Valongo

N. 8 — SPECIAL EDITION
OCTOBER 2024

* Valongo:
Better Health, More Citizenship

melhor saúde + cidadania*

Observatório Internacional da Democracia Participativa

Serras do Porto Valongo

Participatory democracy and health

HEALTH, PARTICULARLY PROTECTION IN ILLNESS, IS PERHAPS THE MOST FUNDAMENTAL OF DEMOCRATIC RIGHTS, AS IT IS IN THIS CIRCUMSTANCE THAT INDIVIDUALS MOST NEED COLLECTIVE SUPPORT. PERHAPS FOR THIS REASON, IN PORTUGAL, A SIGNIFICANT NUMBER OF PEOPLE ASSOCIATE THE DEMOCRATIC REGIME WITH THE CREATION OF THE NATIONAL HEALTH SERVICE

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Participatory democracy and health

José Manuel Ribeiro
Mayor of Valongo

Portugal is a country in which most citizens associate the democratic regime in which they have lived since the 25th of April - which celebrates its 50th anniversary this year - with the birth of the National Health Service (SNS). The collective memory associates democracy with the Welfare State, in which health care is on a par with education and social security. And rightly so, this means that the last 50 years of public life have been marked by the accomplishments of republican civic principles of Liberty, Equality and Fraternity, social justice, equal opportunities and social mobility.

Health, aid during illness, is perhaps the most basic of democratic rights, since it is in this circumstance that the individual most needs the support of the collective. That's why it's so important to invest in both the population's political literacy and its health literacy.

At the Municipality of Valongo we try to respond in the best way to this double-edge challenge. As this magazine demonstrates, we consider it essential to involve the population in the creation of Valongo's municipal health strategy, which began in 2020. Over the years, we have asked citizens to participate in the municipal strategy and make proposals to continuously improve and adjust it to public health requirements.

When it comes to health, Valongo is also a participatory municipality! In fact, Valongo currently chairs the Network of Participatory Municipalities in Portugal, and is a national benchmark for the involvement of citizens - of all ages, generations and genders - in the decision-making of local political bodies. Since health is a central issue of democracies' social contract, it is our duty in the participatory process to create opportunities to present and share knowledge in this area.

The encouragement of citizen participation and dialogue with elected representatives to influence local political decisions is how we in this municipality have responded to the challenge of involving citizens in politics and increasing their literacy in this area. We do this because we realise that participatory democracy mechanisms improve political choices and empower everyone in the community. In fact, they benefit the quality of public policies.

This theme was at the heart of the 23rd conference of the International Observatory for Participatory Democracy - IOPD, held in Valongo on 17, 18 and 19 October 2024, following on from the conference held in Rio de Janeiro in 2023 and in Grenoble in 2022. This year's theme was "Populist threats: Building Democratic Resilience with Participatory Communities", the conference in Valongo centred on the potential of participatory democracy mechanisms to combat the disinformation that invades contemporary societies, whether online through social networks or through traditional media such as television.

Participatory processes contain within themselves the virtues of democratic systems and their rules and processes, becoming schools of democratic practice and true incubators of resilience to "fake news".

The future of democratic regimes and the welfare state lies in democratic participation since it brings science, evidence-based knowledge, academic methods, reflection and studies that are verified, audited and scrutinised by peers to the centre of debates.

Whilst this is true in all areas of collective life, it is particularly relevant when it comes to health. This led us to hold the 1st Valongo Health Biennial in April 2024, in Ermesinde, centred on the theme of "Health and the Wellness Economy". Designed not only to publicise the most advanced trends in health policies in the municipality of Valongo, but also to promote dialogue between the citizens and their community representatives and the experts speaking at the event. This was the reality for the first edition in 2024, and it will be the same for future editions.

The quality of the health system in a country, region or municipality is certainly one of the main predictors of its level of human development and the quality of life of its citizens. It is also an essential way of building a balanced, healthy, innovative and thriving society. A democratic and participatory society.

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O Serviço Médico à periferia (Remote Medical Services)

Medical and Nursing Team · SMP-1979 · Graciosa Island - Azores · Courtesy of P. Serrano

Alcindo Maciel Barbosa
Public Heath Doctor, specialist in public health

The Remote Medical Services (SMP) was created by Order of the Secretary of State for Health on 23 June 1975, and it was implemented for the first time the following year.

It was a compulsory step for young doctors to be able to start speciality internships and, at the same time, ensured rapid health coverage for the population living far from the country's major centres.

For the young doctors, it was an opportunity to learn about the reality of healthcare outside the hospital environment, which was not a large concern of medical schools at the time.

My SMP experience was in the municipality of Bragança in 1978, working in the Health Centre, the Pension Fund Institution and the Hospital.

I felt the difficulties people had in accessing healthcare, when I had to do house visits 50 kilometres away from Bragança or when an ambulance took 6-7 hours to get to Porto.

In short, it was a winning experience: the population won, the young doctors won, the country won, because it highlighted the need for a National Health Service (SNS) that would cover the entire population and integrate all the health services, which until then had been separate, parallel structures with centralised management.

There was a need for a change, focused on people's health needs, that improved access to services, that encouraged the complementary intervention of: health promotion, disease prevention and vaccination services – the Health Centres; the Pension Fund Institution "posts" that provided outpatient treatment to their members (however, many professions and activities did not have access to these services) and the various hospitals.

It was a phase of my professional life that I see as extremely positive: I learnt a lot, clinically, professionally and civically speaking; we were received very well by the population, in a caring and respectful way, despite some obstinate local forces labelling us "dangerous communists who had come from Porto", but people quickly realised that, after all, we just wanted to work hard and ended up accepting us as such; it gave us an idea of how it was possible to decentralise decisions and to see how the local doctors responsible for managing the different services took care to coordinate and work together, always putting the interests of the patients first and making the most of the few existing resources; and it was an excellent lesson in how ethical and deontological principles need to be lived and how they should guide the lives and performance of health professionals.

Bragança's doctors were few in number, but they were experienced, knowledgeable and completely willing to contribute to providing care to the population, always prioritising public service over their legitimate interests in private practice.

To understand that working well only depends on the people, let's look at this example from Bragança: a patient who wanted to be admitted to surgery would go to an outpatient clinic on Tuesday afternoon, and after being seen by the surgeon, he would immediately have a lung X--ray, ECG and clinical analyses, and if everything was normal, he could be operated on the following morning. At the same time, at the S. João Hospital in Porto, the results of a request for analyses for a patient would only reach the doctor almost eight days later...

The SMP was an excellent training phase for young doctors, and vastly contributed to the creation of the SNS.

National Health Service – the right to protection and the duty to defend an

Maria de Belém Roseira
Jurist, Politician, and Former Minister of Health

This year marks the 45th anniversary of the creation of the National Health Service (SNS).

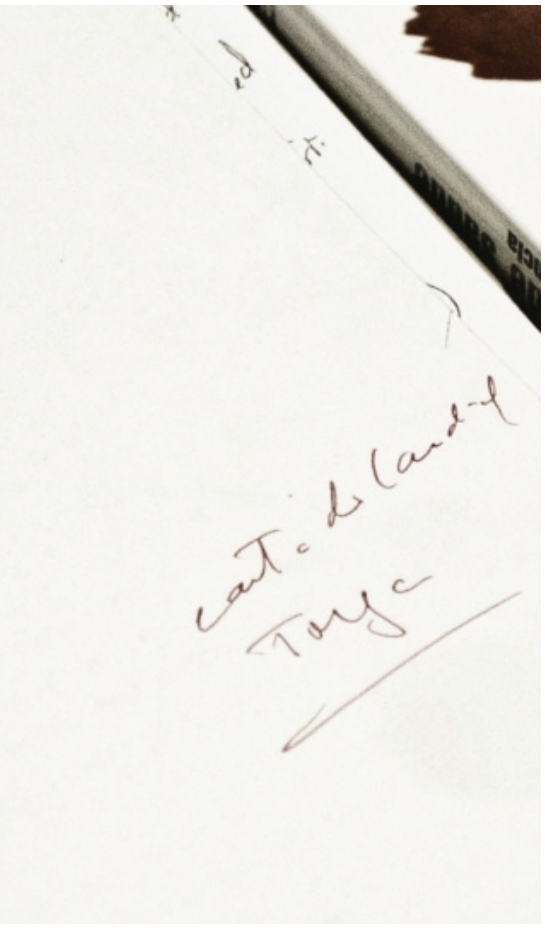
In fact, its very conceptual foundation was enshrined in the 1976 Constitution of the Portuguese Republic, the Constitution that emerged from the April 25 Revolution, the 50th anniversary of which we also celebrate this year.

At the time, it was considered by the Constituent Members to be the model that would best enable the exercise of the right to health protection, as well as the duty to defend and promote it.

Such a conceptual model, however, would only have practical relevance if there was availability and accessibility to services, their quality and the means required for their provision.

It is these attributes that give it meaning, enshrined by Law 56/79 of 15 September, a law that was only passed because António Arnaut, who is considered the "Father" of the SNS, fought so hard.

A great humanist and a Man of Causes, he assembled the team that prepared its original draft when he was Minister for Social Affairs, but he was unable to get it approved by the government. It had to remain a decree that recognised universal access to health care, effective only for the services it covered, but the crusade he waged to establish it in law culminated in the downfall of the PS-CDS coalition government, a party that advocated another model of universal right to health protection based on conventional medicine, not guaranteed by a public service. The government ended up falling before realising its dream of ensuring that everyone had access to the healthcare they



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needed, whether they were rich, poor or middle class, and that no one was at risk of becoming impoverished in order to achieve this, as had been the case until then.

It wasn't until the following parliamentary term, as a Member of Parliament, that he proposed the law that ended up being approved following the whole legislative process of the Assembly of the Republic. I highly recommend reading the minutes of the general debate, which can be easily accessed digitally, because they are highly educational in many ways. In terms of argumentative elegance, respect for different perspectives and observance of formal rules that favoured an oratory vigour that didn't use vulgarity to contradict arguments that the simplest evidence would disprove.

And this is how the institution that I consider to be the permanent embodiment of "Human Rights in Action" was born and built, and which is the only public law institution that has earned us a prestigious place on the international stage. Unfortunately, none of the others have.

The success in reducing infant and maternal mortality, as well as the extraordinary progress we have made in most health indicators, is well known and internationally recognised.

There is one, and only one, that doesn't match up to the level of the rest, but whose construction doesn't depend directly on the NHS but rather on our living conditions and our ability to make the right decisions.

I'm referring to the indicator of years lived in good health after the age of 65 which, in Portugal, doesn't reach 10, while in the Nordic countries - our comparator in all the other indicators - it's almost double. And let's not forget the inherent inequalities of generic statistical expressions and whose removal is a basic obligation of a competent public policy.

It is therefore essential to make a collective effort to resolve this problem, which leads to years of quality life lost, avoidable illness, disability and death, various social dysfunctions and brutal financial pressure on the NHS.

At central government level, the efforts that have been made to act in intersectoral terms have proved unsuccessful. The dominant culture prevents this and the various attempts that have been made cannot resist the irresistible obstacle of policy change, which leads to the inefficiency of all the investments made in this direction.

That's why, for many years now, some of us have argued that these multifactorial issues should be worked on in communities, where the people are and where specific collective problems can be addressed and resolved in a much more efficient and effective way. I myself championed this approach, trialled and programmed with positive results when I had government responsibilities in this area over 25 years ago and had the pleasure of leading a highly competent, creative and committed team.

This is where the Local Health Systems were founded, along with other innovative experiments, with variable forms - the country is not all the same - and which must involve providers and social and economic partners who contribute to the health of individuals, families and social groups on the ground.

In this context, local councils, whose autonomy and action to develop the country is also a conquest of 25 of April's Portugal, can and must play a central role, not only through their direct action but also in calling all partners to this fight for a long, productive and healthy life that is worth living.

Not only through the creation of Local Health Plans that list the strengths and vulnerabilities of their area, but also, following due identification, by getting all the players involved in health promotion and disease prevention activities, solving access problems and reducing inequalities.

I believe that Valongo has already embarked on this path through the diagnosis that its Local Health Plan has enabled and, from now on, there is an urgent need to involve all local players in the planned and responsible construction of the level of health that each of Valongo's inhabitants, whether native or by choice, has the potential to achieve.

Let no-one be left behind in this endeavour!

Learning by being useful - the family architects workshop and health promotion through intervention in the built environment

Aitor Varea Oro, Marta Sousa, Bruna Lee Azado
FAUP – Faculty of Architecture, University of Porto

Despite the great importance of treating diseases when they arise, health promotion is increasingly important to ensure the well-being of the population. Less emphasis on building hospitals and more on creating the conditions to make them less necessary. For this strategy to work, a single health policy must shift to the inclusion of health in all policies. There is solid evidence for this. According to the WHO, there are five dimensions that need to be addressed to ensure this convergence: healthcare; employment and working conditions; income security and social protection; living conditions; and social and human capital. All this mirror social inequalities and translate into health inequities, but the last three referred have unique characteristics: they are responsible for 2/3 of the inequalities observed, which makes them key points for enhance health equity.

Infrastructure intervention is a strong lever for achieving these goals. Promoting a housing policy that facilitates affordable houses, with safety and comfort conditions, located close to green areas, facilities and transport, and avoiding social segregation can help mitigate the onset of chronic diseases such as stroke, chronic obstructive pulmonary disease, diabetes, hypertension with complications or obesity.

From this point of view, architects can also be health promoters, which conflicts with society's usual view of these professionals, which we could easily summarise in two main talking points: "architects only complicate things" and "architects are only for those who can afford them". If you want to contradict this impression, you have to travel back 50 years to the mythical Serviço de Apoio Ambulatório Local - Local Outpatient Support Service (SAAL), where architects, residents' associations and public authorities worked hand in hand to ensure cheap, accessible housing in central locations for people who already lived there. This process ended up being associated, literally, with a revolution. But could we win back this role for architecture?

Workshop arquitetos de família - family architects workshop (WAF)
In operation since 2017, and under the motto "learning by being useful", this initiative addresses two easily identifiable gaps in public policies: on the one hand, the difficulty that the most deprived populations have in accessing state financial resources for the promotion of decent housing, which is largely due to the lack of specialised mediation structures; on the other hand, the lack of spaces in the curricula of architecture faculties where students can learn the necessary tools to mobilise housing policy in the direction where it is most needed. By creating a bridge between these two needs, the workshop aims to put the architect in a different place in the assembly line: in the creation and viability of offer, rather than just its execution.

Throughout six editions, the WAF has had three different training objectives. Firstly, to familiarise the students with the housing policy and land management instruments needed to implement public policies. Secondly, that spaces be designed with a different approach: less focussed on issues related to architectural language, more aimed at removing all risk factors (unsuitable areas, architectural barriers, thermal surroundings, etc.). Thirdly, awareness of the social space that needs to be created so that proposals can get off the ground: there's no point in having the perfect project if you don't have, for example, the approval and involvement of the main funding and licensing bodies.

To date, the work of the WAF has made it possible to leverage around one million euros for the rehabilitation of buildings for the benefit of people who cannot afford technical support, 70 per cent of which in the fifth edition, proving the importance of accumulating knowledge and consolidating a network of public sector partners. In addition to the qualification of the physical space for the benefit of households without resources, it is important to mention two other dimensions in which the initiative has an impact: the qualification of future technicians (there are already 52 students who have had the opportunity to start a different professional profile); the standardisation of other types of architecture (the worskhop has allowed these topics, normally absent from the professional debate, to be present at the 2021 Venice Biennale).

Balance and future prospects
Built space can be transformed from a contentious element into a tool for promoting health, but for this to happen, it will be necessary to secure resources that currently do not exist or do not interact with one another. Financial support to materialize the projects, the definition of principles that allow action on the dimensions that shape population health, and the training of professionals who can bridge these dimensions are essential for this process. The WAF helped address gaps in public policy, guiding other training initiatives, such as the one organized in 2021 by the Northern Regional Section of the Order of Architects, aimed at architecture professionals, with a greater focus on leveraging financing from the Recovery and Resilience Plan (PRR).

The challenge, however, remains to anchor these initiatives in the DNA of public institutions, which requires two paths of intervention: on one hand, acting on policies, rather than within existing frameworks, so that they more directly align with the health promotion objectives described here; on the other hand, acting on the social structures necessary for the promotion of these policies, overcoming the segmentation that characterizes public administration. Only in this way can we shift from the concept of housing as an object to the goal of access to housing, as proposed by the New Generation of Housing Policies (2018) and improve the quality of the habitat—not just housing itself—as demanded by the Basic Housing Law (2019).

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Healthy Cities: the vision, values and goals of a project that became a global movement

The Healthy Cities initiative was launched with the aim of placing health high on the social and political agenda of cities [1] by promoting health, equity and sustainable development through innovation and change. Its creation was based on the recognition of the importance of action at the local urban level and on the key role of local governments.

The mayor of the city has much more power over his or her area than the Prime Minister has over the country; a city administration ca much more easily instruct different sectors to work together in health; and community participation is not a theoretical issue; it is daily at the finger-tips of the whole city administration. (Jo Asvall, WHO Regional Director for Europe, who first launched the WHO European Healthy Cities Network in 1988 [2])

Following a decade of debate on health and medicine and setting the values and principles of a new public health era, the late 1970s and 1980s provided the opportunity for political legitimacy and the strategic means to advance an agenda of Health for All, based on powerful concepts and ideas, including engaging a wide range of new actors. Most notably, the Declaration of Alma-Ata [3], the strategy for Health for All [4] and the Ottawa Charter for Health Promotion[5] inspired new types of leadership and partnerships for health that transcended traditional sectoral and professional boundaries.

The WHO European Healthy Cities Network was created in 1988 as the WHO Regional Office for Europe's strategic vehicle to bring Health for All to the local level and was the result of several initiatives and developments in the early 1980s both at the local level and at WHO [1,5]. The Healthy Cities initia-

tive quickly caught the imagination of European politicians, and soon, one after another, the WHO regions launched their own WHO networks of cities. Since the 1970s, many WHO resolutions reflected the importance of working at the local and community levels, but this understanding was not generally regarded as approval for WHO to engage with local political leaders. Today, three decades later, engaging with local governments is accepted as a key element in successfully implementing most global and regional public health strategies, and the Healthy Cities initiative is recognized as an important vehicle for mobilizing local action and commitment [6].

A healthy city is not one that has achieved a particular health status. Rather, a healthy city is conscious of health and striving to improve it. It continually creates and improves its physical and social environments and expands the community resources that enable people to mutually support each other in performing all the functions of life and developing to their maximum potential.

The Healthy Cities initiative was launched first as a political, cross-cutting project with the aim of engaging local governments and working directly with local leaders and diverse stakeholders.

From its inception, the Healthy Cities initiative has been rooted in a firm set of values: the right to health and well-being; equity and social justice; gender equality; solidarity; social inclusion; and sustainable development. The Healthy Cities approach is based on the principles of intersectoral collaboration, community participation and empowerment.

Well-being is a political choice. It is the outcome of the policies, institutions, economies, and ecosystems in which people live. This requires a whole-of-society approach involving action across all levels, stakeholders and sectors, from communities and within organizations to regional and national government [7].

These values and principles are more relevant than ever [8], although over the years, their meaning, content and evidence base have evolved significantly. For instance, evidence for the underlying causes of health inequalities has vastly increased in the last 30 years. Similarly, terms such as intersectoral action for health and community empowerment have evolved conceptually in both scope and depth, although the goal of effectively reaching out to other sectors and engaging society remains as challenging as ever.

The main goals of the Healthy Cities initiative [9] can be articulated as:

1. promoting health and equity in all local policies and fully aligning with the Sustainable Development Goals agenda;

2. creating environments that support health, well-being, healthy choices and healthy lifestyles;

3. providing universal health coverage and social services that are accessible and sensitive to the needs of all citizens;

4. investing in health promotion and health literacy;

5. Investing in a healthy start in life for children and providing support to disadvantaged groups such as migrants, the unemployed and people living in poverty;

6. strengthening disease prevention programmes, with special focus on obesity, smoking, unhealthy nutrition and active living;

7. promoting healthy urban planning and design [10];

2023 Healthy Cities Conference in Utrecht

8. investing in green policies, clean air and water as well as child-friendly and agefriendly city environments and addressing climate change–related issues such as lowering emissions and identifying climate-resilient pathways;

9. supporting community empowerment, participation and resilience and promoting social inclusion and community-based initiatives;

10. strengthening the city's public health services and capacity to respond to public health emergencies.

These goals are based on the current knowledge base on health and well-being and formulated to address the urban challenges that most significantly affect the health, well-being and living conditions of city residents. Fig. 1 presents these goals in nine main Healthy Cities action domains.

Overview of Healthy Cities action domains

Strengthen local public health services and capacity to deal with health-related emergencies

Plan for urban preparedness, readiness and response in public health emergencies

Improve city governance for health and well-being

Reduce and minimize health inequalities

Promote a health in all policies approach

Promote community development and empowerment and create social environments that support health

Create physical and built environments that support health and healthy choices

Improve the quality of and access to local health and social services

Consider and plan for all people in the city and give priority to those most in need

Healthy cities action domains

The Healthy Cities initiative can exert influence on health and equity with a wide range of mechanisms and processes, including the following.

Regulation. Cities are well positioned to influence and enact policies, laws and regulations and enforce them (such as land use, building standards, water and sanitation systems, occupational health and safety regulations and restrictions on tobacco use).

Integration. Local governments can develop and implement integrated policies and strategies for health promotion, social and sustainable development (such as integrating health in their overall city development strategy).

Intersectoral governance. Cities' democratic mandates convey authority and the power to convene partnerships and encourage contributions from many sectors and stakeholders from the private and voluntary domains (such as representation from multiple sectors in a city committee for urban planning).

Community engagement. Local governments have everyday contact with citizens and are closest to their concerns and priorities. They present unique opportunities for partnering with civic society and citizens' groups (such as youth councils so the next generation has a voice in local decision-making).

Equity focus. Local governments can mobilize local resources and deploy them to create more opportunities for poor and vulnerable population groups, and to protect and promote the rights of all urban residents, such as using the results of city health profiles to create targeted interventions) [9].

Effectively addressing today's public health challenges requires the full engagement of local governments. To maintain its relevance, the Healthy Cities initiative was designed as a dynamic and open framework that would continually evolve and reinvent itself, integrating knowledge from practice and new evidence, as well as grounding itself in local concerns and perspectives. Moreover, Healthy Cities was created to generate knowledge for all urban communities to learn from and not an esoteric movement to benefit only its member cities. Thus, evaluation of Healthy Cities activities has always been an integral part of the approach and is available.

***in* "City leadership for health and sustainable development: critical issues for successful Healthy Cities initiatives in the WHO European Region."**

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Democracy and health

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When I was asked to write on Health and Democracy, I immediately felt I would be discussing something naturally inseparable. Although the right to health, like the right to education, is not exclusive to democratic regimes, we know that there is a strong relationship, which has already been demonstrated through a number of scientific studies.

The concept of democracy and the concept of modern healthcare, particularly regarding the practice of medicine, emerged at the same time and in the same socio-political context. The birth of democracy, as a system that expands popular participation in politics, came about in 514 BC following the reforms carried out by the Athenian legislator Clisthenes. Later, in 460 BC, the man who would revolutionise health was born in Kos, giving medicine an autonomous status, separating it from natural philosophy. Aristotle is therefore considered the father of the medical profession, practised on a scientific and ethical basis. These are two important concepts born in ancient Greece, the fruit of a changing environment, and which have influenced humanity to this day.

With the arrival of democracy in Portugal in April 1974, the need quickly arose to guarantee the population access to basic health care, which led to the creation of the national health service (SNS) in 1979. In the meantime, following advances in science and technology, the SNS has promoted increasingly differentiated care which, together with improved socio-economic conditions, has contributed to a significant increase in life expectancy and an equally significant reduction in maternal and infant mortality.

After 50 years of democratic life, the country's health is going through a new process of change, which is the implementation of various non-state health systems, allowing citizens to have options other than the SNS. However, these are not alternative health services, because users, as taxpayers, continue to fund the SNS. This being the case, it would be only fair that health expenses incurred outside the SNS should be completely subtracted from the tax base. The state cannot ignore the fact that recourse to private health systems is the only alternative to bypass waiting lists or to make up for the absence of some specialised services in the SNS.

Health Communication: 50 years of transformation

"The whole world wants to be vaccinated with the BCG"

Miguel Telo de Arriaga
e Leonor Quelhas Pinto
Disease Prevention and Health Promotion Services
Directorate-General of Health

Over the last 50 years, Portugal has witnessed a remarkable evolution in its health indicators. The creation of the National Health Service and the evolution of the Health System means that today we can achieve benchmark results in the National Vaccination Programme, infant mortality and life expectancy at birth, which reflects the effectiveness of public health policies and generalised access to healthcare. Demographic evolution, epidemiological transition and changes in behaviour, environments and access to information have redefined the population's health needs and priorities. In response, Health Communication has taken centre stage.

Over the last few decades, the way we communicate about health has evolved substantially. While previously the approach was essentially informative and one-sided, today it is much more interactive, inclusive and participatory. Until recently, messages were transmitted in a linear fashion, with little or no interaction or feedback from the population, and communication was predominantly static and unidirectional, through posters, leaflets and campaigns, the focus of which was on disseminating basic information about diseases or healthcare.

Today, communication is not just about transmitting information, but about ensuring that it is understandable and used in a practical way by citizens. In other words, rather than disseminating data, the aim is to enable people to navigate between trusted sources, apply information critically and make informed decisions.

In the age of digital technology, this communication process has been greatly facilitated, but also exposed to new challenges. Social networks and digital platforms, despite broadening the reach of health communication, have also become vectors of misinformation. This proliferation of misinformation can jeopardise citizens' ability to distinguish between reliable and unreliable sources. It has therefore become imperative to develop effective strategies to combat misinformation and guarantee access to credible, evidence-based content, which is essential for promoting appropriate health behaviours.

The emergence of Artificial Intelligence (AI) is revolutionising the field of health communication even more. In addition to the development of systems that make it possible to personalise recommendations, chatbots or the use of algorithms for data analysis and support in predicting and researching behaviour, these technologies allow for precise and segmented communication, tailored to individual needs, promoting health in a more proactive and personalised way.

At the same time, the decentralisation of powers in the health sector has led to closer ties between local authorities and citizens, facilitating the creation of health policies that are better adapted to the particularities of each community. The active participation of the population in the construction of these policies guarantees their relevance and effectiveness, since they are moulded on the basis of the specificities of each region and the socio-economic and cultural characteristics of its inhabitants.

Municipalities in Portugal are playing an increasingly active role in communicating and promoting health through strategic plans and the many actions that result from them (local and municipal health plans; municipal health councils). The decentralisation of powers has given local authorities new strategic tools to develop and implement public health policies tailored to the specific needs of their communities. In turn, the collaborative approach is particularly visible in initiatives promoted by municipalities, which play a crucial role in implementing health promotion and disease prevention programmes. The involvement of communities and the co-creation of solutions has made it possible to develop responses that are better suited to local problems. Innovative initiatives such as the use of micro-influencers (community health workers) to disseminate health information more closely and effectively, and projects at the different stages of the life cycle, which make it possible to empower, involve and utilise knowledge, have been good practices implemented through close coordination between the national, regional and local levels.

Developments in health promotion in Portugal have endeavoured to keep up with the new challenges. The new National Health Plan and the Health Literacy and Behavioural Sciences Action Plan 2023-2030 aim to respond to the new demands of citizens and get them actively involved in their health. Partnerships between local authorities, civil society organisations and health professionals are therefore crucial to ensuring coordinated and efficient action in line with the real needs of the population, strengthening social cohesion and encouraging the adoption of healthy behaviours by creating health-promoting ecosystems.

"Peripheral" medical service

A snapshot of everyday life

Cecília Shinn
General Practitioner

The journey to the "peripheries" is a path I travel every day, and although difference can be considered "a constraint", from another perspective it is a privilege to be able to work in an environment with different cultural expectations, unusual beliefs about parenting, health, illness, family, profession and society; different languages and clothing, different ways of expressing emotions and interpreting symptoms, different needs in terms of psychological safety in a healthcare environment, etc.

The resources we find and use keep us attentive to the needs of "the other", teamwork needed to offer culturally appropriate care forces us to work in a close-knit network with our team and our surroundings, and the differences we face every day make us learn, grow and realise that the human experience has multiple facets, and that thinking only in terms of "normality" is a closed and limiting concept.


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