 2005.* Available at: www.eurohealth.ie [downloaded 15 March 2006].
Writing Group for the Women´s Health Initiative Investigators: *Risk and Benefits of estrogen plus progestin in healthy postmenopausal women.*

Principal results from Women´s Health Initiative Ramdomized Controlled Trial. JAMA 2002; 288, num.3: 321-33.