LOCAL GENDER EQUALITY

Guide for the integration of the gender perspective at the local level in

Healthcare and Social Action

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Title
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My Municipality for Equality.

Locally We Build a Better Life for Women and Men.

Healthcare – Groundings

The motifs?

THE EUROPEAN CHARTER FOR EQUALITY of women and men in local life
Article 14 – Health

2.The Signatory recognizes that in securing equal opportunities for women and men to enjoy good health, medical and health services must take account of their different needs. They further recognise that these needs arise not only from biological differences, but also from differences in living and working conditions and from stereotypical attitudes and assumptions. > Part III > The service delivery role.

3. The Signatory commits itself to take all reasonable actions, within the range of its responsibilities, to promote and secure the highest levels of good health of its citizens. To this end, the Signatory undertakes to carry out or promote, as appropriate, the following measures:

- Incorporating a gender based approach to the planning, resourcing and delivery of health and medical services
- Ensuring that health promotion activities, including those aimed at encouraging a healthy diet and the importance of exercise, include a recognition of the different needs and attitudes of women and men
- Ensuring that health workers, including those involved in health promotion, recognise the ways in which gender affects medical and health care, and take into account women's and men's different experience of that care
- Ensuring that women and men have access to appropriate health information.

(CMRE, 2006: 21-22)

› The greater socioeconomic vulnerability faced by women makes them more vulnerable as regards their health, whether in terms of contracting diseases or in accessing prevention, diagnostic and treatment methods. As such, this inequality requires taking into account within the framework of health and safety and social security policies.

› Women experience a longer average lifespan than men (currently 84 for women and 78 for men), which correspondingly means a larger number of older women than older men. This requires taking into account when considering the level of healthcare in the elderly. It should also be noted that living longer does not necessarily imply living well.

The lengthening in the average lifespan means there is an increasingly large number of older people. In 2050, there will be 2.95 million people over the age of 65 in Portugal.
(INE, 2012)

According to Eurostat, healthy life expectancy at 65 is 5.6 years for women and 6.9 for men.

› This lengthening of the average lifespan also raises the number of people suffering from dementia, especially Alzheimer's disease (which represents at least 50% of all dementia cases). In addition to women experiencing the greatest probability of being directly affected, as they live longer, they are also indirectly the most affected as primary care providers.

› Women constitute the main victims of domestic violence and all other kinds of violence throughout every phase of their lives, which drives their search for healthcare services. These services should be prepared to appropriately respond, both in terms of diagnosis and in patient referral.

› Domestic violence results in a series of problems for the health and well-being of children and victims, whether in mental or in physical terms, in addition to the other immediate problems that require studying withing the goal of prevention and treatment.

› There are women and girls living in Portugal who were or who will still be submitted to female genital mutilation, whether inside the country or during trips taken to the countries their families originate from.

› Women experience particular reproductive health needs, for instance those related to maternity. The maternal mortality rate is one indicator that reveals a continuous and significantly positive evolution in healthcare quality in Portugal.

› Progressively, the right to choose and the establishment of conditions and facilities regarding planned parenthood, contraceptive methods and the voluntary termination of pregnancy have gained recognition among women.

Reproductive rights, involve a person's and a couple's right to:
_ Freely and responsibly decide how many and when they want to have children;
_ Possess the right information, education and means to make these decisions;
_ Access the highest standard in sexual and reproductive health;
_ Make decisions regarding reproduction, free of discrimination, coercion and violence.
(UNPF, 2014: 60)

› In the health sector, women are regarded as the almost exclusive beneficiaries of sexual and reproductive healthcare as mothers. However, this largely ignores the implicating factors of the effects of gender on morbidity rates.

› The adoption of a male perspective, deploying men as a standard, even in the study of diseases afflicting both genders impacts negative on the quality of care for women as some symptoms tend to get overlooked, misinterpreted or misdiagnosed. This perspective also shapes accessibility to healthcare, the employment of diagnostic resources and therapeutic processes.

Research on gender in healthcare

A study conducted in Sweden revealed that, in myocardial infarction cases, the delay between initial symptoms and arrival at a hospital is one hour greater for woman than for men. Additionally, women receive lower priority while awaiting an ambulance and on average wait twenty minutes longer than men before being seen in hospitals.
(Schenck-Gustafsson, 2006 in DGS, 2008)

At the national level, a study developed by the ENSP – the Portuguese School of Public Health analysed the gender distribution of the appliance of technological resources in response to cardiovascular illnesses and discovering an accessibility deficit favouring men, regarding the employment of catheters and bypass surgery. In addition, the existence of representations of this pathology type as a "male disease" and women supposedly experiencing greater difficulties in recovery following invasive treatment. Moreover, there are gender discrepancies existing in terms of waiting time for elective surgery, measured from the time the patient obtained a referral to the time they are admitted for treatment.
(Fernandes, Perelman e Mateus, 2007 in DGS, 2008)

› Furthermore, while men serve as the reference framework for the study of the generality of illnesses, they are almost entirely excluded from sexual and reproductive healthcare and services aside from the

health effects that certain generally accepted masculine social practices have not yet been fully taken into consideration (Gideon, 2006 in DGS, 2008: 46).

› The patterns of masculinity, associated with robustness and toughness, push men away from utilising healthcare services, which might result in pernicious long term health consequences.

Women are overall less satisfied with state of health than men. Over the course of 2004 to 2014, 85% of men self-classified their health as good or very good, whereas that percentage for women was, for the same period, 77%.
(DGS, 2015)

› The analysis of the National Health Survey results from 2014 (INE (Portuguese Statistics Institute)), 2015a) clearly demonstrates that, in relation to men, women are significantly more affected by illnesses that cause pain (arthrosis, cervical pain or other chronic neck problems, lumbar pains and other chronic back problems), which both diminishes their quality of life and increases their healthcare expenses.

› Regarding mental health and in accordance with data from the WHO (World Health Organisation), the ratio of women stating they suffer from depression (17.1%) proves considerably greater than men suffering from the same illness (5.9%) (INE, 2015a: 3), which, in many cases, constitutes a symptom of the burden of female domestic responsibilities and providing care for minors and dependents.

› Women are also more greatly affected by obesity than men and in a rising trend over recent years (INE, 2015a: 2). This data may interlink with the fact that women also have less time for themselves and do less exercise.

In every stage of the life cycle, the consumption of alcohol, harmful consumption practices and addictive and dependant usage are more prevalent among males.
(SIDAC, 2014: 10)

› The exhibition of "masculinity" exposes men and boys to pernicious behaviours which are detrimental to their health, such as the consumption of alcohol and tobacco or even simply endangering their own lives through car crashes and similar. The risk behaviours men are more exposed to explain their greater likelihood of violent and premature mortality, especially early on in life and at those ages when most exposed to such risks.

› Suicide rates are higher in men. However, probably due to economic recession, there was recently a considerable spike in female suicides (an increase of 24% in 2014 compared to 2013, according to data from the Death Certificate Information Centre, 17th July 2016).

› HIV infection rates in Portugal still remain worrisome. Even with the decrease recorded in new cases, ascertained figures are still greater than those reported by the vast majority of countries in Western Europe. People over 49 years of age, women and young males having sex with males are a recent trend in Portugal. Infection transmission through sexual accounted for over 90% of the total reported cases in 2013.

› Populations such as the homosexual and transgender groups exhibit greater health risks in relation to the general population in terms of their depression and attempted suicide rates. LGBT people are faced with various struggles in accessing competent and adequate healthcare, some of which stem from the lack of identification and disregard for diverse sexual orientations on behalf of healthcare professionals (ILGA Portugal, 2014). Trans-people do not yet have access to competent and inclusive national healthcare services.

› The Roma population faces additional healthcare struggles, such as the respiratory issues associated with poor living conditions. With regard to women, there is an almost complete lack of preventive practices in relation to gynaecology, the number of Roma women who have never undertaken exams such as mammographies and Pap smears remains significantly high.

› In addition, sexual workers are particularly vulnerable in terms of healthcare, with all the consequent health hazards to their health and to public health, such as the propagation of sexually transmitted diseases (of which HIV is of note) and drug addiction, among others. In social terms, this population is frequently vulnerable, especially whenever subject to exploitation, illegal immigration networks or human trafficking.

› While there is a deficit in terms of the data available on healthcare access by migrant populations, a recent study by ERS – the Health Regulatory Entity (2015) revealed there are still substantial flaws in this regard, which are only aggravated in cases of illegal immigration.

› In terms of human resources, healthcare, alongside other fields of social action, emerges as a feminised sector and with data indicating this is likely to remain as such. In the health field, women predominate on every study program with this prevalence overwhelming in fields such as nursing and physical and rehabilitation medicine, in which their percentage exceeds 80% (Pordata, 2016b).

› Healthcare curricula do not yet appropriately incorporate a gender perspective, focusing almost exclusively on the biological aspects of sex.

Principles and methodologies

How to proceed?

Specific attention should be paid to providing information and access to healthcare services throughout the different phases of life.

› Women and men have different healthcare needs stemming either from either their different biological constitutions or from their distinctive lifestyles. Such differences should be incorporated into healthcare practices and policies.

What is active ageing?

Active ageing is the process of optimising opportunities for health, participation and security, with the aim of maintaining quality of life in spite of age.
(OMS, 2002: 12)

› Municipal policies should take into account the effects of ageing on health and resident quality of life. Measures should be designed with the goal of promoting active ageing.

› One area of particular note in terms of ageing is dementia. Preventive measures to ensure quality of life for patients, their families and carers should be implemented in conjunction with patient associations.

› The gender perspective should be incorporated into the planning and attribution of resources as well as healthcare service provision (CMRE, 2006: 22).

› The PNI – the National Equality Plan has adopted the commitment to producing technical referentials on gender equality in healthcare, spanning the health profiles of women and men, and on non-discriminatory access to healthcare (PCM, 2013).

The guarantee that health promotion activities should include recognising the different needs of men and women (CMRE, 2003: 22), as well as other groups that make up the population: people with minority gender identifications or sexual orientations, people with different cultural backgrounds, immigrants and disabled persons

› Government healthcare facilities should all foster the participation of women's associations, representatives of other discriminated against groups and the promotion of gender equality.

› The physical location of healthcare facilities may itself constitute an obstacle to equality in accessing healthcare. People living in rural areas experience greater indirect costs in reaching healthcare services or even potentially unable to access them (economic resources, transport means, physical mobility impediments, etcetera). There is thus the need to guarantee support enabling either their commuting or alternatively the movement of healthcare services to the residences of these people/populations.

› Education and information regarding sexual and reproductive health is an important facet of the right to healthcare access. Special attention should be given to areas such as adolescent sexual and reproductive health and unwanted pregnancies as well as preventing sexually transmitted diseases. Men and women have the right to be informed and to have access to safe, effective and accessible contraceptive methods.

› This should also foster the involvement and accountability of youth and adult males in sexual and reproductive health.

Factors that contribute to the successful integration of reproductive health services for men

_ Using a name for the programme/facility that welcomes men and women;
_ Decorating the facility in a way that appeals to men and women;
_ Designating a male restroom;
_ Including reading materials that interest men in waiting areas;
_ Making information, education and communication materials readily available to men;
_ Making condoms easily available;
_ Creating an individual medical chart for each male rather than keeping his medical information in his female partner's file;
_ Providing facility space and time for seeing couples so that men and women can receive counselling together, if desired;
_ Creating awareness of men's reproductive health in the community. The availability of men's reproductive health services should be advertised; and
_ Adapting clinic hours to meet men's needs.

(UNFPA, 2003: 33)

› Sexual and reproductive health policies should equally take into account the sexuality of disabled women, which frequently get infantilised. Health and social action specialist staff should be specifically trained in this field.

› Campaigns and initiatives to promote accident and disease prevention from a gender perspective should also undergo implementation. Campaigns, for example, on preventing drug use are not thought out in such a way that they reach out equally to males and females, which can render them ineffective. Women should see themselves reflected in this kind of campaign that requires the usage of non-sexist language.

› Making healthcare communication and information accessible to everyone requires taking steps aimed at diverse communities, such as non-Portuguese speakers, the visually or hearing impaired and the illiterate.

› Cultural differences, including different gender norms, ought to be taken into account with regard to health related issues.

› Sexual orientation and gender identity issues should be taken into account in healthcare services, recognising sexual orientations beyond heterosexuality and gender identities outside of cisgender in every field of healthcare but especially in sexual and reproductive health services and in the effects of discrimination on mental health.

› Transgender people access to appropriate and competent healthcare services should be supported and provided.

› Health promoting initiatives aimed at sex workers should be carried out. Healthcare, with close and accessible social support facilities may, for instance, require deploying street teams.

› Promotional health initiatives aimed at specific groups, such as particular groups of women, for instance in the Roma community, should take place, investing in alternative methods to the traditional (written) and drawing on references from the community. For example, this might involve Roma women in prevention and health promoting campaigns, including on sexual and reproductive health issues (Vicente,2009).

› Appropriate measures for safeguarding the rights of healthcare users require implementation. The right mechanisms for complaints and reports, ensuring anonymity and confidentiality, ought to be made available.

› Information and communications about healthcare issues should not replicate gender stereotypes, instead contributing to their deconstruction (for example, by identifying a man as a caregiver).

› All healthcare communications – written, image and signage forms – should comply to gender equality principles (for example, referring to both male and female users or replacing expressions such as "going to the doctor" with "attending a medical appointment").

› There is a need to guarantee that healthcare staff recognise how social gender relations affect medical and health care and take into account the different experiences men and women encounter in these services. Research sources reveal gender inequalities in healthcare, demonstrating the need for gender equality training on behalf of healthcare professionals, inclusively at the level of the board of directors, administration and management working bodies.

› Research into the determining factors of female health, which are not duly covered by male health standards and/or solely focuses on sexual and reproductive health, should be encouraged.

› Healthcare services should be prepared to deal with situations of gender violence, which mostly affects women, especially by coordinating with the other support, reporting, guidance and professional facilities with proper training for handle such cases.

› Healthcare services should integrate the municipal and supra-municipal support network for domestic violence victims.

› Healthcare services should be made freely available for female victims of domestic violence and their children in addition to the care provided following episodes of aggression.

› Professional healthcare services should be endowed with the ability to identify situations of female genital mutilation (FGM), registering cases and their specific details in order to, alongside other entities, especially local councils, contribute to the municipal level diagnosis of the FGM situation so as to inform intervention procedures.

› In combating and preventing HIV infection, the respective measures need adjusting to and targeting at risk behaviour profiles beyond those already contemplated. This should highlight cases of older women who get sexually infected by partners engaging in high risk behaviours.

› The breakdown of data by gender and age is fundamental for monitoring differences in accessing healthcare and the different usages of said healthcare. In addition to gathering data from other entities, the practice of gathering and analysing administrative data, separated by gender criteria, on council services pertaining to health should also be encouraged.

› Decisions and interventions regarding healthcare at the local level should be complemented by diagnosis of the national situation in terms of gender equality. Producing this diagnosis requires the compilation of statistical data but which should be complemented by information gathering methods which enable inputs from different population categories and groups as well as those from professionals and experts.

Instruments
Which resources?

The list below stipulates examples of questions for which answers are required whenever seeking a gender equality based diagnosis. There are many stakeholders involved in the diagnosis, from decision makers, with emphasis on the local council and health sector, the municipal health council, without overlooking women's and gender equality associations and other third sector representatives. The group of indicators proposed in table 2 are for deployment in answering the questions listed.

› Table 1. – Examples of gender equality diagnostic questions in the field of health

What is the county situation regarding accessibility to healthcare? Are there any differences between men and women?
Are there health diagnoses with a gender perspective in the county? Is the administrative data separated by gender? Are survey processes in effect?
What are the main healthcare needs of men and women?
What are the main needs specific to older men and women?
What healthcare promoting initiatives with a gender perspective have been developed in the county? Who did they concern and who were they aimed at?
What is the quality of the maternal healthcare provided? What actions have been developed for involving fathers in maternal caregiving? Who were they aimed at?
What is the quality of sexual and reproductive healthcare? Are the existing facilities enough? What is the level of demand?
What is the participation of men in sexual and reproductive health appointments? What about in paediatrics? What initiatives/actions are under development to boost the accountability and participation of men? Which segments of the population and which entities are thereby covered?
What is the response from healthcare services to victims of gender violence, including domestic inicidences? And regarding drug addiction? And regarding HIV positive individuals? What initiatives/actions are under development? For what problems? For what segments of the population?

› Table 1. – Examples of gender equality diagnostic questions in the field of health

What is the situation in terms of accessibility and quality of healthcare for specific groups, such as sexual orientation minorities, gender identity, ethnic, immigrant and disabled people? What initiatives/actions are under development to improve healthcare accessibility and quality for these populations?
Are healthcare professional training initiatives focusing on the inclusion of gender equality accessibility and quality? Of what kind? Which professionals are covered? At what entities?

› Table 2 – Gender indicators in the field of health

Area	Indicator	Source
Statistical information available on a municipal level		
Health and population	Gross birth rate	Statistics Portugal, PORDATA
	Gross rate of child mortality	Statistics Portugal, PORDATA
	Perinatal deaths of mothers residing in Portugal	Statistics Portugal, PORDATA
	Residing disabled population, by type of disability and sex	Statistics Portugal, Population Censuses
	Resident for five or more years old population, with difficulties, by type of difficulty and sex	Statistics Portugal, Population Censuses

› Table 2 – Gender indicators in the field of health

Area	Indicator	Source
Statistical information for municipal council assessment		
Condition, state and health habits	Number and % of users without general practitioners, by sex and age	School Groups
	Main healthcare needs experienced by men and women, by age group	Health Survey*
	Self-assessment of health status, by age group and sex	Health Survey*
	Number and % of chronically ill people, according to type of illness, age group and sex	Health Survey*
	Aged over 15 population with probable incidence of psychological suffering, by age group and sex	Health Survey*
	Population that took medication prescribed by the doctor in the last two weeks, by sex	Health Survey*
	Population that uses contraceptive methods, according to the contraceptive type, by age group and sex	Health Survey*
	Average daily walking time of the population aged between 15 and 69, by age group and sex	Health Survey*
	Number and % of men and women in planned parenthood appointments	Local Health Centers and other entities with family planning
	Number and % of men and women in maternal health appointments	Local Health Centers and other entities with maternal health consultations
	Number and % of mothers and fathers in paediatric appointments	Local Health Centers and other private health entities
	Number and % of people addicted to drugs, by type of addiction and sex	Hospitals, Local Health Centers and supporting institutions for drug addicts
	Number and % of HIV positive people, by age group and sex	Hospitals, Local Health Centers and supporting institutions for people with HIV

› Table 2 – Gender indicators in the field of health

Area	Indicator	Source
Domestic violence	Number of domestic violence motivated appointments, by victim sex	Local Health Centers
	Number of domestic violence fee payment exemptions, by victim sex	Local Health Centers
	Number of participations/reports of domestic violence observed by healthcare services, by victim sex	Local Health Centers
	Number of domestic violence victims forwarded by healthcare services, by victim sex	Local Health Centers
	Number and type of protocols established between healthcare services and other domestic violence victim support entities	Local Health Centers
Mobile Health Services	Types of mobile health services in operation within the county	Local Council
	Number and % of beneficiaries of mobile healthcare services, by sex and county	Local Council
	Level of mobile health service user satisfaction, by sex, age and place of residence	Local Council
Feminisation	Number and % of representatives on the Municipal Health Council by sex	Local Council
	Number and % of healthcare directors, by sex and job position	Local Health Centers
Gender equality competencies	Number and % of representatives in the Municipal Health Council with training in Gender Equality (GE)	Municipal Council of Health
	Number and % of healthcare directors with GE training, by sex and role	Local Health Centers
	Number and % of doctors with GE training, by sex and specialty	Local Health Centers
	Number and % of nurses with GE training, by sex and specialty	Local Health Centers
	Number and % of healthcare staff with GE training, by sex and service	Local Health Centers

› Table 2 – Gender indicators in the field of health

Area	Indicator	Source
Actions/initiatives/campaigns	Number of GE awareness actions/training regarding developed for healthcare directors, by role and service	Hospitals, Local Council and Local health Centers
	Number of healthcare directors in the field of health encompassed by awareness actions/training, by role, service and job position	Hospitals, Local Council and Local health Centers
	Number of GE awareness actions/training developed for healthcare professionals, by professional type	Hospitals and Local Health Centers
	Number of healthcare professionals encompassed by GE awareness/ training, by professional type and sex	Hospitals and Local Health Centers
	Number of health promoting campaigns developed with a perspective on gender, by type of campaign and gender of targeted audience	Local Council and Regional Administration of Health
	Number of GE health promoting campaigns specifically in sexual and reproductive healthcare, maternal and paediatric health, by type of campaign	Local Council and Regional Administration of Health
	Number of actions/initiatives in the field of health for immigrant populations, by type of action/initiative and public	Local Council, Regional Administration of Heath and Local Health Centers
	Number of immigrant people encompassed by health promotion actions/initiatives, by sex	Local Council, Regional Administration of Heath and Local Health Centers
	Number of actions/initiatives in the field of health directed toward LGBT people/issues, by type of action/initiative and public	Local Council, Regional Administration of Heath and Local Health Centers
	Number of people encompassed by health promotion actions/ initiatives for LGBT issues, by sex	Local Council, Regional Administration of Heath and Local Health Centers
Satisfaction	Level of resident satisfaction with healthcare services, by sex and age	Local Council

* Indicators included in the National Health Survey, without any representation at the municipal level, which could be replicated by resident survey processes

With who?

Local councils need to coordinate with a group of other entities for the development of healthcare strategies and proposed actions. Municipal Health Councils, as part of an aggregating working body spanning various areas and entities, here play a crucial role and are especially well positioned to function as initiative boosters.

- City Council (health department);
- Parish Councils;
- Municipal Health Council;
- Intermunicipal Communities (CIM);
- Ministry of Health;
- Hospitals and health centres;
- IPSS – Private Social Security Institutions;
- Pharmacies;
- Healthcare professionals, including doctors, nurses and other professionals; directors, administrators;
- Researchers, research centres and universities;
- Professional healthcare training institutions;
- Orders, associations and healthcare unions;
- Student associations within the field of health;
- Women's associations and gender equality promoting associations;
- Patient associations;
- Immigrant associations;
- LGBT associations and gender equal education associations;
- Associations representing other vulnerable groups;
- Other NGOs;
- Social network and media outlets (local, regional and national).

Best practices
What examples?

Hereafter, there are some particular examples of best practices but that require adaptation to each context and specific reality.

Information gathering and data production

› Promoting Municipal Health Surveys, integrating a gender perspective.

› Performance of health diagnosis processes with a gender perspective.

› Gathering administrative data in the field of health, separated by sex and other pertinent variables.

Empowerment of strategic agents

› Supporting training actions on inclusion, equality and diversity of sex for healthcare professionals.

In 2015, the General Directorate of Health hosted a **training session on Discrimination and Violence against LGBT** people directed at healthcare professionals, run by the Portugal ILGA association.

(http://igualdadenasaude.ilga-portugal.pt/)

Advocacy, awareness and community mobilisation

› Promoting training actions/awareness on the integration of the gender perspective in healthcare for strategic actors (policymakers, healthcare professionals).

HIV Prevention Campaign, promoted by CESIDA – State Coordinator for HIV and AIDS in Spain, launched in 2014, focusing on women, especially Latin-American women.

(http://www.cesida.org/campana-vih-2014/)

› Promoting programs/actions/campaigns raising awareness over accident prevention, the abusive consumption of alcohol and other drugs, high risk behaviours and eating disorders with a gender perspective.

› Promoting gender equality actions in the field of sexual and reproductive health.

The Oeiras Municipal Council carried out **awareness raising health and gender actions in the field of sexual and reproductive health**. These sought to promote equality in sexual and reproductive health, especially striving to eliminate gender and planned parenthood stereotypes. This reached about 700 students at primary and secondary schools in the council.

(http://www.cm-oeiras.pt/amunicipal/AcaoSocial/igualdadedegenero/Documents/Plano%20Municipal%20para%20a%20Igualdade%20de%20G%C3%A9nero%20do%20Munic%C3%ADpio%20de%20Oeiraspdf)

REDE PORTUGUESA MUNICÍPIOS SAUDÁVEIS
Associação Parceira da OMS

The **Portuguese Network for Healthy Cities** is an association with its main goal incorporating the dissemination, implementation and development of the Healthy Cities project in councils that seek to accept promoting health as a priority on the agenda of political decision makers.

Formally established on 10th October 1997, the Network furthered its reach based upon the following guidelines: Supporting and promoting the formulation of local strategies capable of favouring general improvements to healthcare; Promoting and intensifying cooperation among the municipalities making up the Network and with the other national networks that are members of the Healthy Cities project of the World Health Organisation (WHO).

(http://redecidadessaudaveis.com/index.php/pt)

Gender equality in municipal practices and in community rendered services

› Designing and implementing Municipal Health Plans, integrating a gender perspective.

› Promoting gender perspectives in public health programs.

› Embracing municipal joint initiatives in the field of health, such as the Portuguese Network for Healthy Councils.

› Mobilising mobile healthcare units, in partnership with council healthcare units and the General Directorate of Health and/or other partners that reach problematic, older, rurally isolated or otherwise disadvantaged populations.

This type of service is already available in various municipalities. Two examples follow: one referring to a more urban context and another to a more rural scenario.

Socio-Medical Mobile Unit fostered by Mértola Municipal Council with the ongoing support of various third sector institutions, which guarantees its functionality and constant availability. This is a mobile unit that roams the council on a daily basis, enabling various campaigns and awareness initiatives to reach anywhere within the county, such as information on smoking, breast cancer or free vaccine campaigns. This contributes toward the social integration of the populations, especially more isolated members.

(http://www.cm-mertola.pt/)

Healthcare on Wheels within the framework of the Healthy Seixal Project, this mobile healthcare unit frequently roams the county with the aim of providing primary healthcare services to populations who are in need, endowed with a multidisciplinary team made up of technical healthcare and social staff.
Among the primary healthcare services are health education, vaccination, maternal and infantile health, post-natal visits, premature diagnostic test and planned parenthood. Its target audience includes children, young people and women, especially in risk situations such as pregnant women and post-birth women. The project is a partnership between Seixal Municipal Council, Seixal Healthcare Centres, Garcia de Orta Hospital and the General Health Directorate. (Healthcare XXI Program).

(http://wwwt.cm-seixal.pt/seixalsaudavel/pdfs/RA_05.pdf)

› Promoting or supporting programs/projects that provide home care for the elderly and dependant populations..

The **Door-To-door Health Project** originates from a collaboration protocol between the Municipal Council of Lisbon with Students Association of the Faculty of Medical Science, Nova University, Lisbon, CUF Hospital – Infante Santo –, Campo de Ourique Parish Council and Estrela Parish Council. The project is rooted in the concept of medical university voluntary work and strives to ensure regular visits to older municipal residents or those in situations of social or socioeconomical health deprivation, reducting social isolation, accompanying and monitoring the health status of those referred, producing therapeutical conciliation measures and flagging up social or health deprivation.

(http://www.cm-lisboa.pt/noticias/detalhe/article/saude-porta-a-porta)

› Facilitating elderly access to healthcare.

The **Health Kiosk** stems from a partnership between the Olaias Parish Council, the Alcântara Parish Council and the Pegões (Montijo) Parish Council with the Conversa Amiga Association. This proposes "a new relationship with health" as a concept – easy, simple, and close by, with social interaction – just as if purchasing a newspaper or magazine from a kiosk.

This represents an innovative healthcare proposal providing an appropriate response for older people and local communities. It mainly serves the elderly without a general practitioner or with limited access to healthcare and/or tending to isolation, with a poor level of social interaction.

(http://conversa.pt/portfolio/quiosque-da-saude/)

› Creating information and prevention facilities for the general community, taking into account the needs of women and men.

In[form] Healthcare. A community space that seeks to facilitate access to information and instruction about subjects related to the promotion of health and the prevention of disease. This includes a documentation centre, open to the community, hosting initiatives such as learning sessions regarding self breast examinations, studies of municipal worker smoking habits and awareness sessions regarding HPV (Human Papillomavirus) and cervical cancer. The target audience is the general public, municipal workers and their families in a partnership between the Viana do Castelo Council, the Polytechnic Institute of Viana do Castelo (Higher School of Nursing), the Alto Minho Hospital Centre, the Alto Minho Public Healthcare Service, Local Health Centres and the HPV Portuguese Society, among others.

(http://www.cidadesaudavel.cm-vianacastelo.pt/index.php?option=com_content&view=article&id=102&Itemid=109)

Gerontological Plans, developed by various municipalities. These plans seek to promote active ageing through an integrated perspective on ageing, implementing projects and actions to this end.
The various Gerontological Plans are available for consultation on the Portuguese Association of Psychogerontoloy website.
(http://www.app.com.pt/planos-gerontologicos)

› Implementing measures nurturing active ageing.

› Making support available specifically for people with dementia and their respective carers.

Technical Office to help carers of people with dementia, launched by the Cascais, Oeiras and Sintra Councils through the protocol established between the Calouste Gulbenkian Foundation, Montepio Foundation, Catholic University and the Portuguese Association of Friends and Family of People with Alzheimer's. This provides technical support, counselling and guidance in the scientific, social and legal domains aimed at tutors and caregivers.
(http://alzheimerportugal.org/pt/text-0-10-47-252-gabinetes-cuidar-melhor-cascais-oeiras-e-sintra)

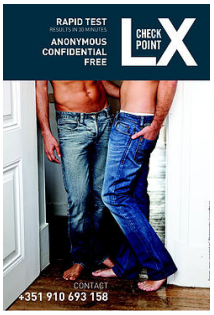
The **Andalusian Alzheimer's Plan,** the responsibility of Andalusia Parish Council, consists of nine strategic lines: holistic attention for affected people and support for caregivers in all stages of the disease; the information, training, guidance and counselling of associations and their respective professionals; the awareness of public opinion, institutions, media entities; the suitability of health and social resources; the advancement of new information and communication technologies; the development of a survey, listing and accreditation systems for family associations; the development of programs to link voluntary work with associations; establishing an evaluation system for the strategic Plan guidelines; the promotion and advancement of disease related research projects.
For the design and implementation of this Plan, a protocol was signed with the Andalusian Confederation of Family Federations of Alzheimer's and other Dementia Sufferers.
(http://www.juntadeandalucia.es/salud/channels/temas/temas_es/P_2_ANDALUCIA_EN_SALUD_PLANES_Y_ESTRATEGIAS/plan_alzheimer/)

› Promoting access to information and healthcare services for non-national residents.

GIS – the Intercultural Office of Health, promoted by the Viana do Castelo Municipal Council to support the foreign community in providing information and assisting with difficulties encountered in accessing healthcare information.

(http://www.cidadesaudavel.cm-viana-castelo.pt/index.php?option=com_content&view=article&id=131:servicos-de-informacao-e-apoio&catid=26)

› Supporting sexual health facilities through screening and the referral of sexually transmitted diseases and illnesses to healthcare entities.



CheckpointLX is a community based centre, directed at men who have sex with men, for anonymous, free and confidential screening for HIV and other sexually transmitted infections, sexual counselling and referral to healthcare services. Access to prevention and gender based health in a more effective and congruent way with reality is facilitated through peer support and education. This stems from a partnership between GAT – Activists in Treatment, the General Directorate of Health, the National Program for HIV/AIDS Infection, Lisbon Municipal Council and the AIDS HealthCare Foundation Europe.

(http://www.checkpointlx.com/)

› Ensuring the link between healthcare services and other support structures for victims of domestic violence.

Espaço Júlia. RIAV – Integrated Victim Support Responses. Established through a partnership between the Lisbon Metropolitan Command, the Central Lisbon Hospital Centre and the Santo António Parish Council, provides an integrated response to victims of domestic violence. The multidisciplinary service is guaranteed by social security representatives and social action technicians. This prevents victims from having to enter police stations and providing an integral and integrated service from the outset.

(http://www.jfsantoantonio.pt/?p=4832)

› Promoting programs for domestic violence aggressors, integrating alcohol and other substance dependency and aggression control aspects, including gender equality contents.

With You Program, promoted by Cascais Municipal Council, in partnership with DGRSP – the General Directorate of Prisoner Social Reintegration and the Portuguese Foundation for the Study, Prevention and Treatment of Substance Abuse, seeks to prevent recurrence of domestic violence, intervening alongside spousal aggressors. It is based on the methodology implemented by another eponymous program implemented in the Azores. The wives of aggressors in this program have the Espaço V at their disposal, an attendance and guidance service for domestic violence victims, which integrates the Cascais Municipal Forum against Domestic Violence.

(http://www.cm-cascais.pt/sites/default/files/anexos/gerais/new/pmcvd_2014-2015.pdf)

› Carrying out health promoting actions for sex workers.

The **Gira Lua** project fits into the mobile health intervention unit of the Healthcare on Wheels project, promoted by the Seixal Municipal Council, and renders clinical and social support to persons engaged in street prostitution. Among the goals set, the prevention of risk behaviours associated with the practice of sexual labour, awareness-raising for the voluntary screening of sexually transmitted infections and other pathologies and the referral to social institutions and specialised appointments.

(http://redecidadessaudaveis.com/index.php/pt/projetos/seixal/gira-lua)

Social Action - Groundings
The motifs?

The European Charter for Equality of Women and Men in Local Life
Article 18 – Social inclusion

1. The Signatory recognises that everyone has the right to protection against poverty and social exclusion and furthermore that women, in general, are more likely to suffer from social exclusion because they have less access to resources, goods, services and opportunities than men.

2. The Signatory therefore undertakes, across the full range of its services and activities, and working with social partners, to take measures within the framework of an overall co-ordinated approach to:

- Promote the effective access of all of those who live or risk living in a situation of social exclusion or poverty, to employment, housing, training, education, culture, information and communication technologies, social and medical assistance
- Recognise the particular needs and situations of women experiencing social exclusion
- Promote the integration of migrant women and men, taking into account their specific needs.

(CMRE, 2006: 24)

The annual Standards of Living and Earnings Survey of households resident in Portugal reports that 19.5% of persons were at risk of poverty in 2014 but, and both before and after social transfers, women always displayed higher risks of poverty to those of men (respectively 45.7%/49.8% and 18.8%/20.1%).
(INE, 2015b)

› Arising out of gender inequalities, women find themselves in more vulnerable economic and social situations. Women are generally more exposed in periods of recession and austerity as they are from the outset the population group making most recourse to and dependent on the social support services generally targets by budget cuts.

In 2015, female single parent households accounted for 87.4% of total single parent households in Portugal.
(Pordata, 2016c)

› Households with children experience greater risks of poverty.

› Women have a longer average life expectancy than men that reflects in how they become the greatest beneficiaries of old age related support systems. Given this longer life expectancy, there are more elderly women than men living alone: 18% of women and 8% of men aged 65 or over live alone (INE, 2011a), which may bear implications both for their income levels and their isolation in society. The poverty risk of the elderly population living alone is also higher than in the population in general (26.8% in 2014).

› The consumption of prescription medication is greater in the female population: 62.7% against 48.6% of men (INE, 2015a). Women thus face higher healthcare expenditure in a factor that worsens with age.

› Women earn lower salaries than men, which impacts both on their earnings while working and on their subsequent pensions. In 2013, Eurostat estimated that the unadjusted monthly wage differential stood at 13% (EIGE, 2015).

› Elderly women, on average, receive pensions with very low average values due both to longer periods outside of the workforce and, when in employment, receiving lower salaries than those paid to men.

In 2005, the average Portuguese female pension who had worked in the private sector corresponded to 59.8% of that of men (€259.76 vs. €434.66).

In 2011, this differential had slipped back to 57.2% (the 1 002 516 female retirees received €304.40 and their 859 590 male peers received €531.76).

(Social Security Statistics, October 2011)

› Women are overloaded with rendering support to third parties. Caring for children, the sick, elderly and dependents predominantly falls upon females and hence they are also more indirectly effected by the availability and quality of support systems targeting these population categories.

› In 2014, the average social response coverage rate for early infant (crèches and baby-sitting) did not however reach 50% on mainland Portugal (GEP, 2015). Furthermore, pre-school is also not yet universal in Portugal. Recently (Law no. 65/2015, of 3 July), this universality was extended to children aged four and over but continues to fall short in the three year old age group.

The pre-school rate in 2013/2014 stood at 87.8% of the 3 to 5 age group and 96.1% for the over-5s, thus falling short of the target of 95% of children aged between four and the beginning of primary school as established under the EU 2020 program.
(CNE, 2014)

› The pre-school attendance rate overly stems from recourse to private teaching establishments that are not accessible to every family. In the 2013/2014 academic year, almost one half of children were attending pre-school in private schools, above all among the 3 to 4 age group and hence failing to be ensured by the public teaching system (CNE, 2014).

› The absence of accessible and quality responses for caring for children continues to represent a barrier to returning or remaining in the workplace. This situation impacts above all on women (mothers, grandmothers), generating consequences on both their autonomy and their earnings. This problem only worsens among poorer households and women who are not able to meet the costs of private education.

› This situation gets repeated across the shortfall in coverage for the elderly population and the dependent population. The social response coverage rate for the population aged 65 or over came in at 12.7% in 2014. In this same year, the average mainland coverage rate for the main responses required by this population (Residential Homes, Occupational Activity Centres and Domestic Homecare Services for dependent persons) stood at 3.8 % (GEP, 2015).

› The paid and unpaid division of labour holds consequences not only for the earnings and pensions of women but also for elderly men living alone and who did not develop over the course of their lives the competences necessary to ensuring their own autonomy in terms of personal and domestic care rendering them dependent on the formal or informal support of third parties to carry out daily tasks and requirements (Perista and Perista, 2012).

› Women are the major victims of domestic violence and hence also most dependent on the support structures and services targeting this social problem.

› The support policies for female victims of domestic violence continue to rest on the withdrawal of women and their respective children from the context due to the lack or ineffectiveness of measures to remove and restrain the aggressor, which frequently results in the loss of jobs, housing and the support of family and friends, exposing women to situations of economic and social vulnerability following their exiting of violent relationships. One of the main problems then confronted stems from the costs of housing (Guerreiro *et al*., 2015).

› Women with disabilities are correspondingly subject to dual discrimination. Among women with two or more healthcare problems or prolonged or chronic disease, 25% are unemployed against around 16% of men facing the same situation (INE, 2011b).

In the survey carried out under the "Inter-generations | Inter-Situations of Social Exclusion and Vulnerability Program", in 2013, in the city of Lisbon, homeless males accounted for 87% of the total population.
(SCML, 2014)

› The homeless community is predominantly made up of males. In a survey carried out in 2009 by the Ministry of Employment and Social Security, men represented 84% of the total homeless population.

› Some populations prove particularly vulnerable, especially immigrants and refugees and persons from the Roma community.

In a survey carried out in 2011 by the European Union Fundamental Rights Agency (FRA) in eleven member states, 80% of the Roma community members responding belonged to households at risk of poverty with the highest levels recorded in Portugal (almost 100%), Italy and France. In a survey carried out on the Roma community under the auspices of a National Study of the Roma Community, almost one half of respondents stated having experienced hunger. This happened despite 83.4% of persons indicating they were in receipt of social support.
(Mendes, Magano and Candeia, 2014: 202)

› Access to housing is one of the traditional problems faced by these population groups. The immigrant population especially suffer from the costs prevailing in the housing market, compounded by added demands and requirements made by landlords and banking institutions (Malheiros and Fonseca, 2011).

According to the National Roma Pastoral Work, almost 1/5 of the Roma population lives in shacks or tents.
(Parliamentary Ethics, Society and Culture Commission, 2009)

› Roma community members continue to experience dual discrimination in accessing housing; on the one hand in the private housing sector when seeking to rent or purchase and, on the other hand, in their access to public housing (Mendes, 2007; FRA, 2009).

› Some persons from minority cultural backgrounds, including the Roma community, are also subject to discrimination carried out by public services and institutions (Mendes et al., 2014: 215).

In 2014, there were 197 reported victims of human trafficking (182 in Portugal and 15 nationals abroad). The majority of the victims are women (123) and these account for almost the totality of victims of sexual exploitation (85 out of 86). In turn, men make up the majority of victims experiencing labour exploitation (54).

(Internal Security System, 2015: 72, 74)

› The trafficking of human beings that has Portugal as its country of origin, transit and destination afflicts women and men in different ways. Men experience a greater likelihood of labour exploitation and women of sexual exploitation (Projeto Euro TrafGuID, 2014).

› As happens in the healthcare sector, social support action is also fairly feminised especially as regards working directly with populations (for example, retirement home care staff), reproducing the image of women as the primary carers.

Principles and methodologies How to proceed?

› Local government entities, as the government bodies closest to the population, perform a central role in diagnosing and providing the means of responding to the needs of persons and household in social action fields.

› in order to meet the needs for social support, the local council should engage with the range of other institutional and sector actors in the council and correspondingly making recourse to its Social Network and CLAS – the Local Social Action Council.

› The Social Network is to, as stipulated by the respective legislative framework, "Integrate the objectives of fostering gender equality in keeping with the National Equality Plan in their planning instruments" (MTSS, 2006: 4277), establishing gender equality as one of its key guidelines for the actions and functions of its organs (art. 4).

› The set of entities involved, with a particular emphasis on the local government, should gather and collect the information necessary for decision making, both breaking down the administrative data (service standards, resources, support, etc.) by gender, and other socially relevant variables as well as undertaking survey processes whenever so justified.

› The most vulnerable populations, including women and other population groups, should be sounded out as regards their needs, expectations and desires within a broad reaching perspective.

› Representatives of women and other vulnerable population groups should be sounded out and the implications incorporated into the decisions regarding social actions.

› This should apply the principle of consultation and participation of the target population for the respective service. There should also be a suggestions/complaints system constantly available and periodically carrying out opinion surveys. The information returned by the suggestion and/or complaints system should be duly processed in order to facilitate its reading by the management responsible and correspondingly informing the planning and functioning of services and as well as responding to the person submitting the suggestion or complaint as quickly as possible.

› While suggestions, and above all complaints, may be made anonymously, the submission form should request information about the gender of whoever is making the suggestion and/or complaint similar to the case with other opinion questionnaires and surveys (García, 2006).

› The social actions structure should integrate, for consultation and for their human resources, persons belonging to the categories worked with (in addition to women, depending on the contexts, persons with Roma backgrounds, immigrants, former drug addicts, homeless, prisoners, etcetera).

The external evaluation report of the municipal Roma mediators program recommends an "openness to a system of possibilities" as a measure displaying a potentially positive impact on breaking down stereotypes around the Roma population, especially as regards their employability as well as ensuring the greater access and adhesion of this population to services. This expands the scope, for example, for the inclusion of Roma members as school assistants or their employment in contexts with high public visibility, such as by parish councils.

(Castro and Santos, 2015: 27)

› Women and other population groups in disadvantaged social situations should be considered as active actors in their own life projects and decision making.

› This requires training in gender equality for professionals working with vulnerable groups, especially through the running of training and awareness programs as well as through the inclusion of such materials onto qualifications in social service, social animation education programs as well as those training residential and other care assistants.

› Inclusive and gender based approaches require integrating into the career development training programs for all types of professionals acting in the social field, including operational and public service staff.

› All communications produced by the service relating to social action – written materials, images and signposting – should comply with the principle of gender equality (for example in Portuguese referring to both the male and female forms of "service users").

› The physical distance to the social action services may constitute a factor of inequality and an obstacle to their utilisation by more isolated members of the population. There is a need to guarantee the access of all persons to the social action services, whether made available through ensuring the means of getting to the service location, decentralising the service or even taking the service to the residences of these population (susceptible to integrating into healthcare services).

› In addition to service decentralisation, the social action structures should be multi-sectoral, enabling the integrated accompanying of each situation, thereby gaining in efficiency, quality and control over such situations.

› This should endow particular attention on the situation of women as the most vulnerable and, within these, especially the most elderly, including those living alone, bearers of disabilities, single female parent families and low paid workers.

› The integration of the gender equality dimension into inclusion policies reflects one means of improving the life of women in situations of greater socioeconomic vulnerability, striving to boost their access to resources, raising their social and economic status and generally empowering this group. It is thus essential to adopt measures for monitoring the social allowances awarded by the solidarity subsystem from the gender perspective as well as monitoring the situation of single parent households, especially those headed by females, who benefit from family welfare payments (PCM, 2013).

› Measures susceptible of encouraging active ageing require designing and implementing for both sexes that span the needs and opportunities of persons holding responsibility for providing assistance to dependent persons.

› As a result of the different processes of socialisation, elderly women tend to be more autonomous within the private domestic sphere and with elderly men tending to be more autonomous in the public space and hence the different needs require meeting in terms of the different responses and support services provided to each gender.

› Women are generally those who approach social support services but the decision making capacity within families frequently belongs to the males, in particular in older generations. The asymmetries of power between men and women, especially in older generations, requires countering but also needs taking into account by the social action support services (Perista and Perista, 2012).

› Every training program run, especially those targeting the unemployed or social reintegration welfare recipient populations, should include gender based perspectives.

› Integrated support structures for female victims of domestic violence and human trafficking need to be available and proximate. Municipality websites should contain visibly and easily accessible information about this subject. Whether via online or telephone, means of assistance and reporting should be available.

› Victim support services need to guarantee they reach female domestic violence sufferers living in rural contexts.

› Campaigns and interventions on domestic and gender violence should include specific details for disabled women taking into consideration their greater vulnerability and exposure to situations of risk.

› This should also ensure accessible facilities for the children of female victims of domestic violence in facilities caring for children in the council for the period of their autonomy building process.

› The victims of domestic violence, as well as other vulnerable single parent families, such as those headed by disabled women, should be granted priority in accessing social or supported housing. When the family is already in receipt of social housing, irrespective of the formal title, the victim should gain the right to remain in the home.

› Local council, as well as the other police and inspection entities, NGOs and trade unions, are core pieces in processes of signposting and helping the victims of human trafficking. The approach to victims should take into account gender not only in the effectiveness of identifying such cases but also because the patterns of exploitation are frequently sustained by this dimension (different sectors of exploitation, means of coercion, etcetera), as well as, following identification, rendering support and assistance to men and women in accordance with their specific needs. The needs of women require particular consideration in the fields of healthcare and housing (Euro TrafGuID Project, 2014: 13, 19).

› The local council should strive to promote measures facilitating access to housing by the immigrant population and to this end making recourse to mobilising the CLAII – Local Centres of Immigration Integration Support network. This should also involve awareness raising actions among banks and property owners not to discriminate against this population and their access to housing.

› This should ensure responses to the demand for facilities for caring for children, the elderly and other dependent persons. This requires an integrated information system for demand and the responses available at services for children, the elderly and dependent persons, constantly updated by council services and the entities running the respective facilities. These entities are to coordinate and interact so that all needs receive a proposal in response.

› Awareness campaigns should focus on the responsibilities of men in caring for dependent persons.

› Measures fostering the inclusion of the least represented gender in infrastructures providing care for children, the elderly and dependents.

› The rights of social action service users require securing. This needs, anonymous and confidential, mechanisms for exposing situations of discrimination in the provision of social action services.

› The decisions and interventions in social action fields at the local level should be underpinned by diagnosis of the council's situation in terms of gender equality.

Instruments
Which resources?

Below, we set out a list containing examples of questions for which answers are required within the framework of attempting to carry out any social action diagnosis from a gender based perspective. There are multiple stakeholders to involve in this diagnosis process ranging from political decision makers, particularly at the council level, and the public and private entities operating in the social action field, without forgetting women and gender equality associations and alongside other tertiary sector representatives. CLAS – the Local Social Action Council, as a body for aggregating the diverse entities acting within the council performs here a central role. The set of indicators proposed in table 4 requires application in responding to the priority questions.

› Table 3 – Examples of gender diagnosis equality questions for the social action field

What are the main differences, in socioeconomic terms, between men and women of a working age in the council?
What are the socioeconomic conditions of elderly persons in the council, especially the females? What are the main needs of elderly women and men? What initiatives /actions have been developed to support the elderly population taking into consideration their gender differences?
Are there active ageing policies for both genders? When yes, are the policies flexible enough for persons who have care responsibilities for other persons?
Who makes most recourse to social action services in terms of gender, age, ethnic group, type of problem, etcetera?
What are the socioeconomic conditions of single parent families in the council, especially those headed by females? What are the main needs? What actions have been undertaken to improve the living standards of these families?

› Table 3 – Examples of gender diagnosis equality questions for the social action field

What is the domestic violence situation in the council? What resources are available for victims of domestic violence and the respective interconnections among services? What initiatives /actions have been developed to improve the quality of support provided in identifying and caring for victims of domestic violence?
What initiatives /actions have been developed to support victims leaving violent situations and the subsequent support for their social integration? Is there an integrated structure for this goal?
What are the socioeconomic situations of ethnic minorities in the council? What are the main needs in terms of gender based issues? What initiatives /actions have been developed to support the integration of ethnic minorities? Who do they target?
What is the prevalence of homelessness in the council? What initiatives have been implemented in support of this population?
What is the coverage of childcare facilities (crèche and pre-primary)? What are the main needs prevailing in the council? What initiatives /actions have been taken to meet any eventual needs?
What is the coverage of pre-school teaching taking into account the public sector and the private sector? What initiatives/ actions have been taken to meet any eventual needs?
What is the coverage of facilities for the elderly and dependent persons? What are the main needs experienced? What initiatives/actions have been taken to meet any eventual needs?
What is the quality of service and treatment of more vulnerable populations? What initiatives have taken place in terms of inclusion and gender equality for persons working most closely with these populations? What type of professionals have been covered? And what entities /institutions?
Have initiatives been developed for the inclusion and participation in decision making by populations covered by social action? What type? What type of population has been targeted?

› Table 4 - Indicators for gender in the social action area

Area	Designation	Source
Statistical information available at the council level		
Population/Households	Masculinity relationships	Statistics Portugal, PORDATA
	Index of ageing	Statistics Portugal, PORDATA
	Index of elderly dependence	Statistics Portugal, PORDATA
	Index of youth dependence	Statistics Portugal, PORDATA
	Average household size	Statistics Portugal, PORDATA
	Family households by type and by council and parish	Statistics Portugal, Census, Family Household Tables
	Family households by no. of dependents, by council and parish	Statistics Portugal, Census, Family Household Tables
	Family households by economic activities (restricted definition) of household members and no. of dependents, by council and parish	Statistics Portugal, Census, Family Household Tables
	% of female single parent households in the total of single parent households	Statistics Portugal, Census, Family Household Tables
	Female single parent households by the mother's level of education, by council and parish	Statistics Portugal, Census, Family Household Tables
	Male single parent households by the father's level of education, by council and parish	Statistics Portugal, Census, Family Household Tables
	Unemployment resident population by age group, by level of education and sex, by council and parish	Statistics Portugal, Census, Population
	Female residents with non-economically active dependents by age group, by economic activity status, by council and parish	Statistics Portugal, Census, Population
	Non-national population that requested residency status by sex	Statistics Portugal, Regional Statistic Yearbooks
	Non-national population with legal residency status bysex (no.)	Statistics Portugal | SEF/MAI, PORDATA
	Non-national population with legal residency status by some nationalities (no.)	Statistics Portugal | SEF/MAI, PORDATA

› Table 4 - Indicators for gender in the social action area

Area	Designation	Source
Inactivity, unemployment and protection	Inactivity rate by sex according to the census (%)	Statistics Portugal, PORDATA
	Social security and state sector pensioners in the total resident population aged 15 or over	CGA/MEF, ISS/MSESS, Statistics Portugal, PORDATA
	No. of beneficiaries of social security unemployment benefits, by sex	II/MSESS, PORDATA
	Amount and number of days of Social Security unemployment benefit by sex	Statistics Portugal, Regional Statistic Yearbooks
	No. of Social Security unemployment subsidy beneficiaries, by sex	II/MSESS, PORDATA
	No. of Social Security sickness beneficiaries, by sex	II/MSESS, PORDATA
	No. of Social Security first parent subsidy beneficiaries, by sex	Statistics Portugal, Regional Statistic Yearbooks
	No. of RSI social inclusion beneficiaries, by sex	II/MSESS, PORDATA
	No. of registered unemployed persons, by age group and sex	IEFP, Unemployment Records by Council, Monthly Statistics
	No. of registered unemployed persons, by level of education and sex	IEFP, Unemployment Records by Council, Monthly Statistics
	No. of persons placed in employment, by sex	IEFP, Unemployment Records by Council, Monthly Statistics
	Unemployed persons registered at professional employment and training centres, by sex	IEFP/MSESS, PORDATA
	Unemployed persons registered at professional employment and training centres, by sex	IEFP, Unemployment Records by Council, Monthly Statistics
Social Responses	Social response coverage rate: crèches and nurseries	Social Charter
	Real rate of pre-schooling	DGEEC/MEC
	Social response coverage rate: Day-care Centres, Elderly Person Residences and Homehelp Services	Social Charter

› Table 4 - Indicators for gender in the social action area

Area	Designation	Source
Statistical information produced or gathered by local councils		
Social Protection	% of parents that take full period of parental leave	Social Security District Centre
RSI	No. of household recipients of RSI social inclusion and % of total no. of families in council	Local RSI inclusion benefit monitoring service
	No. of household recipients of RSI social inclusion, by family type	Local RSI inclusion benefit monitoring service
Guardians and caring for children, the elderly and other persons dependents	No. of children on pre-school teaching waiting lists, by age	School groups
	No. of children on waiting lists to attend AAAF – Family Support and Animation Activities, by parish	School groups
	No. of children on waiting lists to attend the CAF Family Support Component, by parish and according to education year	School groups
	No. of children and young persons on waiting lists to attend free-time activities, by education year	School groups
	No. of children and young persons on waiting lists to attend summer holiday free-time activities, by education year	School groups
	No. of elderly on waiting lists for social support responses, by type and sex	Private Institutions of Social Solidarity
	- No. of other dependent persons (physically or mentally disabled, etc.) on waiting lists for social support responses, by type and sex	Private Institutions of Social Solidarity
	No. of protocols in effect with Social Security for social support, by response type	Social Security
	No. of carers/ dependent persons, by sex, age and place of residence	Local Council
	No. of support actions provided to carers of dependent persons, by sex	Local Council
	No. of actions/initiatives promoting gender equality (GE) in the care of dependent persons	Local Council
	No. of children and young persons at risk identified by the CPCJ minor protection agency, by sex, age and type of problem	Children and Young People Protection Commission
	Type of family origin of children and young persons at risk	Children and Young People Protection Commission

› Table 4 - Indicators for gender in the social action area

Area	Designation	Source
Social action organisms and professionals	Representatives on the Local Social Action Council, by gender	Local Council of Social Action
	Number and % of representatives on the Local Social Action Council with GE training	Local Council of Social Action
	Number and % of social action team members with GE training, by sex and position	Local Council of Social Action
	No. GE awareness/training actions held for social action service staff, by type of person, entity and intervention area	Local Council of Social Action
	No. of professionals covered by GE awareness/training actions, by sex, staff title and area of intervention	Local Council of Social Action
Social action services and support	No. of student beneficiaries of school social action, by family type	Local Council, Regional Directorate of Education
	No. of households supported by the Local Council social action services and % in the total of council households	Local Council
	No. of beneficiaries of social action services, by area and sex	Local Council
	No. of beneficiaries of donated clothing, by sex	Local Council and Private Social Security Institutions
	No. of beneficiaries of donated medication, by sex	Local Council and Private Social Security Institutions
	No. of beneficiaries of purchased medication, by sex	Local Council and Private Social Security Institutions
	No. of beneficiaries of charity stores, by sex	Local Council and Private Social Security Institutions
	No. of beneficiaries of support payments (water, electricity, rent payments, medication, etc.), by sex	Local Council and Regional Social Security Office
	No. of persons in receipt of support from the Municipal Council social emergency fund, by sex	Local Council
	No. of persons in receipt of support from the Social Security social emergency fund, by sex	Regional Social Security Office
	No. of persons making recourse to the social emergency number, by sex	Social Security
	Number and % of beneficiary households of social electricity tariffs, bysex of the contract holder	Electricity suppliers
	Number and % of beneficiary households of social water tariffs, by sex of the contract holder	Water supplier
	Holders of social housing contracts, by sex and family type	Local Council
	No. of social housing /housing support requests, by sex and family type	Local Council

› Table 4 - Indicators for gender in the social action area

Area	Designation	Source
Social action services and support (cont.)	No. of priority housing cases, by sex of applicant	Local Council
	No. of beneficiaries of rent subsidies, by family type	Local Council
	No. of houses for female victims of domestic violence	Local Council
	No. of houses for disabled women	Local Council
	No. of houses for members of the Roma community	Local Council
	No. of houses for immigrants/refugees	Local Council
	No. of persons with cultural minority backgrounds performing roles in social action structures	Local Council
	Level of user satisfaction with the social action services, by service, sex and age	Local Council
Domestic violence	Complaints/reports of domestic violence, by victim sex	Public Security Policy/ National Republican Guard
	Complaints/reports of violence against elderly persons, by victim sex	Public Security Policy/ National Republican Guard
	No. of domestic violence victim care centres /shelters, by type of managing entity	Local Council
	No. of domestic violence victims (DVV) registered, by entity and victim sex	DVV support network entities
	No. and type of awareness/training action on domestic violence, by action running entity	Local Council of Social Action
	No. of persons in attendance at domestic violence awareness raising actions, by target public	Local Council of Social Action

With who?

Local councils should interact with a set of other entities in the development of their strategies and the programs proposed for the field of social action.

- Municipal Councils (social action department);
- Parish councils;
- CLAS - Local Social Action Councils;
- CIM – Inter-municipal communities;
- Ministry of Social Security and district social security centres;
- GIP – Professional Integration Offices;
- IPSS – Private Institutions of Social Solidarity;
- Professionals working in services and diagnosing needs and support in the social action area and responsible for facilities for the elderly and dependent persons (assistants, social welfare workers, service managers, etcetera);
- Professional social area associations;
- Domestic violence victim support structures and their professionals;
- Professional training institutions for social service and welfare workers and others in the social action field;
- Professional training institutions for elderly person facilities and other support professionals in the social action area;
- Women and gender equality promotion associations;
- Immigrant, homeless, disabled and other vulnerable group associations;
- Other NGOs;
- Researchers, research centres and universities;
- Media outlets (local, regional and national);
- Volunteers.

Best practices
What examples?

Below, we set out a list containing concrete examples of best practices. These should be adapted to each context and specific reality.

Information gathering and data production

› Fostering and/or supporting the carrying out of studies charting and portraying the situation of women in the council in terms of their earnings, living standards and social support.

› Gathering and analysing, broken down by gender and other relevant variables, the administrative data of relevance to social action.

Empowering women and establishing strategic partnerships

› Fostering the inclusion of representatives from associations representing women and other vulnerable groups on CLAS bodies and in local council social action services.

In 2014, the ILGA Portugal association ran, in collaboration with CIG, a two day initiative on **raising awareness about Discrimination and Violence against LGBT Persons** specifically aimed at Social Security staff from various parts of the country: Beja, Évora, Setúbal, Santarém and Lisbon.

(http://www.dgs.pt/?cr=26929)

Empowering strategic actors

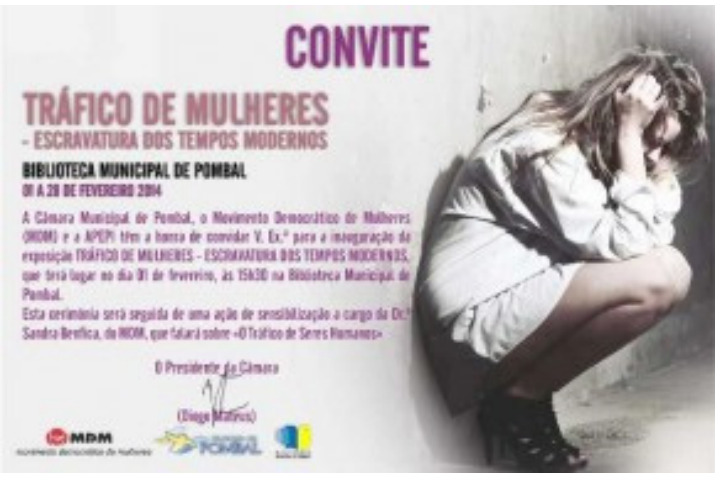
› Fostering inclusive training actions and gender equality for technical staff at local councils and other entities working directly with vulnerable population groups.

Advocacy, raising awareness and mobilising the community

› Supporting awareness campaigns and combatting human trafficking from a gender perspective.

Under the auspices of the **Briseida project – Combatting the trafficking of human beings for labour exploitation**, run by APAV, 2014 saw the launch of a campaign boosting knowledge and prevention designed for the public in general. The campaign, run through the website www.naoaotrafico.pt, included posters displayed in 21 municipalities from the north to the south of the country.

(CIG, 2015: 7)



The **Trafficking Women – Breaking Silences** project, organised by the MDM – Democratic Womens Movement, strives to generally deepen public knowledge and especially of women in particular as regards the trafficking of women. The project scope included the design of an exhibition and awareness raising actions that took place in various municipalities.

2012 saw the signing of the protocol with Lisbon Council for the development of the **Breaking Silence in Lisbon** project, which incorporated awareness raising actions, provided information and means of prevention targeting both the general public and specific publics.

(http://www.cm-lisboa.pt/viver/intervencao-social/igualdade/trafico-de-mulheres-romper-silencios-em-lisboa)

Gender equality in council practices and services provided to the community

› Decentralised structures in territorial terms and centralised in terms of the various social action services provided in the most isolated or problematic areas and with the greatest coordination of the services/supports provided.

GASP – Proximity Offices of Social Action run by Lagoa Municipal Council. Offices located in at risk territories enabling an expansion in proximity social intervention to every parish in the council, with technical staff made available by partner institutions and who, in close cooperation with the Municipal Social Action and Health Unit, enable the population to access the services and supports made available. The key objectives include identifying situations of need; measuring the responses presented by the diverse entities/services and citizens; and shaping and supporting the drafting and implementation of social programs and projects in accordance with the needs detected.

(http://www.cm-lagoa.pt/pt/794/gasp---gabinetes-de-apoio-social--de-proximidade.aspx)

› Mobile social support teams that can reach the most isolated and/or problematic locations and the populations most distant from accessing services.

Proximity Social Attendance and Support, an initiative run by Portimão Municipal Council in participation with the Portimão Healthcare Centre, Portimão and Mexilhoeira Grande Parish Councils, the Social Security District Centre and IPSSs in the council. This strives to raise the living standards of municipal residents in the peripheral zones of the council, providing psychological care, social support, advising on administrative procedures as well as delivering foodstuffs and clothing. The unit also provides healthcare services such as measuring blood pressure, glycemia and cholesterol testing, injections, other basic treatments, booking appointments, etcetera. This also distributes information of relevance to residents, especially about the local council, healthcare services, socio-cultural activities, etcetera. This is made up of a team including a social action technician and a nurse. The target group includes the elderly and family living in isolated locations and experiencing precarious economic and housing conditions.

(http://www.cm-portimao.pt/index.php/servicos-municipais/acao-social-e-saude/atendimento-e-apoio-social-de-proximidade)

› Integrated support and information services for municipal residents.

The **Agency for Local Life**, set up by Valongo Municipal Council, constitutes a particular structure within the context of social action policies. An open office where citizens may enter to obtain support and information on diverse matters. This is a structure endowed with the capacity to develop concerted activities with the various council departments with the advantage of dealing closely with the questions and issues arising out of conciliating personal and working lives, thereby seeking to strengthen citizenship and social cohesion. The Agency is also responsible for developing, among others, the following initiatives: i) Immediate Infant Spaces. Attributing five hours of childcare per week to families in specialist local facilities; ii) Time Bank. This is an adaptation of this concept designed for young persons and seeking to induce a spirit of responsibility and the capacity for autonomy from a logic of "supporting for receiving", and acting at the risk behaviour prevention level.

(http://www.cm-valongo.pt/)

› Setting up an information system and managing the searches and responses for care services for children, the elderly and dependents.

The communities in the Rhône (France) department provide a **specialist diagnostic service for ascertaining childcare needs**. This service undertakes the collection of data for each department and supports initiatives on the community scale. This also brings together the partners encharged with diagnosis and formulating the proposals for citizens.

In Rennes, and from a perception of equal opportunities and out of the concern for the wellbeing of children, a survey was made of parents with children in the collective crèches to ascertain their needs.

Mantes-la-Jolie, in turn, stands out for its services weighted in accordance with the different community components in the municipality: «recreational spaces» for parents and children, free-time workshops that foster the connection between the primary school and the priority housing targeting the Val Fourré population, a problematic neighbourhood.

› Guaranteeing/meeting the needs of families in receipt of the Family Support Complement, including equality in the proposals and pedagogical practices.

› Including integrated services for the promotion of gender equality and support for victims of domestic violence in local council provided services.

The SIGO – the Promoting Gender Equality Service run by Póvoa de Lanhoso Municipal Council is an attendance, monitoring, referring and information service for victims of domestic and gender violence. Based on a network of partners, this operates without added costs to the local council and the remaining partner entities, seeking to boost the effectiveness of already existing support measures. This includes a full time council telephone hotline for domestic violence victims. This regularly undertakes information actions focusing on the different local actors making up the Social Network; awareness campaigns targeting specific publics (families, children and young persons, teachers, local leaders, etcetera); organising and disseminating the information available about protection and support for situations of violence as well as intervening in emergencies. Beyond domestic violence, this also approaches issues such as equality of opportunity, human trafficking, female genital mutilation, bullying, etcetera.

Under the auspices of SIGO, the **Guide to Rights for the Promotion of Gender Equality** was produced and compiles a vast range of information about this issue and the respective dedicated council services.

(www.mun-planhoso.pt/accao-social-e-habitacao/servico-para-a-promocao-da-igualdade-de-genero.html)

› Supporting the functioning of gender equality and victims of domestic violence support services.

Balcão de Igualdade de Género (BIG)

BIG – the G**ender Equality Counter**, run by the APSD – the Portuguese Solidarity and Development Association, functions in Carnaxide parish in a store loaned by Oeiras Municipal Council. This ensures attendance, counselling and referring domestic violence victims and their assailants. The counter provides support across the psychological, social and juridical fields, also making available facilities appropriate to specialist group therapy for victims and perpetrators.

(http://www.cm-oeiras.pt/noticias/Paginas/BalcaodeIgualdadedeGeneroemCarnaxide.aspx)

› Enhancing the visibility of support/services/measures/information on domestic violence on local council websites.

The home page of the Póvoa de Lanhoso Municipal Council website visibly displays the "Domestic Violence Victim Helpline", ensuring information on this matter is also available by clicking through.

(http://www.mun-planhoso.pt/)

› Promoting or supporting integrated and mobile services for supporting victims of domestic violence and of human trafficking and dealing with perpetrators in accordance with the specific populations.

Touring Intervention Counters in the councils of Oeiras, Amadora and Odivelas, backed by the APSD – the Portuguese Association of Solidarity and Development in partnership with local councils and other entities. They target both national and non-national victims and perpetrators, providing an integrated and systematic response as regards information, attendance and psychological and juridical support across the fields of Domestic Violence and Human Trafficking.

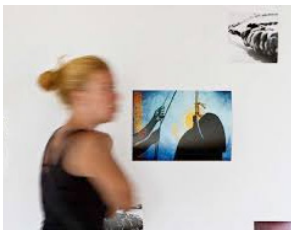
(http://www.apsd.pt/index.php/noticias/156--balcoes-de-intervencao-itinerantes)

› Providing housing to female victims of domestic violence, persons from the Roma community, immigrants and other vulnerable groups.

Housing pool for Female Victims of Domestic Violence (with various municipalities participating). Cooperation Protocol signed between the State Secretary for Parliamentary Affairs and Equality and the National Association of Portuguese Municipalities, with the objective of establishing a relationship of cooperation and awareness at municipalities over supporting the autonomy processes of domestic violence victims at the time of leaving sheltered accommodation. "The municipalities signing up to the protocol thus commit to including victims of domestic violence among their priorities in attributing social housing or, and in accordance with their option, making available housing that they hold in their assets for low cost rental schemes. Each municipality should therefore, whenever finding that the previously allocated housing has run out, deploy its social action services to render the support necessary to female victims of domestic violence in seeking housing in the rental market within their respective territorial area."

(http://www.apav.pt/apoios/index.php/protocolos-cartas-compromisso/protocolos/protocolo-de-colaboracao-de-apoio-as-mulheres-vitimas-de-violencia-domestica-entre-a-secretaria-de-estado-dos-assuntos-parlamentares-e-da-igualdade-secretaria-de-estado-da-administracao-local-e-reforma-administrativa-e-a-associacao-nacional-de-municipios)

› Integrating projects preventing and combatting human trafficking.



The **(En)Forced and (Un)Equal and Hands (Rein)Forced**, projects run by OIKOS according to a decentralised action methodology based on the capacity to achieve and multiply the core civil society structures involved in combatting trafficking in human beings, involves five municipalities: Barcelos, Braga, Guimarães, Póvoa do Lanhoso and Vila Nova de Famalicão.

(http://www.oikos.pt/traficosereshumanos/m2-oikos-contra-trafico.html)

› Establishing Municipal Plans/Programs for welcoming refugees.

Various municipalities, including Lisbon for example, already run, or are in the implementation phase, Municipal Plans for the Welcoming of Refugees through establishing protocols with entities working in this area alongside partnerships with local entities.

(http://www.am-lisboa.pt/documentos/1444307049B9bHL8dw2Fm66PP9.pdf)

› Remote service provision for the elderly and dependents.

The Remote Provision of Services for elderly and dependent persons are under implementation in various municipalities with one example that run by Serpa Municipal Council.

"At home and not alone" – Remote Homehelp Project, backed by the Serpa Municipal Council and Parish Councils (signposting). This is a remote domestic support service for the elderly and/or dependent populations with the objective of combatting loneliness and safeguarding security. Operated around the clock (24 hours per day and year round), this responds to users experiencing emergency situations: household accidents, sudden healthcare situations, panic, theft, fires and other situations that threaten user safety and security. This also responds to social need situations, for example isolation, through providing contact with the Central Desk, whenever users require. The service is free with the acquisition of equipment and monthly service support charges paid for by the municipality. The user incurs only the cost of the call.

(http://www.cm-serpa.pt/artigos.asp?id=1063)

› Provision of domestic social support to the elderly and dependent populations.

***Senior Minder Project*, promoted in partnership with Amadora Municipal Council and the "Os Vigilantes" association. This provides services designed to overcome needs through setting up a support network that visits homes. The main objective is to support the elderly and socially disadvantaged populations, whether because of lacking necessary resources or due to situations of family isolation. The main service is the distribution of meals during the week and at weekend as well as meeting other daily needs. The target public is the elderly population that, socially exposed and facing situations of isolation, visit Health Centres and Casualty Units not in the search for solutions to real healthcare problems but rather for social contact and interaction. The intervention contributed towards greater efficiency and effectiveness in healthcare service provision**.

(http://www.cm-amadora.pt/noticias-solidaria/1685-camara-municipal-apoia-os-seniores)

› Domestic home help services in support of the elderly and dependent populations.

Home Help Workshops, run by various municipalities whether by their municipal or their parish councils.

These are vehicles that visit households to undertake minor repairs. This seeks to support the elderly, citizens with mobility limitations and other disabilities through completing domestic tasks such as plumbing, electricity, woodworking and other small DIY type tasks.

› Means of compiling information for elderly persons.

Guide to Lisbon for the Advanced in Age.

Lisbon Municipal Council launched the "Lisbon Guide for the Advanced in Age", with the objective of raising the awareness and informing the senior population, their families and technical staff working in ageing fields about the resources existing in this area, such as public utility services, emergency, healthcare, social security, juridical support, culture and leisure services. The Guide information is subject to regular updating within the scope of the objective of encouraging active participation and fostering the rights of citizens and social inclusion, nurturing the conditions for the personal and social development of the senior population.

(http://www.cm-lisboa.pt/viver/intervencao-social/envelhecimento/guia-para-a-idade-maior)

› Institutional support and referral of homeless persons.

Project One Homeless Person, One Friend from the Conversa Amiga Association. The Project, ongoing since 2006, supplies emotional and human support in order to reduce loneliness. Making available time and motivation, this strives to ensure the homeless have somebody to actively listen to them and show concern: "a friend". This seeks to foster dignity and self-esteem, and find solutions, especially through referral to social responses, for each homeless person.

This project also extends to **"Street health",** which provides healthcare to this type of population in the city of Lisbon.

(http://conversa.pt/portfolio/projecto-um-sem-abrigo-um-amigo/)

› Fostering measures for desegregating the employment market, providing preferences, when other circumstances are equal, to the least represented gender in the support services provided in homes and other care institutions for dependent persons.

› Including representatives of disadvantaged and/or discriminated groups in services within the logic of diversifying experiences and the level of self-representation in decision making structures and interventions with these same groups

Municipal Roma Mediators Program, financed by the High Commission for Immigration and Inter-cultural Dialogue, which deploys a mediator for the training-working program in municipal services and/or projects in order to improve interventions in and dialogue with this specific community.

(http://www.programaescolhas.pt/conteudos/noticias/ver-noticia/4dd2aa058b7ec/projecto-piloto-mediadores-municipais)

› Establishing criteria for inclusive recruitment and the diversification of municipal services (for example, contracting Roma community members to work with this population within a logic of self-representation).

In the Oslo District of Grünerlokka – the Department of Diversity and Integration of Oslo Municipal Council –, established **criteria for recruitment able to foster the recruitment of persons with distinctive cultural backgrounds for municipal services,** bringing about diversity, proximity to problems and self-representation.

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