Portugal

In Portugal life expectancy is rising, and has now reached the EU average. The leading female causes of death in Portugal are diseases of the circulatory system(THIS VALUE JUST LIKE THIS DOES NOT MEAN ANYTHING). In particular, the rate of mortality due to cerebro-vascular disease is much higher than the European average.

In Portugal, as in the majority of EU partners, the fertility rate as displayed very significant variations over recent decades. Nowadays births tend to be in the 20-34 year age group. Despite the actions developed within the scope of family planning that contributed to a significant decrease in the percentage of live births by adolescent mothers (from 10.6% in 1979 to 5.0% in 2005), Portugal still has the second highest rate in the former EU-15.
Let us mention that abortion was prohibited by law until very recently (except for a few stringent exceptions); until that time, around 5,000 women were hospitalised each year due to complications related to illegal abortions. In the beginning of 2007 through a referendum abortion became legal in Portugal for pregnancies up to 10 weeks.

Portugal sits at the lower end of the spectrum for deaths from breast cancer (28.7 per 100,000 population) and has a reasonably low death rate for cervical cancer (3.8 per 100,000 population). Breast cancer is however the primary cause of death among women aged 35-54 years, and cervical cancer appears as one of the ten main causes of death among the 35-44 year age group.

Portugal has the lowest rate of females smoking among the countries reviewed and of deaths resulting from for lung cancer. Girls in Portugal begin smoking at a later age (13.2) than all other countries reviewed, except Greece (14.0), and have by far the lowest rates for girls engaging in dieting and weight control behaviour.

Portugal has the highest percentage of women per population (51,9%), as well as one of the highest percentages of women in the labour force.

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Women's health

Women's health in Portugal appears to be related to historical issues, namely the establishment of democracy in the 70's. The last 30 years are characterised by improvements in the majority of social and demographic indicators. Corollary, health indicators show a remarkable development.

Nowadays, health indicators in Portugal, for both men and women, are roughly comparable to indicators for other Western European countries. We briefly review the main issues on women's health, mostly relying on reports by the WHO (2003 and 2004) and the United Nations (2005) reports, and on Bentes et al. (2004).

- *Life expectancy at birth*

Life expectancy increased consistently over the last 20 years for both men and women in Portugal. Life expectancy for women was 74.6 years in 1980, and 80.5 years in 2002. This last indicator is similar to the OECD average (80.6). However, there is a remarkable difference in life expectancy between men and women (6.7 years) in Portugal, as compared to the OECD average (5.9 years).

Similarly to European life expectancy trends, in last decade Portuguese rates showed considerable improvements regarding this indicator. Moreover, there are significant differences between men and women rates; in 2004, life expectancy at birth was 81 years for women and 74.5 years for men.

- *Fertility rates*

Following Western Europe countries movement, the fertility rate has been decreasing over the last 20 years, from 2.2 children per woman aged 15-49 years in 1980 to 1.5 in 2005. Although this number is considered low (the necessary level for replacement of the population is 2.2), it is still higher than in other Mediterranean countries (Spain, Greece, Italy) and than in all Eastern European countries.

- *Subjective health and chronic diseases*

The commonly accepted concept in public health literature is that women die later but are in worse health than men (Annandale, 1998). This statement seems to be confirmed by statistics from the National Health Interview Survey. The survey, conducted in 1998/1999, points to a worse self-perceived health status for women: 24.2% women stated being in a bad or very bad health condition, compared to 15.2% of men. As for chronic conditions, the survey shows higher rates of women declaring to have diabetes, epilepsy, asthma, hypertension and back pain.

- *Causes of death*

Diseases of the circulatory system, namely strokes, coronary disease and ischemic heart disease are the leading causes of mortality in Portugal (Directorate-General of Health, 2007).
In 2001, those diseases accounted for 31.2% of all the deaths among women. In particular, the rate of mortality due to cerebrovascular disease is much higher than the European average (905.7 vs 457.0 per 100,000 for women older than 65). On the contrary, rates are lower for ischaemic heart disease (342.2 vs 539.5 per 100,000 for women older than 65).
The issue of cerebrovascular disease is one of the major public health concerns in Portugal, in particular for women's health. The National Programme for Prevention and Control of Cardiovascular Diseases was launched in 2003; in 2006 were implemented Referencing Networks for Cardiovascular Emergencies, with a greater involvement of emergency Fast Tracks for myocardial infarction and stroke, so as to improve accessibility of emergency patients to the most suitable hospitals (Directorate-General of Health, 2007).

Cancers are the second cause of death, and the highest cause among women aged 25-64 years. Gastro-intestinal tumours are the most frequent type of cancer among women (4% of all deaths), followed by breast cancer (3.3%). Breast cancer also represents the main cause of years of life lost. Yet, the age-standardised mortality ratio is still lower than the OECD average (83.3 vs 113.9 per 100,000 in 2002), and has experienced a higher decrease. Lung cancer accounts for a lower percentage of death among women (1%), but the age-standardised mortality ratio has increased by 17.9% between 1995 and 2002, for an average 11.7% in other European countries.

Finally, external causes (mainly, motor vehicle traffic injuries and suicide) should be mentioned as the second most common cause for years of life lost among women. The standardised mortality ratio for motor vehicle traffic injuries (RTAs) is 7.4 per 100,000, while the European average is 4.3. In addition, the numbers in Portugal have been decreasing at a slower pace than elsewhere in Europe.

In a nutshell, deaths due to cerebro-vascular disease and to external causes, as well as the increase in mortality due to lung cancer, are nowadays the main causes of concern.

- *Maternal mortality*

Regarding maternal mortality, alike other indicators, the improvements are considerable; maternal mortality rates present a declining trend, from 42.9 per 100,000 (living births and stillbirths) in 1975 to 5.3 per 100,000 in 2003.

- *Reproductive health*

In Portugal, 98% of the deliveries are attended by a skilled attendant. The maternal mortality ratio is consequently very low (8 per 100,000 live births), among the lowest in Europe.

We may advance two main causes of concern related to reproductive health in Portugal. First, the rate of caesarean sections is extremely high in Portugal (one in four births), i.e. the second highest rate in Europe after Italy. A recent paper by MacDorman et al. (2006) reveals the risks of caesarean sections in terms of neonatal mortality, among deliveries without indicated risk.

Second, there are in Portugal 20 births per 1,000 women aged 15-19. This is the highest rate among the former EU-15, e.g. twice the figure for Spain. However, the number of births in this group presents a decreasing trend. Taking for example the period 1985 to 2004, the proportion of births in 15-19 years old girls decreased 49% (from 10.4 to 5.3%).

- *Contraception*

According to data from the National Commission for Equality and Women's Rights (CIDM), the percentage use of the contraceptive pill increased from 52.3 to 62.3% between 1993 and 1997, and the use of condoms from 9.3 to 14.6%. Nearly 80% of women in fertile age use a reliable birth control method.[1].

- *Abortion rates:*

Portuguese abortion law was quite restrictive until very recently (a referendum legalized abortion in February 2007). It was legal in certain situations upon the woman request: if it was the only way to prevent serious physical or psychological injuries or death to the woman (during the first 12 weeks); if there was a high risk of serious disease or malformation to the newborn (during the first 24 weeks); if the pregnancy was the result of a sexual assault situation (during the first 16 weeks). According to published data, in 2004 were performed 834 legal abortions in NHS hospitals. As referenced by Dias et al. (2000), many abortions were practiced clandestinely in Portugal (the highest rate in Europe), putting women's lives in risk (according to the WHO, 17% of maternal death in Europe are due to unsafe abortions).

- *Lifestyle behaviour*

[1] This study was conducted with a representative female sample in fertile age (15-49 years), so it only gives evidence for women and not men's reality regarding contraception.

Related to the increase in women's death due to lung cancer, the major concern is the continuous increase in smoking habits among young women, while rates remain stable or decrease among men. A similar observation holds for alcohol consumption. We detail this issue further.

- *Violence against women*

Lisboa et al. (2005) interviewed 2,300 women at health care centres and concluded that 33.6% had been victims of violence in previous years (physical, sexual, psychological or other). The authors emphasise the dramatic consequences of that on the health condition of abused women when compared to non-abused. Results show important differences, not only in terms of injuries and their consequences, but also in terms of psychological health. Notice, however, that the sample only considers women seeking for care at health care centres, so that results cannot be extrapolated to the country as a whole.

Specific health policies for women

Women's health in Portugal appears to be strictly related to sexual and reproductive health issues; in that sense the politics in this matter have been orientated to focus specific domains concerning family planning. That is to say that women's health has not yet been considered as an independent field, instead it has been closely associated with specific pathologies or domains such as pregnancy surveillance, delivery, screening for cervix and breast cancers. Despite not being an independent field with clearly defined boundaries there has been an investment in projects concerned with gender issues, namely related to domestic violence and its implications to women' physical and psychological health. Also organisations such as CIDM (Commission for Women's Equality Rights), APEM (Portuguese Association for Women's Study) or APF (Portuguese Family Planning Association), among others, have been carrying out efforts to include gender and equality issues into women's policies in general, but also in the domain of health care.

According to the authors, the answer by the Bulgarian team holds for Portugal: 'There is neither a separate body, coordinating the activities of the different institutions, to be responsible for the development of the state policy in women's health and monitor its implementation, nor a separate Minister, Department or other sort of governmental structure that is specifically devoted to women and health issues'.

However, specific issues related to women's health are explicitly mentioned in the Ministry's attributions, through a series of governmental institutions:

- Ministry of Labour and Social Solidarity: Mission Structure against Domestic Violence, and Commission for Equality in Employment Rights and at Workplace (promotes non

discriminatory practices between men and women at workplace, in particular through protection during maternity and paternity)

- Presidency of the Council of Ministers: the Commission for Equality and Women's Rights briefly expresses a concern for inequalities between men's and women's health, in particular when chronic diseases are present.
- Ministry of Health: the Directorate-General of Health states domestic violence has one of its concerns and started to advocate more systematically a gender perspective as an important health determinant.

We were able to identify at least 50 non-governmental organisations (NGOs) oriented towards defending women's rights. However, none of them states women's health as its main objective. The role of the Association for Family Planning (APF), an active NGO in the field of reproductive health, should be highlighted. This Association has organized several sexual education courses, and provides free consultations to people aged between 10 and 24 years in Lisbon.

In Portugal, regarding women's issues, a much stronger focus is set on gender inequality in labour market participation and working conditions. In addition, there is a lack of knowledge on women's health in Portugal. The lack of evidence may certainly prevent the implementation of gender-oriented health policies. Recently, the Ministry of Health has ordered a report on gender related inequalities in health and health care (Fernandes et al., 2006). This represents an important lead towards bring about evidence on this issue.

Gender-sensitive health policy design

Regarding health policies it cannot be said that different male and female conditions are clearly addressed. There are some initiatives that begin to focus on sex and gender as health determinants (example of that are some reports conducted by Directorate-General of Health, namely regarding young people's health). However, despite this on-going interest, particularly in the academic domain, up till now we can not say that men and women health needs are being taken independently in a systematic way. Giving evidence of some of these initiatives, the Directorate-General of Health is now starting a project that aims at establishing a core of research and planned action regarding sex and gender as health determinants. The project will allow putting into practice gender mainstream in health policies at three different levels. First, by characterising more deeply mortality and morbidity trends in Portugal, in the last decade, stressing sex and age differences and similarities. Concurrently, sex and gender critical approach will be addressed in order to account to biological and social determinants of health. Second, by conducting

quantitative and qualitative approaches to address how sensitive are health professional in their current practices to sex and gender issues. Finally, by attending to legal, normative and technical documentation in health sector, namely how sex and gender have been acknowledged as determinants of both men and women health status.

In Portugal, equity in health care is the object of the second paragraph of the *'Lei de Bases da Saúde'* (Health Comprehensive Law). Quoting the law, 'it is a major objective to reach equality among citizens in access to health care, independently of their economic condition and place of living, as to achieve equity in the distribution of resources and the use of services'. In other terms, inequity is mainly understood as unacceptable differences related to socio-economic status, and no reference is made to gender. Several groups are specifically quoted as requiring particular attention: children, teenagers, pregnant women, elderly, disabled persons, and drug addicts. Women are not considered as a vulnerable group; it is implicitly considered that equity has been achieved between men and women in access to health, as in many other countries.

However, beyond this basic statement, one may identify the adoption of a gender perspective in specific areas of governmental action. The Ministry of Health identifies four areas of priority intervention: the health of the elderly, control and prevention of oncologic diseases, control and prevention of cardio-vascular diseases, and prevention of HIV/AIDS infection (DGS, 2004). Let us briefly review those issues to check whether gender is accounted for.

The National Programme for the Health of the Elderly explicitly integrates a gender perspective. It is recognised that health determinants are related to gender, and that one must account for the biological and social differences between men and women. However, this gender perspective is not explicated among the strategies for action.

The National Oncologic Plan sets screening of cervical and breast cancer among its main priorities. Nevertheless, no gender perspective is adopted as far as cancers that are not specific to women are concerned.

The National Programme for Prevention and Control of Cardio-vascular diseases adopts a gender perspective in its major aims. In terms of strategies for action, the gender perspective is essentially present concerning smoking habits. It is stated that smoking habits among women under 15 years old reduces the protective action of estrogens. In addition, the tobacco-related risks for conception, pregnancy, feeding, premature birth and infant mortality are also quoted.

The National Coordination for HIV/AIDS infection does not adopt any gender perspective.

Three primary issues and how they apply to women

- *Breast and cervical cancer*

Breast cancer is the primary cause of death among women aged 35-54 years in Portugal. Cervical cancer, although it has a lower impact on mortality, appears as one of the ten main causes of death for women in the 35-44 years age group. In addition, mortality due to cervical cancer has increased among 45-54 year olds and women older than 75 during the period 1990-2002.

A National Oncology Plan was adopted in 2001 recommending the following:

- A mammogram every 2 years for every woman aged between 50-69 years.
- Screening for cervical cancer every 3 years for every woman aged 30-60 years (after 2 negative yearly screens)

The National Health Plan 2004-2010 declares breast and cervical cancer as public health priorities. It also sets a 60% screening goal for both diseases for 2010 (on the target population). However, the strategy of the Health General Directory (DGS) is solely based on increasing physicians' awareness about screening, and does not include any systematic and/or national screening programmes. Screening is merely 'opportunistic', that is, women in the target group will be recommended to be screened when consulting for any reason. There are regional or local experiences of systematic screening, including sending letters to women in the target group and keeping registers of mammograms. However, there is no systematic screening at the national level, covering all regions.

One should notice, however, that primary care consultations in Portugal are provided at public health care centres at low prices, and screening can also be performed at those centres.

A study conducted by the Portuguese National Health Observatory (Branco et al., 2005), in 2004, observed the preventive practice for both diseases, using a sample of 1,149 women older than 18. The two main results were the following:

- 80.1% women aged 40-69 years had a mammography in the last 2 years.
- 71.4% women aged 30-60 years were screened for cervical cancer over the last 3 years.

The authors conclude that preventative practices for breast cancer were good, as the percentage of women being screened can be considered high (values obtained for Spain and Denmark amount to 79 and 71%, respectively). The authors indicate that results obtained for cervical cancer are consistent with those obtained in the literature for other countries. The values were below the ones obtained in the UK, Sweden and Denmark (around 80%), but higher than the ones in France, Spain and Italy. According to the authors screening practices for breast and cervical cancer can be

considered fair in Portugal both when compared to other European countries and to national public health targets. We should however stress the limited number of people surveyed; this certainly represents a major drawback, and precaution leads us to avoid conclusive statements regarding this issue.

- *Reproductive health*

As already referred, the main issue of concern is probably the high rate of teenage births, the second highest in Europe. We also previously mentioned that abortion has been legalized very recently. As for the use of the abortive pill (RU 486), it is now allowed to be acquired by hospitals.

Family planning consultations have been organised in Portugal since the late 70s. However, its larger diffusion goes back to the early 80s. Access to family planning consultations for patients younger than 18 has been allowed since 1984. Nowadays, all health centres propose at least one family planning consultation per week. It is important to remind that since 1984 that family planning consultations and contraception are free of charge in the NHS; in addition, pregnant women, children younger than 12 and low-income categories are exempted from payments. Health care centres are also obliged by law to have free contraceptive pills at disposal (Decree-law nº 259 of the 17/10/2000).

The main difficulty, however, lies in the limited number of health care centres in certain regions, resulting in long waiting lists and frequent use of emergency services at public hospitals. According to Bentes et al. (2004), Portugal has one of the lowest numbers of physician contacts per person in Europe. There were in Portugal 3.23 physicians per 1,000 habitants in 2004, compared to a 3.48 EU average (Santana, 2005). The number of skilled nurses is also among the lowest in Europe. The geographic distribution of health care centres is claimed to be inequitable in regard to poor and isolated areas (Bentes et al., 2004).

Finally, sexual education courses are compulsory at public secondary schools (representing 82% children in 2002). However, although they have been enforced by law since 2001, they are poorly organised in practice, mostly due to lack of skilled staff.

- *Alcohol consumption and smoking habits*

The issue of alcohol consumption is particularly relevant in Portugal, as it is the 2nd highest alcohol consumer in Europe (14 litres per capita in 2000, WHO 2003). The Portuguese National Health Survey includes questions on alcohol consumption. Marques-Vidal and Dias (2005)

describe the trends in alcohol consumption in Portugal using 83,733 questionnaires answered in 1995, 1996, 1998 and 1999. Those authors indicate that the prevalence of drinkers decreased in men and remained stable in women (although percentages are still almost the double for men). However, alcohol consumption slightly decreased among younger people, both male and female.

As for tobacco, Portugal remains among the lowest consumers in Europe (WHO, 2003), although the percentage of smokers has increased between 1995 and 1998 (from 18.1 to 19.2%, DGS 2005). The proportion of smokers is much higher among men: 30.5% of men older than 15 were smokers, compared to 8.9% women. However, Santana (2005) writes that, taking 1995 as reference, the increase in the total number of smokers was essentially due to women. Data from the WHO (2004) are particularly enlightening: in 1997/1998, there were 10% smokers among 15-year-old girls, compared to 13% for boys. This proportion was completely reversed in 2001/2002, with 19.5 girls smoking and 13.1% boys. In other terms, there is a huge increase in the proportion of girls smoking, while the proportion of boys remains stable. In addition, in 2001/2002, the percentage of smokers among girls exceeds the EU average, while this is not the case for boys.

- *Sexually transmitted infections*

Regarding HIV/AIDS, there were 27.013 cases registered in Portugal in 2006. Distribution by sex highlights an over representation of men, that accounted 82.5% of the new cases in the last 20 years. However, women vulnerability has been well documented, namely gender patterns that reinforce inequalities. Female condom is in fact the only method in women control now available to prevent both unplanned pregnancy and HIV infection. In Portugal, female condom was commercialised during 90's although it ended out being retrieved for weak acceptation. Taking into account these issues, it is now being conducted an investigation that aims at determining the acceptability of female condom. The study is orientated towards a female sample in order to determine satisfaction regarding this method, women's perception about partner's satisfaction and determinants of its use.

Specific healthcare policies for young girls

There are no healthcare policies designed specifically for young girls. Although, infant and juvenile health program, which frames the provision of health care to the youngest, take into consideration boys and girls separately. Also, a national health program to the youngest (10-24 yrs) is now in course. In this regard sex and gender issues are clearly defined as health determinants; moreover, there are established recommendations to assemble health issues in young people in a sex and gender perspective as a way of accomplishing girls and boys needs. Also, there are health services designed and organised for young people; the degree of

differentiation various between services although there are some that offer a variety of healthcare and other support to attain to young people needs. Despite not being exclusive for young girls evidence suggest that they are the main users.

An example of 'best practice' in women's health

An example of a good practice is the creation of the network of health promoting schools (the response to this question is based on the study carried out by Loureiro, 2004). This network intends at integrating health promotion into every aspect of the school setting (curriculum, healthy practices in daily routines, improve working conditions and relationships with community health providers).

Although this is not a specific Portuguese initiative (this programme is part of the European Network of Health Promoting Schools, a project of the European Commission), it is worth mentioning its success in Portugal and its impact on integration of sexual education at school. In 2003, one third of the students in the public system were enrolled in one of the schools of the network. In a nutshell, the purpose of this network is to integrate health promotion into the overall dynamics of the school, creating formal links with health care centres and national representatives for health and education. Preliminary evaluations indicate that this programme increases students' self-esteem and improves relations between students and staff, and is a good example of the benefit of specialised services in health promotion, and the development of the educational potential of the health care services.

Our main interest lies in the impact of the network on the implementation of sexual education at school. Loureiro (2004) has compared schools inside and outside the health promotion network along this dimension. As already mentioned, the organisation of sexual education courses at school became compulsory in Portugal in 2001. A questionnaire was sent to 5,000 schools 8 months after the law was voted in, and 4,267 valid answers were received. Loureiro (2004) shows significant differences between members and non-members of the network. In particular, school membership is associated with better integration of sexual education in the curriculum. In addition, member schools have been integrating sexual education into the whole education process, working in partnership with health professionals (health centres, municipality, NGOs). They also have a higher likelihood to develop strategies with parents' and students' associations. Although all schools report a lack of competence in sexual education, this lack is much higher among non-member schools. This experience certainly shows the potential of the health promoting network to increase schools' awareness about health issues, the existence of health

resources in the community, and the possibility, for non-professionals (teachers), to contribute to health education, and sexual education in particular.

One example of best practice are the health units to support the provision of care in the most vulnerable context or groups. At the moment there are 9 working units distributed for all the country; all orientated towards special intervention in maternal and infant health care and family planning. Besides healthcare provision there are also health promotion intents; these units are conceptualised in non bureaucratic, confidential and gratuitous standards, which has been promoting access to healthcare to the most vulnerable ones.

Further gender influences on patterns of health

Women's health in Portugal has experienced a huge improvement since the late 70s and the implementation of the National Health System. This system, financed by taxation, ensures all citizens nearly free access to primary care centres and public hospitals. Between 1980 and 2000, the female life expectancy increased from 74.6 to 79.7 years old, infant mortality decreased from 24.3 to 5.5 per 1,000 live births, and perinatal mortality dropped from 22.4 to 5.2 per 1,000 total births. Bentes et al. (2004) indicate that 'the successful evolution in infant mortality (…) may in great part stem from more than 30 years of well-defined policies, strategies, programmes, and selective investments in perinatal, maternal and child care'. Indicators clearly show huge improvements in men's and women's health since the 1974 Revolution, with Portugal reaching health levels comparable to other Western European countries. The dramatic improvements in maternal health are worth noticing.

Gender has not been a major issue of concern in Portugal. Health care policies have been mostly oriented towards reaching socio-economic equity in access and efficiency in health care provision. Indeed, Portugal appears as the EU country with the highest level of inequity in access to specialist care, e.g. (see Van Doorslaer et al., 2004). Portugal is also one of the poorest countries in Europe, and is confronted with an important lack of health provision (both equipments and skilled staff). Most scientific contributions also focus on those two areas of research (equity and efficiency objectives).

Consequently, there is a lack of information about gender differences in health and health care in Portugal, and a subsequent absence of gender orientation in health policies. A recent paper by Fernandes et al (2006) shows that women have a lower access to high-technology treatments for cardio-vascular diseases, although this represents the first cause of death for both men and women. This result might be a sign of discrimination or prejudices about women in the medical

profession. It may also reflect socio-economic inequalities in the Portuguese society, with women having a poorer access to care. The particularly high wage gap between men and women would certainly advocate in favour of this last argument.

Health indicators give clear evidence about how gender patterns determine men and women health status. Besides some pathology related to biological vulnerabilities or other associated with sex, there is epidemiological evidence that highlights inequalities in health status in a diversity of ways. If we look to life expectancy or mortality rates, namely those due to violent causes, there are no doubt that men are at most risk of suffering a premature and avoidable death. Also lifestyle patterns, such as smoking or drinking appear to be more prevalent in men (despite women's progressive movement towards these behavioural patterns). Besides this epidemiological standpoint, we ought to explore how gender influences provision of healthcare; for that the Directorate-General of Health is conducting a study that aims at exploring gender awareness among health professionals, in academic and clinical domain.

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