National Health Plan 2012 – 2016

4.2. Goal for the Health System - Promoting Supportive Environments for Health Throughout the Life Cycle

(January 2012)

National Health Plan
2012–2016

4.2 - PROMOTING SUPPORTIVE ENVIRONMENTS FOR HEALTH THROUGHOUT THE LIFE CYCLE

4.2.1. CONCEPTS **2**
4.2.2. FRAMEWORK **11**
4.2.3. GUIDELINES AND EVIDENCE **19**
4.2.4. VISION FOR 2016 ..... **23**

Health and well-being are the result of actions and opportunities that promote them and prevent the disease and its complications throughout the life cycle, within the environments in which it occurs.

4.2.1. CONCEPTS

WHAT IS THE RESPONSIBILITY OF THE HEALTH SYSTEM?

.1. **The Health System (SdS) assumes the responsibility for promoting, enhancing and preserving health, recognising individual potential, over the life cycle, at every moment and environment**.

REFER TO THE GLOSSARY:
Critical Periods, Window of Opportunity, Needs Assessment, Frail Elderly, Salutogenesis

WHAT ARE THE PROSPECTS FOR THE PROMOTION OF HEALTHY ENVIRONMENTS?

.2. Health does not accumulate but **results from a history of health promotion and prevention of disease and its complications, from the adoption of healthy behaviours and experiences in healthy environments.** Health losses may have a cumulative effect throughout life.

BOX 4.2.1 - STRATEGIC PROSPECTS FOR THE PROMOTION OF HEALTHY ENVIRONMENTS

- Identification of individual needs and strengths over the life cycle;
- Promotion of accountability on health in each environment;
- Multidisciplinary salutogenic culture.

- NEEDS AND STRENGTHS OVER THE LIFE CYCLE

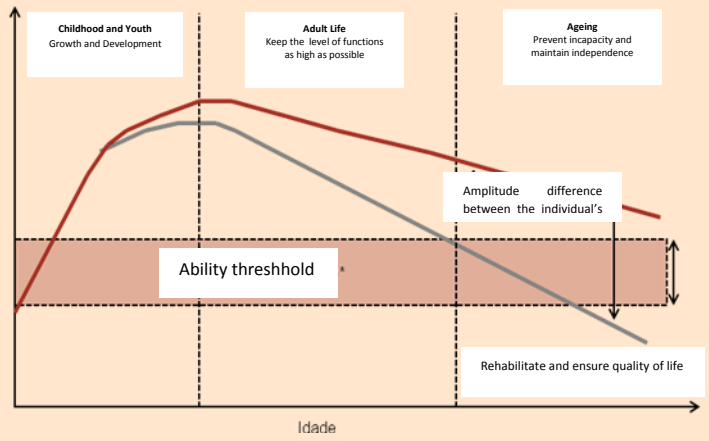
.3. The **individual health journey is not constant; it has specific needs and particularly important moments - CRITICAL PERIODS** (Health promoting Health Systems. WHO, 2009) which, depending on the way they arise, directly influence, positively or negatively, the following stages of life. The intervention in these moments - **WINDOWS OF OPPORTUNITY** - promotes and protects health and might have great relevance in the medium- and long-term. (Social determinants of health and the role of evaluation. WHO, 2010).

.4. The perspective of the life cycle approach:

- Highlights the **importance of early intervention** on risk factors, crucial for the prevention of chronic disease and its complications through screenings, early diagnosis and promotion of patient compliance, as well as the rehabilitation and/or integration of people with disabilities.

- Returns **gains in health and sustainability**, by strengthening a chain of maximisation of the positive effects or of mitigation of the negative effects of risk factors and determinants. Cumulative losses in health determine the early onset of disability and chronic and degenerative disease (FIGURE 4.2.1.). The Health System and healthy environments are protective factors and a key strategy for the growth of the elderly population not to be proportional to the increase of chronic disease (Fries JF *et al*, 1980).

FIGURE 4.2.1 - LOSS OF HEALTH CAPITAL OVER THE INDIVIDUAL JOURNEY.



Source: Active Ageing: A Policy Framework WHO, 2002.

.5. The life cycle approach allows:

- Promoting an **organisation and an integrated and continued intervention** including primary, hospital and integrated long-term care, on protective, risk and other factors, as well as on biological, behavioural and social determinants, among others, from family planning and birth to death;

- Guiding **society and healthcare** towards the assessment of needs and intervention opportunities, in critical periods and windows of opportunity, throughout the life cycle (Women, Ageing and Health: A Framework for Action, WHO 2007), which may integrate environments and the input of other occupations, ensuring better implementation and ongoing monitoring of care;

- Strengthening the **responsibility of society** for the specificity of critical periods and windows of opportunity of the healthy citizen and also of the acute and chronic patients and those in rehabilitation (Health-promoting Health Systems, WHO 2009).

BOX 4.2.2. - LEVELS OF HEALTH PROMOTING ENVIRONMENTS (EUROPEAN STRATEGIES FOR SOCIAL INEQUALITIES IN HEALTH, WHO, 2006; CONTINUUM OF CARE, WHO, 2010)

- **micro-system** : families, informal caregivers and proximity relations;
- **meso-system** : community, workplaces and leisure facilities, schools and universities, care institutions, volunteering, religious organisations, parish councils;
- **macro-system** : national or regional policies with impact on society, local authorities;

- PROMOTION OF ACCOUNTABILITY ON HEALTH IN EACH ENVIRONMENT

.6. These contexts, with an impact on the health potential of healthy, ill or disabled citizens, **are synergistic in creating opportunities for health promotion among themselves and with the health services**. Individual experiences take place in social, labour, institutional or other contexts, which are promoters of health and protectors of disease (European strategies for social inequalities in health, WHO,

2006), organising themselves as a salutogenic environment. Each context also has a potential health risk which should be properly recognised and minimised. Contexts with various levels may be considered (BOX 4.2.2), according to health determinants (see chapter on Healthy Policies). These are associated with life stages (e.g. schools, nursing homes), with stages of greater vulnerability (e.g. informal caregivers), or are cross-sectional (e.g. family or community).

.7. The perspective of promoting the individual health potential, in each context:

- Is a **prerequisite for the promotion of a holistic and positive culture of health**, where the environments are recognised and held accountable for their influence and contribution (through institutions and professionals);
- **Mobilises institutions, social and community resources in** the assessment of health needs, influence and ability to contribute, according to their specificity;
- **Promotes synergies between contexts and health services**, with the same responsibility and recognising complementarity, whether in health promotion, prevention of disease and its complications, rehabilitation or integration.

- MULTIDISCIPLINARY SALUTOGENIC CULTURE

.8. **Each profession or activity, in its context, impacts on health and on the well-being of individuals and the community in fields such as education, empowerment, identification of critical situations, adequate access to health services, and safety**, among others. Professionals must cultivate a **holistic and salutogenic perspective** of health and value their work also by its impact on health and well-being. Health shall result from a multidisciplinary work, in which each profession contributes with its knowledge and responsibility.

IMPACT OF NEEDS AND SPECIFIC CONTEXTS OVER THE LIFE CYCLE:

.9. Stages of the Life Cycle, as defined in the NHP 2004-2010, are defined as per Box 3.2.3. Death is also addressed in Dying with Dignity. For each step, the needs and specific health determinants are described.

BOX 4.2.3. STAGES OF THE LIFE CYCLE:

- **Be Born Healthy**, pregnancy and neonatal period;
- **Growing Safely**, post-neonatal up to 9 years;
- **Young People Seeking a Healthy Future**, 10 to 24 years;
- A **Productive Adult Life**, 25 to 64 years;
- An **Active Ageing**, over 65 years.
- **Dying with Dignity**.

- BE BORN HEALTHY

.10. **BE BORN HEALTHY** encompasses the health of pregnant women from conception until puerperium and the health of the embryo, foetus and new-born up to 28 days.

- Teen pregnancy (<20 years) or late pregnancy (> 35 years) are related to preterm births, poor weight progression and perinatal mortality. Births to young women are associated with social factors and inadequate healthcare. Older mothers have a higher prevalence of pregnancy complications, such as hypertension and diabetes, and the foetuses have higher incidence of congenital anomalies;
- Anomalies and preterm births are the leading cause of perinatal death in the EU. Low birth weight remains as one of the most important risk factors with impacts on health in the long-term (EUGLOREH, 2007);
- There is evidence of health benefits in the long-term from interventions at the level of:

i) Planning and follow-up of pregnancy; ii) Preparation for parenthood; iii) Healthy lifestyles of the pregnant woman (including the prevention of alcohol and tobacco consumption); iv) Preparation for childbirth; v) Breastfeeding; vi) Immunisation.

.11. The contexts that are particularly relevant to the pregnant woman are the work, family and community contexts.

- GROWING SAFELY

.12. **GROWING SAFELY,** from 28 days to 10 years of age, refers to several critical periods: first year of life; preschool age, until the age of 6; school age, from 6 to 10 years of age.

- Morbidity and mortality in children and young people is preventable through appropriate environments, safe housing, nutrition, potable water and healthy lifestyles, as well as accessible services. There are warning signs that predict the recurrence of infections such as tuberculosis; the increase of non-communicable diseases, such as asthma and allergies; and a new morbidity due to illegal substance abuse, injuries and mental disorders. Also the increase in socioeconomic inequalities causes adverse effects on children's health (WHO/Europe, website, 2011);

- The perinatal death is the leading cause of infant mortality and stems from prematurity and congenital malformations. Accidents are the most frequent cause of death among 1 to 14 year old children (EUGLOREH, 2007), including road accidents (39%) and drowning (14%) (Eur Report on Child Injury Prevention, WHO/Euro, 2008);

- There is evidence of health benefits in the long-term from interventions at the level of: i) Promotion of parental relationships; ii) Healthy lifestyles; iii) Prevention of risk behaviours, violence and abuse; iv) Early diagnosis and intervention; v) Health services adjusted to the child;

- It develops within the family context, in kindergartens and schools, places of leisure and sport, in communities and care institutions.

- YOUNG PEOPLE SEEKING A HEALTHY FUTURE

.13. **YOUNG PEOPLE SEEKING A HEALTHY FUTURE**, from 10 to 24 years of age, encompasses adolescence, from puberty until the age of 20, and youth, from 15 to 24 years of age. The practice of healthy lifestyles contributes to a better health throughout life, and childhood and adolescence are **privileged periods for the acquisition of healthy behaviours**.

- Period of great physical and psychological changes, at the level of social interaction and relationships. Suicide, violence and road accidents are the leading causes of death at this age. Others have to live with chronic or infectious diseases. The increase of chronic diseases in adolescents is an overburden to society and the Health System, over the coming decades (WHO/Europe website, 2010);

- In the EU, approximately 9,000 children and adolescents up to the age of 19 die annually in road accidents and 335,000 are injured. The highest proportion is among adolescents from 15 to 19 years of age (EUGLOREH, 2007);

- The number of overweight and obese children ranges between 5 and 25% in the EU (EUGLOREH, 2007), from 11 to 13 years of age, a risk factor for chronic disease associated with premature mortality. The consumption of alcohol at younger ages has been increasing;

- There is evidence of health benefits in the long-term from interventions at the level of: i) Promotion of parental relationships; ii) Healthy lifestyles; iii) Prevention of risk

behaviours, violence and abuse; iv) Support to mental health; v) Healthy relationships and family planning; vi) Health services adjusted to adolescents;

- It develops within the family; schools and universities; job integration; communities; leisure and sport facilities; care institutions.

- A PRODUCTIVE ADULT LIFE

.14. A **PRODUCTIVE ADULT LIFE** concerns the period from 25 to 64 years of age.

- In the European Union, the main causes of death are: cardiovascular diseases, cancer, accidents and injuries, poisoning and other consequences of external causes. Depression, anxiety and stress-related factors are the main causes of morbidity in the long-term. About 15 to 20% of adults in the European Union have already suffered from some mental health issue (EUGLOREH, 2007);

- Overweight and obesity are a cause of increased risk of hypertension, hyperlipidaemia and diabetes, due to the relationship between abdominal obesity and metabolic syndromes (EUGLOREH, 2007);

- Cancer is the second leading cause of death and morbidity, after cardiovascular diseases (WHO/Europe website, 2010);

- Differences between genders increase: higher mortality due to accidents, in particular labour and road accidents, for men, and morbidity due to problems related to reproductive health and mental health, for women. Increase in pathologies such as lung cancer due to the higher prevalence of smoking among females;

- There is evidence of health benefits in the long-term from interventions at the level of: i) Healthy lifestyles; ii) Promotion of mental health; iii) Control of risk factors such as overweight, arterial hypertension, smoking, alcohol, high cholesterol levels, poor fruit and vegetable intake and physical inactivity; iv) Adherence to screenings and early diagnosis interventions; v) Culture of active participation and accountability for one's own health; vi) Monitoring and self-management of chronic diseases; vii) Appropriate and specific responses by gender;

- It develops within the family context; places of work and leisure; in communities; in prisons and care institutions.

- ACTIVE AGEING

.15. **ACTIVE AGEING**, from the age of 65. Period with growing demographic and social expression, due to increased life expectancy that reflects medical advances and improved living conditions but represents a challenge to society, to the Health System and social protection system.

- This group is heterogeneous, and that should be considered in developing strategies: active elderly, elderly patient with chronic pathology, dependent; frail elderly, over 85 or any age but with multiple pathologies and functional decline due to the association of the effects of ageing and disease (Paw *et al.* 2003; Lally e Crome, 2007);

- The increase in life expectancy favours: i) Increase in chronic disease and comorbidities that are reflected in increased demand for healthcare; ii) Increased incapacity and dependency with variable burden for the family and the health system (e.g. increasing demand for diagnostic, therapeutic, rehabilitative and mental health procedures (Escoval, 2010); iii) Sustainability of social security;

- Cancer and cardiovascular diseases are the main cause of death. The most frequent diseases and disorders are those of the mental field, such as depression and

Alzheimer's. Also falls and accidents that reduce mobility and independence and increase the risk of premature death, arthritis, osteoporosis and cancer. Urinary incontinence, hypovitaminosis, memory, sight and hearing changes, and skin problems are factors of great vulnerability;

- Interventions should be based on the principles of autonomy, active participation, self-fulfilment and dignity of the senior citizen. These develop within the family context; places of work and leisure; in communities; in care institutions (e.g. nursing homes).

- DYING WITH DIGNITY

.16. **DYING WITH DIGNITY.** A patient is considered an **End-of-Life Patient (DeFTV)** when the clinical condition indicates that death is near, and the clinical decision is primarily geared towards symptoms relief.

- The End-of-Life Patient should be cared for with emotional understanding and respect, without futile therapies, at home or in the hospital, within a private and, whenever possible, family environment. All care should lead to a dignified, socialised, recognised and accepted death (CNECV, 1995);

- The End-of-Life Patient, in a situation of intense suffering caused by incurable disease at an advanced stage and rapidly progressive, requires palliative care which may promote the possible well-being and quality of life until death (CNECV, 1995).

STRATEGIES AND RESOURCES TO PROMOTE SUPPORTIVE ENVIRONMENTS FOR HEALTH OVER THE LIFE CYCLE

.17. The following are identified as **strategies and resources** to promote supportive environments for health:

- **Strategic management and sharing of operationalisation** between different sectors, with the ability to plan and mobilise social institutions and organisations (e.g. Community Councils of the ACES), integrated services (e.g. screenings at schools) and funding models, and use of common resources;

- **Orientation guidelines for the assessment of health needs** according to life cycle stage, gender, physiological status (e.g. pregnancy), and medical condition, adapted to local health resources and the different contexts, which may promote the identification of critical periods and windows of opportunity, articulation and integration of procedures;

- **Guidelines and protocols for cooperation and articulation between institutions and sectors** that promote the sharing of responsibility, foster synergies and optimise resources. These include assessment, communication and referral systems (e.g. between school and healthcare);

- **Multi-sectorial programmes**, capable of establishing diagnoses, potentials and referrals for easiness of intervention, articulation and integration of activities, strengthening multidisciplinary partnerships;

- **Management of multi-sectorial/interdisciplinary knowledge,** by identifying knowledge, best practices, research and innovation with impact on health, establishing spaces of communication and influence at the level of professionals and institutions; on the training of health or other professionals on the health potential of the different contexts;

BOX 4.2.4. - RESOURCES TO PROMOTE SUPPORTIVE ENVIRONMENTS FOR HEALTH OVER THE LIFE CYCLE:

- Strategic management and operationalisation shared between different sectors;
- Guidelines for needs assessment and multi-sectorial interventions;
- Guidelines and protocols for cooperation and articulation between institutions and sectors;
- Multi-sectorial programmes;
- Management of multi-sectorial/interdisciplinary knowledge;
- Systems for information, monitoring and assessment of the health status and impact on health;
- Communication, training and empowerment of citizens and informal caregivers.

- **Systems for information, monitoring and assessment of the health status and impact on health which allow:**
  - **Monitoring the influence of each context** such as epidemiological surveys, detection and signalling systems, epidemiological surveillance, among others;
  - **Identifying characteristics that promote and protect health** for each context;
  - **Integrating actions across sectors** (e.g. school and health) in order to avoid fragmentation of care and promote synergies between them.
- **Communication, training and intersectoral empowerment of citizens and informal caregivers for health.** Health messages and education opportunities will be maximised if consistently conveyed and promoted within the several contexts of experience.

BOX 4.2.5. - OPPORTUNITIES ARISING FROM THE PROMOTION OF SUPPORTIVE ENVIRONMENTS FOR HEALTH THROUGHOUT THE LIFE CYCLE:

AT THE LEVEL OF SOCIETY:

i) Strengthening of the salutogenic approach, adapted to the needs;

ii) Greater social expectation on intersectoral cooperation and shared responsibility in the definition of policies and actions;

iii) Enhancement of Health System stakeholders as partners, integrating the social, private and health sectors and family, work and school contexts;

iv) Reduction of the burden of disease as a result of an effective and customised investment, aligned between stakeholders.

AT THE LEVEL OF POLITICAL DECISION-MAKING:

v) Strengthening of the accountability and culture of planning and multi-strategic intervention;

vi) Increased evidence and best practices in planning and intersectoral and multi-institutional intervention, networking and institution participation.

AT INSTITUTIONAL LEVEL:

vii) Sharing of resources, management mechanisms, knowledge and strategies. Strengthening of local health strategies;

viii) Empowerment, transparency and social accountability, intervention capacity, evidence and identification of the best practices;

ix) Valuing social responsibility of institutions and their professionals.

AT THE LEVEL OF HEALTH PROFESSIONALS:

x) Strengthening of the network of support and work in other sectors, according to the needs of citizens;

xi) Ability for an intervention that promotes health, prevention and early diagnosis of the disease in other contexts;

xii) Action and knowledge that facilitate interventions and multidisciplinary strategies, within teams and among institutions.

AT THE LEVEL OF CITIZENS:

xiii) A culture of health and well-being which is coherently valued, extended and integrated, into all contexts of life, with greater support to the desire of leading a healthy life.

BOX 4.2.6. - THREATS TO THE PROMOTION OF SUPPORTIVE ENVIRONMENTS FOR HEALTH OVER THE LIFE CYCLE:

AT THE LEVEL OF SOCIETY:

i) Lack of perception as to the limitations arising from non-articulated or non-coherent actions across sectors;

ii) Society dazzled by technological breakthroughs and that devalues salutogenic behaviours;

iii) Orientation of the society towards the creation of economic wealth, within a highly competitive context that devalues health, quality of life and well-being as at least an equally important social purpose.

AT THE LEVEL OF POLITICAL DECISION-MAKING:

iv) Lack of capacity-building and/or *empowerment* of institutions for fulfilling local health strategies;

v) Low investment in individualised and integrated actions, within contexts of experience;

vi) Instability in the professionals' availability and capacity, and non-articulated changes in policies and priorities.

AT INSTITUTIONAL LEVEL:

vii) Resistance in assuming shared responsibility within contexts of other sectors;

viii) Difficulty in assessing the medium/long-term impact of multi-sectorial actions on the population's health status;

ix) Lack of incentive to sharing resources, management mechanisms, information and knowledge between institutions;

x) Shy sectorialised and non-integrated investment policies as regards the promotion of health and the prevention of disease.

AT THE LEVEL OF HEALTH PROFESSIONALS:

xi) Difficulty in sharing perspectives and languages of other sectors and in understanding the potential impact on health of other sectors' operations;

xii) Lack of training and skills for inter-sectorial and multidisciplinary work;

xiii) Difficulties in integrating the inter-sectorial and multidisciplinary relationship in case management and risk management, due to a lack of conditions for an appropriate response to the needs of the citizen/family.

4.2.2. FRAMEWORK

.1. The framework is developed according to **LIFE CYCLE and CONTEXTS**, with the following organisation:

i) Analysis of the health situation;

ii) Policies, strategies, resources and interventions;

iii) Areas with intervention recommendations to consider.

LEGAL, LEGISLATIVE, REGULATORY AND STRATEGIC FRAMEWORK

.2. The **National Health Plan 2004-2010**, in *Strategies for obtaining more health for all*, promotes an approach centred on family and life cycle and the integrated management of the disease through programmes and based on contexts (NHP 2004-2010). The indicators and targets of the NHP 2004-2010 were monitored by the ACS (ACS, 2010, WebSIG).

LIFE CYCLE:

- BE BORN HEALTHY

.3. **HEALTH SITUATION** (see Box 4.2.7.):

- The main causes of mortality are: prematurity and low birth weight associated with increasing maternal age, infertility, gemelarity and smoking; congenital malformations (NHP in focus, ACS 2008). Vulnerable groups, such as immigrants, show worse results in these indicators (Immigrants, Machado *et al*, 2007);
- Complications in the perinatal period are the 2nd cause of PYLL from causes considered amenable to healthcare and to health promotion.

BOX 4.2.7. - BE BORN HEALTHY

Evolution of NHP 2004-2011 Indicators (ACS, Dec 2010)

Target met:

% of adolescent births
Foetal mortality rate
Perinatal mortality rate
Neonatal mortality rate

On the way to the target:

Life expectancy at birth
Perinatal mortality

In the opposite direction:

% of births to women> 35
% of preterm births
% of children with low birth weight
% of births by caesarean section

Not monitored:

% of women who breastfeed exclusively for the first three months
% of women who smoke during pregnancy

.4. The following support the drafting of **policies related** to pregnancy and the perinatal period:

- **National Commission for Maternal, Child and Adolescent Health (CNSMCA)** (Order No. 21929/2009), advisory body to the MS, with the mission to develop programmes and activities in areas such as health promotion, quality, equity and access, available resources, prenatal diagnosis, domestic violence, teen pregnancy, promotion of healthy environments. The CNSMCA coordinates with **Regional Committees of Maternal and Child Health** (Order No. 9871/2010), available in 3 ARSs (North, Centre and Lisbon and Tagus Valley);
- **Functional Coordinating Units (UCF) of Maternal and Neonatal Health** (Order No. 9872/2010), articulation between Primary and Hospital Care;
- **Exemption from user charges** (DL No. 173/2003) for pregnant women, recent mothers and children under 12 years of age.

.5. As organised **strategies and interventions** for the promotion of health at this stage of the life cycle, we highlight:

- **National Committee for Maternal and Neonatal Health Programme** (2006);
- **Programmes of the DGS**: National Shared Assistance Plan for Pregnant Women, Newborns, Children and Adolescents; Maternal and Child Health Handbooks (1975); Maternal and Child Referral Network (2001); Model Programme of Action for the Health of Children and Young People (2002); National Vaccination Programme (2006); Action for the Health of Children and Young People at Risk (Order No. 31292/2008);
- The follow-up of pregnant woman and new-borns is of the responsibility of Primary Health Care, of the Doctor and Nurse, in articulation with hospital care in risk situations. An unknown percentage of pregnant women and children is followed by Obstetricians and Paediatricians in the private system.

.6. Areas with **intervention recommendations to consider**:

- Family planning and control of abortions;
- Adequate follow-up of pregnant women in Primary Health Care and of risk pregnancy in reference services;
- Prevention of prematurity and low birth weight and appropriate postnatal care in these situations.

- GROWING SAFELY

.7. **HEALTH SITUATION** (see BOX 4.2.8.):

BOX 4.2.8. - GROWING SAFELY

Evolution of NHP 2004-2010 Indicators (ACS, Dec 2010)

Target met:

Life expectancy from 1 to 4 years;

Infant mortality rate;

Mortality rate from 1 to 4 years;

Mortality rate from 5 to 9 years;

Risk of dying before 5 years of age.

- BOX 3.2.6. shows the evolution of the previous NHP's indicators. The infant mortality rate has fluctuated over the past three years (3.4 ‰ in 2007; 3.3‰ in 2008; 3.6 ‰ in 2009) due to increased perinatal mortality, prematurity and congenital anomalies of the circulatory system;
- From 1 to 4 years, mortality is related to external causes, including accidents. Risk situations emerge, such as childhood obesity, chronic disease and rare diseases, childhood depression, cancer, neglect and abuse, and special education needs, among others (Machado, 2009);
- Road accidents are the no. 1 cause of PYLL from causes considered amenable to healthcare and to health promotion.

.8. As organised **strategies and interventions** for the promotion of health at this stage of the life cycle, in addition to those identified in the previous stage, including the National and Regional Committees and programmes of the DGS, we highlight the following:

- **Programmes of the DGS:** Implemented in the 5 ARS - National School Health Programme (Order No. 12045/2006); Action for the Health of Children and Young People at Risk (Order No. 31292/2008). National System for Early Childhood Intervention (DL No. 281/2009).

.9. Areas **with intervention recommendations to consider**:

- Prevention of prematurity and low birth weight and appropriate postnatal care in these situations (cited above);
- Prevention of accidents, obesity and childhood depression;
- Early intervention in cases of rare diseases and disability.

- YOUNG PEOPLE SEEKING A HEALTHY FUTURE

.10. **HEALTH SITUATION** (see BOX 4.2.9.):

- BOX 3.2.9. shows the evolution of NHP indicators. Noteworthy is the increase in obesity, smoking (more pronounced in females) and alcohol consumption, in particular from 15 to 24 years of age;
- Road accidents are the 1st cause of PYLL from causes considered amenable to healthcare and to health promotion;
- The main cause for hospital admission among youths is respiratory disease.

BOX 4.2.9. - YOUNG PEOPLE SEEKING A HEALTHY FUTURE

Evolution of NHP 2004-2010 Indicators (ACS, Dec 2010)

Target met:
Life expectancy from 15 to 19 years;
Adolescent births.

On the way to the target:
Mortality rate from 10 to 14 years;
Mortality rate from 15 to 19 years;
Mortality rate from 20 to 24 years;
Self-appreciation of health status.

In the opposite direction:
Tobacco consumption;
Alcohol consumption;
Overweight and Obesity.

.11. The following support the drafting of **policies addressed to youth**:

- **National Commission for Maternal, Child and Adolescent Health and Regional Commissions**, cited above.

.12. The following are the **specific the legal frameworks** of this stage of the life cycle:

- **DL No. 259/2000,** adolescents as priority intervention group in reproductive health and in the prevention of sexually transmitted diseases; it creates consultations at CSP, as a friendly and interactive space. E.g.: *Aparece* (1999) at the Primary Care Centre of Lapa; *Olá Jovem*, at the Primary Care Centre of Amadora (2001);
- **DL No. 259/2000, Law No. 120/99**, reinforce the right to reproductive health, set the conditions for promoting sex education and youth access to healthcare (sexuality and family planning);
- **DL No. 259/2000, Sex Education in Schools**, establishes the implementation regime of sex education in schools and its contents;
- **Order No. 9871/2010**, extension of the paediatric age group up to 18 years;
- **Exemption from user charges** for children under 12 years of age (DL No. 173/2003).

.13. Other health programmes and activities:

- **Of the DGS, other than those mentioned:** National Youth Health Programme (2006), HPV vaccine (2007) in the 5 ARSs; National Programme for Prevention and Control of Chronic Obstructive Pulmonary Disease in 3 ARSs (North, Centre and LVT); National Programme for the Control of Asthma in 2 ARSs (North and LVT);
- **Programmes of the National Institute of Drug Addiction (IDT)/Service for Intervention on Addictive Behaviours and Dependencies (**SICAD): National Programme for the Reduction of Alcohol-Related Problems (2009-2012); National Plan against Drugs and Drug Addiction (2009-2012); Action Plan against Drugs and Drug Addictions (2009-2012);
- **Of the Portuguese Youth Institute (IPJ): Cuida-te** (Take Care of yourself) Programme (Ordinance No. 655/2008), intersectoral with the public and private sectors (e.g. ACS, ARS, Portuguese Sports Institute). It is characterised by the use of **Mobile Units**; **Training**; creation **Youth Health Offices**. **Youth Health and Sexuality Offices** (in the 5 ARSs) with health professionals (doctors and psychologists).

.14. **Areas with intervention recommendations to consider**:

- Health determinants: reduction of tobacco and alcohol consumption; promotion of physical activity, safe sex, and safe and responsible driving;
- Control of chronic respiratory diseases, including asthma;
- Management of chronic illness;
- Control of teenage pregnancy;
- Expansion of the system for the exemption from user charges, coincident with the paediatric age.

- A PRODUCTIVE ADULT LIFE

.15. **HEALTH SITUATION** (see Box 4.2.10.):

- Regarding the evolution of indicators**,** life expectancy has gradually increased, with circulatory diseases (IHD and stroke), malignant tumours and respiratory diseases still as the main causes of death;
- The following are identified as the main causes of PYLL from causes considered amenable to primary healthcare, in decreasing order of years lost: accidents with motor vehicles; malignant tumour of the trachea, bronchus and lung, chronic liver disease (INE, 2010);
- The main PYLL from causes considered amenable to healthcare include: malignant tumour of the female breast; stroke; ischemic heart disease (INE, 2010);

BOX 4.2.10. - A PRODUCTIVE ADULT LIFE

Evolution of NHP 2004-2010 Indicators (ACS, 2010) (2005/2006 for INS's indicators)

Target met:

Life expectancy from 45 to 49 years;
Premature Mortality Rate (<65 years) due to Ischemic Heart Disease;
Premature Mortality Rate (<65 years) due to Stroke.

On the way to the target:

Mortality rate from 25 to 44 years;
Mortality rate from 45 to 64 years;

In the opposite direction:

Births in women aged 35 or more;
Mortality due to female breast cancer;
Mortality due to cervical cancer under the age of 65;
Daily consumption of tobacco from 25 to 44; from 45 to 64 years;
Overweight and obesity.

- Arterial hypertension and obesity are the main risk factors, and diabetes has also been increasing (Diabetes: Facts and Figures, 2010) as well as disorders related to mental health.

.16. The following support the **drafting of health policies** for this stage of the life cycle:

- **Programmes of the DGS/ACS**: Implemented in the 5 ARSs - National Programme for Cardiovascular Diseases; National Programme for Prevention and Control of Oncological Diseases; National Mental Health Plan; Prevention and Control of HIV/AIDS**;** National Programme for Prevention and Control of Diabetes (2008); National Programme Against Obesity (2005) and National Platform Against Obesity; Prevention and Control of Healthcare-associated Infections. In 3 ARSs - National Programme for Integrated Intervention in the Determinants of Health and Lifestyles (North, Centre and the Algarve). In 2 ARSs (North and LVT) - National Programme for Pain Management (2008). Not implemented - Accident Prevention Programme;
- **Programmes of the IDT/ SICAD**: National Programme for the Reduction of Alcohol-Related Problems (2009-2012), National Plan against Drugs and Drug Addiction (2009-2012) and Action Plan against Drugs and Drug Addictions (2009-2012);
  - The **Regional Offices** manage the local intervention units (Centres of Integrated Response - CRI) that provide direct and personalised intervention in the fields of Prevention, Treatment, Risk Reduction and Mitigation of Damages, and Rehabilitation, and the **Specialised Units** which integrate Rehabilitation Units, Therapeutic Communities and Alcoholism Units;
  - Their strategies are: citizen-centred; in active partnership with civil society and shared

responsibility; proactivity and proximity policies; prevention in school, work and family environments;

- They have seven priority areas of intervention: Young people, children and pregnant women; Road Accidents; Adults and Working Environment; Prevention, Training, Communication and Education; Information and Data Collection Systems; Treatment; Reintegration.

.17. The following are the **relevant legal frameworks** for this stage of the life cycle:

- **Exemption from user charges** for people with chronic diseases, blood and bone marrow donors, as well as vulnerable and low income groups (DL No. 173/2003; Order No. 6961/2004; Ordinance No. 349/96; DL No. 201/2007; DL No. 38/2010; Ordinance No. 1319/2010).

.18. Areas **with intervention recommendations to consider**:

- Promoting safe and responsible driving;
- Primary, secondary and tertiary prevention of oncological diseases;
- Primary, secondary and tertiary prevention of cardiovascular and cerebrovascular diseases;
- Health determinants and healthy lifestyles: reduction of tobacco and alcohol consumption; promotion of age-appropriate physical activity and a healthy diet; safe sex;
- Management of chronic illness.

- ACTIVE AGEING

.19. **HEALTH SITUATION** (see Box 4.2.11.):

- Tumours, cardiovascular, respiratory and digestive diseases are the leading causes of death;
- The level of health of the population in nursing homes is unknown, as well as the responses at the level of health that those institutions have to offer.

BOX 4.2.11. - ACTIVE AGEING

Evolution of NHP 2004-2010 Indicators (ACS, 2010)

Target met:

Life expectancy from 65 to 69 years.

On the way to the target:

Negative self-perception of health status (65 to 74 years).

In the opposite direction:

Daily tobacco consumption from 65 to 74 years of age;
Overweight from 65 to 74 years of age;
Obesity from 65 to 74 years of age.

.20. The following support the **drafting of health policies** for this stage of the life cycle:

- **DGS Health Programme: Implemented in 1 ARS (Alentejo) - National Programme for the Health of the Elderly (**Normative Resolution No. 13/DGCG; DGS, 2004**). Implemented in 2 ARSs - National Programme for Pain Management (North and LVT). National Oral Health Programme, specific area for this age group.**

.21. The following are the **relevant legal frameworks** for this stage of the life cycle:

- **Exemption from user charges** covering citizens over 65 years of age. (DL No. 173/2003; Order No. 6961/2004; Ordinance No. 349/96; DL No. 201/2007; DL No. 38/2010; Ordinance No. 1319/2010).

.22. As organised **strategies and interventions** with an impact on the promotion of health at this stage of the life cycle, we highlight:

- **National Long-term Care Network,** implemented in the 5 ARSs although still insufficient in Lisbon and Oporto. In 2010, 24,004 patients were referred, of which 79.9% were over 65 years of age and 40.3% over 80 years of age. It is part of the **National Palliative Care Programme**, implemented in 3 ARSs (North, Alentejo and the Algarve);
- Great diversity of responses from social security and the 3rd sector: Solidarity supplement for the

elderly (ObSS, 2009); Dependence supplement (Decree-Law No. 265/99 of 14th July); Survivor's pension (Decree-Law No. 322/90, of 18th October 1990); Social old-age or disability pension (Decree-Law No. 208/2001 of 27th July 2001. Portuguese Official Gazette I, Series A); Old-age pension (Decree-Law No. 187/2007 of 10th May 2007); User charges (Ordinance No. 1637/2007 of 31st December 2007). Despite this support, it turns out that "of the 25 EU countries, Portugal is ranked fourth in the percentage of elderly people living in poverty. 29% of the population over the age of 65 is at risk of poverty, with an income below 60% of the average income (Zaidi *et al*, 2006).

.23. Areas with **intervention recommendations to consider**:

- Management of Chronic Illness and multiple pathology;
- Health determinants and healthy lifestyles: reduction of tobacco and alcohol consumption; promotion of age-appropriate physical activity and a healthy diet; safe sex;
- Promotion of autonomy;
- Fight against exclusion/social isolation.

HEALTH-PROMOTING CONTEXTS

.24. Following the continuity and expansion of the contexts included in the NHP 2004-2010, the following are now included: family, schools, kindergartens, universities, workplaces, places of sport and recreation, leisure facilities, care facilities (nursing homes, care for people with disabilities, care for children and women at risk), prisons, communities (BOX 4.2.12.).

BOX 4.2.12. HEALTHY LIFE-PROMOTING CONTEXTS:

- **Family;**
- **Kindergartens, schools, universities;**
- **Workplaces;**
- **Places of recreation, sport and leisure;**
- **Care institutions** (homes, boarding schools, care for people with disabilities, care for women and children at risk);
- **Prison context;**
- **Communities**.

- SCHOOLS

.25. **HEALTH SITUATION** (see BOX 4.2.13.) The percentage of students with a health check-up at 6 and 13 years of age remains insufficient.

.26. The following are **specific health programmes** within this context:

- **DGS Health Programmes**: **National School Health Programme** (Order No. 12045/2006), implemented in the 5 ARSs in the fields of surveillance and health protection, acquisition of knowledge, skills and competencies in health promotion; aimed at kindergartens, Elementary and Secondary Schools, and institutions with an intervention in the school population;
- **Protocol between the Ministries of Education and Health (2006)** with a commitment to: i) Promote the principles and practices of health promotion in schools; ii) Promote the National School Health Programme, in health services; iii) Enhance partnership models in the implementation of the Health-Promoting Schools.

.27. The following are the **specific legal frameworks for health promotion** within this context:

- **DL No. 259/2000, Sex Education in Schools**; Law No. 60/2009, establishes the enforcement regime of the sex education in schools and its contents;

- Portugal is part of the **Network of Health-Promoting Schools** (http://www.schoolsforhealth.eu/) since 1994 (3407 schools in 2002).

.28. As organised **strategies and interventions** for the promotion of health within the school environment, we highlight:

- The Ministry of Education, through the **Directorate-General of Education** (http://www.dgidc.min-edu.pt) establishes priority areas in Health Education, intervention protocols for promoting health at school with other institutions (other ministries and institutes, companies of the food industry, producers of educational content, etc.), projects and activities of interest. The **Centre for Health Education and School Social Action** (NESASE) annually supports projects in the field of Health Promotion and Education. In 2010-2011, 803 schools/groups (73% of the total) applied, whose main project partner was the Primary Care Centre (88%), followed by the Parents Associations (54%), Local Authorities (47%) and Governmental Bodies (41%). The support of the Primary Care Centres consisted of Clarification Sessions for Students (90%), Clinical Support (Medical Appointments for Students - 86%), Scientific and Technical Support to Teachers (81%) and Support with Sessions for Parents and Guardians (80%).

BOX 4.2.13. - SCHOOL HEALTH

Evolution of NHP 2004-2010 Indicators (ACS, 2010)

Target met

Students with solvable special health needs who have their problem solved by the end of the academic year.

On the way to the target

% of students whose health status is being monitored at the age of 6 and 13;

Students with up-to-date PNV at the age of 6 and 13.

In the opposite direction

Primary care centres with School Health Teams;

Schools with good health and safety standards.

.29. The following are **particular resources for the promotion** of health, which are applied within the school context:

- *Health Behaviour in School-aged Children* (HBSC), integrated in studies conducted by the WHO, every 4 years, to diagnose health behaviours of adolescents aged 11, 13 and 15;
- **IDT's School Studies Programme which includes two projects**: the INMe - National Survey in School Environment and the ECATD - Study on the Consumption of Alcohol, Tobacco and Drugs, which is an expansion of the project ESPAD - *European School Survey Project on Alcohol and other Drugs.*

- HIGHER EDUCATION INSTITUTIONS

.30. Higher education institutions should be influenced and covered in order to value school health and health promotion, as a dimension of personal and social development of young people. Some examples are:

- **University Social Services,** organised and lead by each institution, in promoting health and medical support, general medicine, nursing, gynaecology, psychology, psychiatry. For example: Department of Academic Integration, Health and Sports (University of Porto) (http://sigarra.up.pt/), with the mission to promote and organise health education programmes and activities, in cooperation with other bodies.

- WORK CONTEXT

.31. The work context refers to the operationalisation of the principles of occupational health and responsibility of public and private institutions for the promotion and protection of the health of employees, customers and society in general.

.32. The following are identified as **specific health programmes**:

- **National Strategy for Health and Safety at Work 2008-2012** (Law No. 59/2008; Law No. 102/2009);

National Occupational Health Programme (2009-2012), implemented in the 5 ARSs. These have as goals: i) professional risk management, surveillance (security) and promotion of the workers' health; ii) the quality of work life, leading to personal and professional fulfilment; iii) the rehabilitation and professional reintegration of individuals with chronic diseases or victims of an occupational accident.

- PRISON CONTEXT

.33. Health within the prison environment is under the responsibility of the Ministry of Justice, through the Directorate-General of Prison Services. Inmates are entitled to receive healthcare equal to that offered to the population who is not deprived of liberty, in compliance with the principle of equity and universality of the Portuguese National Health Service.

.34. The following are the **specific legal frameworks for health promotion** within the prison context:

- **Decree-Law No. 125/2007**, establishing a model of internal organisation for the area of penitentiary treatment: matrix structure grouped by centres of expertise, particularly in the provision of healthcare;
- **National Action Plan for the Fight Against the Spread of Infection Diseases in Prison** (PANCPDI), in the prevention and treatment of addictions and consumption-related pathologies;
- **DR 71/2011**, each prison facility prepares a plan for the promotion of health and prevention of disease, with particular focus on reducing risk behaviours.

.35. Regarding health indicators, their monitoring has not been viable due to the lack of an information system on the health status of the inmate population and of prison employees.

.36. Areas **with intervention recommendations to consider**:

- Reintegration of citizens with pathology in society;
- Management of the disease while on parole or during weekends outside prison walls;
- Rules of hygiene, safety and prevention of occupational hazards;
- Activities developed within the programmes and projects of the Directorate of Prison Services;
- Promoting health within prisons: examples of healthy food in prison canteens and bars and physical activity;
- Fight against tuberculosis and STI.

- COMMUNITY AND LEISURE FACILITIES

.37. We highlight those areas related to the quality of housing, the availability of green areas and recreational spaces for children, young people, adults and senior citizens.

.38. The following are **specific health programmes** within the community context:

- There are several programmes and projects that promote and protect health, developed both at municipal level and at the level of parish councils. The **National Network of Healthy Cities** or the **Senior-Friendly Cities** are some examples;
- National Health and Environment Programme/National Programme for Environmental Health implemented in **3 ARSs (North, Centre and the Algarve).**

4.2.3. GUIDELINES AND EVIDENCE

AT THE LEVEL OF POLITICAL DECISION-MAKING

.39. **Developing benchmarks and guidelines** that encourage opportunities for promotion and protection of health and prevention of diseases and their complications throughout the life cycle (critical periods and windows of opportunity), contexts, physiological conditions and special needs.

- Guidelines should be developed in order to **reinforce accountability**:
  - Of the **health services**, including the empowerment of families, informal care, community and articulation with institutions outside the health sector;
  - Of **other institutional contexts** (schools, workplaces, prisons, sports associations, etc.).
- These guidelines should allow **identifying health needs which are sensitive to the influence of context, possible interventions and expected benefits, and impact assessment** (e.g. at the level of the professional and of the institution);
- These should include **operational recommendations to be achieved by the different sectors** in the most relevant contexts, as well as intersectoral collaboration guidelines and protocols to establish shared responsibilities, foster synergies and allow optimising intersectoral resources.
  - As an example, *The Guide to Clinical Preventive Services* (2008. U.S. Preventive Services Task Force) has been used as clinical guidance for Primary Healthcare. The health promotion and disease prevention guidelines for health services are updated based on evidence and proposing cost-effective interventions, organised according to age, gender, and risk factors.

.40. **Including recommendations, mechanisms and tools in programmes and clinical guidelines that may facilitate the identification and understanding of health needs sensitive to the influence of context and encourage the integrated action of other professionals**.

- The highlights are the guidelines pertaining to health determinants, risk factors and protective factors, trying to use an individualistic or specific perspective, depending on the life cycle stage, on the context or on influential institutions;
- Examples are the recommendations to Schools (Healthy School), the Platform Against Obesity, for a healthy food supply in school canteens and bars, including suggestions for menus, identifying barriers to healthy eating in school and the construction of a School Food Policy, including diagnosis, implementation, monitoring and evaluation (http://www.plataformacontraaobesidade.dgs.pt).

.41. **The programmes, recommendations and quality/accreditation criteria of practices and institutions outside the health sector should include guidelines and tools that facilitate the identification and understanding of health needs which are sensitive to the influence of context and promote social responsibility.**

- Intersectoral/interdisciplinary knowledge management processes, such as collecting evidence, identifying recommendations and best practices, sharing experiences and research (with particular emphasis on impact assessment), should be encouraged for

different professionals;

- Consideration should be given to a health and safety perspective in different contexts (for example, schools and companies) that may include aspects related to well-being, conciliation and mental health;

- For example, the *Health-Promoting School* (Vilnius Resolution, 2009) is an accreditation in which the school implements a structured and systematic plan for the health, well-being and the development of social capital of all pupils and of teaching and non-teaching staff. School is identified as a community resource that promotes the reduction of health inequalities and collaborates in areas such as youth, social policies and sustainable environment.

.42. **Developing benchmarks and guidelines to identify critical periods and windows of opportunity where the potential for health promotion and disease prevention are high, for signalling and articulation with healthcare.**

- The following are examples of **critical periods/windows of opportunity detectable in different contexts**, relevant for signalling and articulating with healthcare (e.g. National School Health Plan, DGS 2006; General Health Check-up, DGS 2006; National Vaccination Programme, 2006,): school ages with a change in study cycle (6 and 13 years of age), marriage, widowhood, retirement, non-therapeutic abortion, drug addiction and alcohol abuse, juvenile crime and minor crime, school failure, school violence (*bullying*) and family violence, prolonged bereavement, the isolation of the elderly;

- The following are examples of **critical periods/windows of opportunity detectable in healthcare**, which deserve an integrated approach of the different levels: hospital admission due to sudden illness, illness/death of close relatives, family dysfunction, depression or non-adherence to therapy.

.43. **Enhance information and health monitoring systems**, so that, in a comprehensive and integrated manner, it may be possible to:

- Know the health and risk potential associated with each context;

- Measure the results of activities and interventions with impact on health;

- Review health indicators from a life cycle standpoint;

  - For example, reporting regularly to schools, universities, prisons, local authorities and other contexts, reports on the evolution of the health status and the most relevant health needs. Local health services shall be particularly responsible.

- Information systems should be developed to meet the specific information needs of every context. For example, on occupational health, the articulation of information with the MTSS - Authority for Working Conditions should be promoted, and include particular aspects of occupational diseases and accidents at work;

- The analysis of health indicators from a life cycle standpoint should allow understanding the health needs by gender, age and context, as well as monitoring the implementation of opportunities for health promotion/disease prevention according to the windows of opportunity and critical periods.

.44. **Assessing the impact on health of policies and practices of other contexts with greatest potential for improvement and/or health risk**.

- Through the (re)acknowledgment of the health impact, the relevance of the different contexts in preserving the health potential of every individual will be valued (see chapter on

HEALTHY POLICIES);

- The different contexts may have greater ability to intervene among vulnerable groups and groups with special needs. For example, within the context of occupational health, opportunities may be created for intervention on immigrant workers, temporary and precarious workers, and people with disability.

.45. **Promoting in society a culture of valuation of health that recognises contributions from individuals, health services and from institutions outside the health sector**:

- Integrating indicators, information and monitoring systems;
- Regularly assessing the health status and needs, as well as the impact of actions and institutional policies with possible repercussions on health (through health surveys in schools, prisons, homes, industries, companies, sportspeople, etc.);
- Reporting and disseminating successes, best practices and the difficulties faced by institutions outside the sphere of health in the interventions aimed at achieving health gains;
- The promotion and protection of health and the prevention of disease appear as a social responsibility of citizens, institutions (e.g. schools and businesses) and community (e.g. town councils and parish councils).

.46. **Strengthening the articulated contribution of health services and local stakeholders in improving the population's health, taking into account the determinants and an approach centred on the promotion and protection of health, and on the prevention and treatment of disease**.

- **Proactively foster communication and interaction between care providers, community stakeholders, institutions, associations and citizens** in the articulation of care with other actions;
- **Setting priorities** at citizen, context, community and local system level, defining resources for health promotion and disease prevention, in that shared responsibility decreases the pressure from the access to health services (primary, hospital or long-term care), allowing the release of resources for improving the performance of the entire system. Of particular importance are the support services in the community, volunteering and informal caregivers, facilitators of proximity healthcare;
- The articulation could be organised in the form of **local health strategies, cooperation protocols or participation in joint projects and initiatives**. This should result in the promotion of interventions, according to a holistic and integrated approach, supplementary skills and capabilities of the institutions, professionals and contexts that comprise it;
- Local authorities and parish councils knowledgeable of health needs of populations and also each institution that should undertake initiatives and projects promoting health with the cooperation and partnership of local health services and other institutions are particularly responsible;
- **Monitoring systems should enhance the perspective of integration and continuity of care throughout life**, considering the different contexts which the individual experiences. This aspect facilitates the emergence of an integrated view of clinical pathways in all situations and contexts, as well as at different levels of healthcare. Simultaneously, the technical and

service coverage and liability should be set, as well as the articulation between these, assessing the efficiency and adequacy both of the network and continuity responses.

AT THE LEVEL OF HEALTH INSTITUTIONS

.47. Identifying health problems and priority opportunities for health promotion within their context and level of performance and **proactively seek the collaboration and contribution of institutions and resources outside the health sector in synergistic and articulated responses**.

.48. **Sharing information and analysis on health needs and potential interventions allowing institutions outside the sphere of health and communities to understand their own health profile, their specific needs and prioritise local or specific health strategies**.

.49. **Develop training, intervention and intersectoral cooperation activities at local, regional and national levels in order to create synergies, continuity of action and the connection of professionals and institutions to give proper response to health needs**.

AT THE LEVEL OF INSTITUTIONS OUTSIDE THE HEALTH SYSTEM

.50. **Collecting and sharing information and analysis on health, environment and health determinants data related to professionals, clients and/or groups of the population directly or indirectly influenced by the activity or responsibility of the institution**, in order to understand the health needs and opportunities for intervention in these groups.

.51. **Developing the social responsibility of institutions and their professionals for providing opportunities for health and healthy choices, promoting a salutogenic culture and for the development of relations and inter-institutional and intersectoral initiatives** aiming at the promotion of health and prevention of disease.

.52. **Enhancing, sharing and developing within a network the health projects and outcomes developed by institutions outside the health sector**.

AT THE LEVEL OF HEALTH PROFESSIONALS

.53. **Incorporating aspects of health and well-being of individuals and populations in the mission of their career, from the standpoint of a Health System stakeholder, with capacity and responsibility of producing and/or protecting health**.

AT THE LEVEL OF CITIZENS

.54. **Creating the expectation, valuing and cooperating with health institutions and those outside the sphere of health in their efforts to promote health and prevent disease, including the development of local, regional and national actions at the initiative of the citizens themselves.**

.55. **Understanding their health potential, health determinants and specificities associated with their life cycle stage and context, and developing the knowledge, attitudes, skills and responsibility to promote health and prevent disease for themselves, their families, communities and context in which they participate.**

4.2.4. VISION FOR 2016

The institutions know the health profile of their professionals, 'clients' or groups under their influence (e.g. municipalities, schools, universities, homes, workplaces, prisons, sports associations, etc.). That profile is developed in collaboration with other institutions, including health institutions (information and analysis), and aims to identify priorities in health which are sensitive to intervention within the context of the institution, either through inter-institutional or intersectoral collaborations. This analysis provides a health potential under the influence or the responsibility of the institution and identifies the resources that the institution has to promote health and prevent disease, including cooperation protocols, interventions with proven effectiveness, or other institutions' and community specific resources accessible to the institution. These profiles are typified and developed, on a regular basis, from the adequacy of models and with networked technical support, including from health professionals and institutions. Institutions, over time, understand the impact of their policies and actions in the health status of populations under their influence.

In each context, the opportunities for health promotion and prevention of the disease, under the responsibility of institutions, are clearly identified, including those that make use of intersectoral resources.

There is a holistic perspective adapted to the life cycle and the notion of health potential worth promoting and preserving. In the different contexts, critical periods and windows of opportunity, as well as their criteria for successful stages, are clear. These include educational and behavioural aspects, of social support and signalling criteria, inter-professional, intersectoral and inter-institutional articulation and referral. These criteria, and the respective networks, are well typified and established, and the development, performance monitoring and assessment are promoted by network collaboration models. The health institutions and professionals collaborate with these networks in aspects such as information sharing, empowerment, joint intervention, consultancy, research and impact assessment.

The institutions collaborate and develop intervention, signalling and articulation networks, with their own monitoring and assessment.

Health institutions and professionals know the networks and inter-institutional resources, as well as the channels of collaboration with professionals from other institutions outside the sphere of health. The clinical guidelines include, where appropriate, specific aspects of the life cycle and the articulation with other contexts that potentiate the activities of the health services. Health institutions share information that allows the different contexts to draw their own health profiles, as well as they collaborate proactively in the development of joint interventions with other sectors on priority issues. The response of health institutions to the cooperation needs of other sectors is known, assessed and valued as part of their social responsibility.

Health institutions and professionals are proactive in engaging professionals and institutions outside the sphere of health in the intervention on individual and population health needs, as well as they respond to the needs of collaboration in contexts outside the sphere of health.

As for major health problems for which gains are expected through the organisation of local or proximity responses, there are intersectoral local health strategies, whose leadership may belong to health institutions or fall outside the sphere of health, and involve local, regional and national resources. These strategies are known, assessed and appreciated, and should be geared towards specific situations in a logic of obtaining health gains.

Local health strategies are developed as a means to articulate responses from several institutions and sectors regarding specific situations, as to obtain health gains.