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Original article

Sexual health and socioeconomic-related factors in Spain

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ABSTRACT

Purpose: The aim of the present study was to describe sexual health in Spain according to three important indicators of the World Health Organization definition and explore the influence of socioeconomic factors.
Methods: We performed a population-based cross-sectional study of sexually active people aged 16–44 years residing in Spain in 2009 (2365 women and 2532 men). Three main aspects of sexual health were explored: sexual satisfaction, safe sex, and sexual abuse. The independent variables explored were age, age at first intercourse, reason for first intercourse, type of partner, level of education, country of origin, religiousness, parity, and social class. Bivariate and multivariate logistic regression models were fitted.
Results: Both men and women were quite satisfied with their sexual life, their first sexual intercourse, and their sexual relationships during the previous year. Most participants had practiced safe sex both at first intercourse and during the previous year. Levels of sexual abuse were similar to those in other developed countries. People of disadvantaged socioeconomic position have less satisfying, more unsafe, and more abusive sexual relationships. Women experienced more sexual abuse and had less satisfaction at their first intercourse.
Conclusions: The state of sexual health in Spain is relatively good. However, we observed inequalities according to gender and socioeconomic position.

Introduction

The term sexual health is increasingly used by researchers as the context of empirical studies, although there is little agreement in its definition. The World Health Organization (WHO) endorses a broad definition: "Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled" [1].

The WHO definition has merit in underlining the importance not only of preventing adverse sexual health outcomes but also of maintaining those that are beneficial, including satisfaction and sexual function. Satisfying sexual experience within a relationship has been shown to contribute markedly to overall relationship satisfaction, and this sense of well-being contributes to better health [2]. These associations are seen in both men and women, although the link between sexual satisfaction and relationship quality appears to be stronger among men [3].

Sexual satisfaction is also related to the practice of safe sex. The use of contraceptive methods is the most effective means of preventing unintended pregnancy and/or sexually transmitted infections (STIs), and the initial and continued use of contraceptive methods are influenced by their impact on sexual pleasure and satisfaction [4,5].

Similarly, sexual violence against women, which is recognized as a global public health and human rights problem in need of urgent

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attention, has been shown to directly increase the risk of STIs and unwanted or mistimed pregnancies, and the physical and mental effects may last long after the violence has ended [6–8]. Furthermore, this abuse may be a marker of more general malaise: evidence suggests that most women who report having suffered violence at the hands of their partners had experienced either a combination of physical and sexual violence or physical violence alone rather than only sexual violence [9]. This problem is not insignificant; according to one study that analyzed different cities around the world, 35%–76% of women had experienced physical or sexual assault after the age of 15 years, mainly by a current or previous partner [6,9].

The aim of the present study was to describe sexual health in Spain according to three important indicators of the WHO definition of sexual health, sexual satisfaction, safe sex, and experience of sexual abuse, and explore the influence of socioeconomic factors. Where the data allow, these were explored at different points in the life span of the individual using response options related to their first experience of sexual intercourse, experiences during the previous year and sexual life in general. As far as we are aware, there have been no attempts to describe sexual health status in this more broad way, and there has been virtually no population-based research on sexuality issues in Spain. The implementation of a new National Strategy for Sexual and Reproductive Health [10], whose aim was to improve the sexual health status of the general population, has created an urgent need for more data on this issue.

Methods

Design, setting, and patients

In this article, we present data from a population-based cross-sectional study of noninstitutionalized sexually active people aged 16–44 years residing in Spain in 2009.

The information source for this study was the first Spanish National Sexual Health Survey (SNSHS), supported by the Women's Health Observatory of the Spanish Ministry of Health, Social Policy and Equality and carried out in 2009 by the Centre for Sociological Research [11]. The survey consisted of a face-to-face interview carried out in the participant's home, which collected sociodemographic data and information about the sexual life of men and women aged 16 years or older. The interview was introduced via a letter signed by the Chief Medical Officer of the Ministry of Health, detailing the objective of the study and providing a free phone number to deal with queries. The interview had a mixed mode of administration, with a self-administered questionnaire for questions related to first sexual intercourse and sexual intercourse during the previous 12 months and an interviewer-administered questionnaire for the remaining items. The mixed mode of administration was considered necessary due to the intimate and sensitive nature of most questions and was tested with a satisfactory outcome in a pilot study [11]. A random, multistage sample selection strategy was used, stratified by Autonomous Communities (the 17 regions into which Spain is divided), and with primary (municipality) and secondary (census section) sampling units randomly selected in proportion to the population size of the Autonomous Community. Individuals from these units were selected using random route procedures with quotas calculated on the basis of sex and age, and these data were then used to apply weighting coefficients to restore proportionality to the sample. The survey covered a total of 9850 adults, and the estimated overall sample error was ±1.01%. Details of SNSHS methodology are described elsewhere [11]. Considering a 95.5% confidence level (two sigma), the real error of the overall sample was ±1.01% [11]. Out of a theoretical sample of 10,000 interviews, a total of 9850 individuals agreed to be interviewed, of which 2532 men and 2365 women aged 16–44 years who had ever had sexual intercourse were selected for inclusion in this study.

Measurements and variables

During the interview, sexual intercourse was defined as any practice performed by two or more persons for the purpose of obtaining sexual pleasure and which does not necessarily include intercourse or lead to an orgasm.

Three main aspects of sexual health, sexual satisfaction, safe sex, and sexual abuse, were explored at different points of the life course and separately for regular and casual partners, where possible. Data on sexual satisfaction were analyzed in terms of satisfaction with sexual life in general and also after sexual intercourse at specific stages of life, namely first sexual intercourse and sexual intercourse during the previous year. The practice of safe sex was examined in terms of contraception use during first intercourse and during intercourse in the previous year. Sexual abuse was examined by asking respondents about experiences of sexual intercourse against their will and also experience of sexual abuse and/or rape at any time in their life. Details of the construction of the dependent variables are provided in Box 1.

We tested for association between these dependent variables and the following independent variables: age (16–24; 25–34; and 35–44 years), age at first intercourse (<16 and ≥16 years), reasons for first intercourse (curiosity; being in love; and risk-associated reasons, such as being forced, having to please their partner, or having taken drugs), type of partner (regular only; regular and casual; and casual only), levels of education (illiterate or incomplete primary education; primary education; secondary education; and university education), country of origin (developed countries, including Australia, Bahamas, Canada, Japan, USA, Norway, Switzerland, Andorra, and the European Union before May 2004 [note that 98% of participants from developed countries were Spanish]; developing countries, including all other countries), religion (Catholic; any other religion; nonbeliever; and atheist), parity (no children and ≥1 children), and social class of the interviewee or of the household's main earner, when this could not be attributed to the interviewee (manual and nonmanual, according to the classification system proposed by the Spanish Society of Epidemiology) [12].

The proportions of missing data were 0.4%–1.9% for men and 0.6%–2.9% for women for all variables except that related to sexual satisfaction during intercourse with a regular partner during the previous year, for which 12.1% of men and 12.3% of women had missing data. Missing values were excluded from the analyses.

Statistical analysis

We performed univariate and bivariate descriptive analyses using the χ^2 test. To examine the relationships between the independent and dependent variables, bivariate and multivariate logistic regression models were fitted, and crude odds ratio and adjusted odds ratio (aOR) and their corresponding 95% confidence intervals (CIs) were calculated, selecting the most appropriate final model in each case.

All analyses were stratified by sex and were performed using STATA, version 10.1 (Stata Corporation, College Station, TX) [13].

Results

Due to variation in the sample size for each dependent variable, we have included the results of a descriptive analysis in the first three columns of each table (Tables 1–7).