

CMD. Finally, it is plausible that both types of health problem, that is, both CMDs and AVD, are the result of severe social adversities in women's daily lives.

Implications of the Stree Arogya Shodh

The major implication of this study for health policy is that mental healthcare should be integrated in all health programmes targeted at women, in particular those for reproductive and sexual health. All health workers in reproductive and women's health programmes must be skilled in, and healthcare facilities adequately resourced for, the diagnosis and management of CMDs and somatoform disorders. There is a substantial evidence base that simple and affordable treatments (including antidepressant medicines and psychological treatments delivered by non-mental health professionals) are effective for the treatment of these disorders in low- and middle-income countries (Patel *et al*, 2007).

Further, there is a need to develop practical and affordable clinical algorithms for the management of AVD and STIs, and to improve the detection of CMDs; this would require the availability of cheap, bedside, diagnostic tests for STIs and bacterial vaginosis. At the very least, all primary health centres should have basic laboratory facilities and trained technicians for the diagnosis of bacterial vaginosis and should establish referral networks with appropriately equipped laboratories for diagnosis of STIs.

Programmes for mental health and reproductive health should enhance their focus on the needs of women living in socially disadvantaged circumstances, for example migrant women and those who live with violent partners. Assessment of violence should be made mandatory, particularly for married women; skills for delivering specific interventions to reduce sexual violence must be included in the training of health workers.

In conclusion, the complaint of AVD and STIs are among the most common health problems affecting women and are a priority in India's reproductive health programme. Although there is consensus that the syndromic approach is not suited

to the management of either health problem, there is, as yet, no evidence-based alternative approach. A critically important research priority is to evaluate the benefits of integrating mental healthcare within reproductive health programmes, targeting the syndrome of AVD. Ultimately, this will provide the most compelling evidence with regard to the importance of integrating mental healthcare within women's reproductive and sexual health programmes.

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COUNTRY PROFILE

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Psychiatry and mental health in Portugal

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Portugal is in the south-west of Europe; its territory includes the Azores and Madeira islands, giving it an area of 91 900 km². The total resident population of Portugal was 10 579 000 in 2006. The population density was 115 per km². The birth rate has been declining, from 20.0 per 1000 population in 1970 to 10.4 in 2004. Life

expectancy at birth in 2006 was 75 for males and 82 years for females. Healthy life expectancy at birth in 2003 was 67 and 72 years, respectively. The infant mortality rate decreased from 10.8 per 1000 in 1991 to 3.5 per 1000 in 2005. The median age of the population has been steadily rising.

Portugal has been a constitutional democratic republic since 1974. The main institutions of state are: President of the Republic, Parliament and government. First two are directly elected by the population. Since 2005, the Socialist Party has formed a government with an absolute majority of seats in Parliament.

Gross national income per capita is \$19960 (sums here and below are in international dollars, purchasing power parity, 2006). Total expenditure on health per capita is \$2080. The health budget represents 9.2% of gross domestic product.

Mental health policy

A mental health policy has been present since 1995, with advocacy, promotion, prevention, treatment and rehabilitation as aims. A substance misuse policy has been present since 1999, and an alcohol policy since 2000.

Ministerial Order 10464 (9 April 2008) set out the current national goals for mental health:

- permanent monitoring of the mental health status of the Portuguese population
- creation of programmes promoting the well-being, mental health, prevention, treatment and rehabilitation of people with mental illness
- organisation of mental health services for adults, children and adolescents
- articulation of psychiatric care with primary healthcare through an integrated continuous care network
- participation of both users and care providers in the rehabilitation and the social integration of patients with serious mental illnesses.

Mental health is one of the priority areas of the National Health Plan 2004–10. Special concerns are depression and alcohol misuse and dependence.

Mental health service delivery and resources

Decree Law 2118 of 1963 approved the principles of mental healthcare provision, and mental health centres were created in 1964. In the early 1970s, the need to integrate mental health services with the general healthcare system became obvious. Thus, in 1984, the General Directorate for Primary Healthcare was created, with a Division of Mental Health Services. Decree Law 127 of 1992 integrated these mental health centres into general hospitals, but this served to reveal problems within healthcare in relation to an over-dependence on the regional health authorities. After recommendations from the United Nations and the World Health Organization regarding an emphasis on community services, it was necessary to change the organisation of mental healthcare, to shift the focus to rehabilitation and social inclusion. Decree Law 36 of 1998 regulated the organisation of services in this sector and created a clear referral system alongside a community care network.

The following points summarise the current principles for the organisation of services, although these are still awaiting nationwide implementation:

- the referral model is that of community care

- local (or regional) mental health services are the base of the care system, together with primary care units and hospitals
- teams are multidisciplinary, and each serves a population of approximately 80 000
- primary care units are the basis for ambulatory services; in-patient and emergency care are both provided at hospitals
- social rehabilitation is carried out in conjunction with the state health sector, social security and employment departments
- psychiatric hospitals provide residential services and specialist in-patient care for patients who have no family or social support.

Portugal has 923 general psychiatrists (401 women, 522 men), 508 child and adolescent psychiatrists (242 women, 266 men), about 1000 psychiatric nurses, 160 social workers and 200 psychologists, organised in a mixed system where public (free) and private practice (supported either by the patients or by insurance companies) work together. Some private institutions and enterprises have service agreements with the public system. The majority of psychiatrists have their practice in both the public and the private domains. In private practice they are not obliged to have any type of service agreement with insurance companies or the public system.

In addition, psychiatric care is provided within the prison service and in the military forces.

Adult public psychiatric care is provided by 30 local health-care services, predominantly located in general hospitals. There are also one psychiatric hospital and three psychiatric centres (two in Lisbon and one in Coimbra).

Psychiatric training

Undergraduate psychiatric training is structured around two disciplines directly connected to psychiatry (general psychiatry and psychiatric practice) and two disciplines indirectly connected to psychiatry (basic psychology and medical psychology).

Postgraduate psychiatric training was recently modified. It is now focused not only on mental pathology but also on the influence of medical and surgical pathology on mental health and the influence of mental health on physical illness. We believe this will contribute to the humanisation of care and to the reinforcement of psychiatry's medical identity. The training is centred on diversity of professional experience. After 12 months of basic medical training, the trainee will have 60 months of training specifically in psychiatry. Of these, 48 months cover in- and out-patient care, day care facilities, drug addiction services, liaison psychiatry, old age psychiatry and forensic psychiatry. Three months are dedicated to neurology and another three to child and adolescent psychiatry. The last 6 months of training are on an optional area. Throughout, trainees must be integrated within a psychiatric emergency team.

Psychiatric subspecialties and allied professions

Child and adolescent psychiatry is organised as an autonomous specialty.

A new and first subspecialty of psychiatry – forensic psychiatry – is currently being developed by the College of Psychiatry of the Portuguese Medical Association (PMA).

Concerning allied professions, the public system offers professional careers to psychiatric nurses, psychologists, occupational therapists and social workers.

Psychotherapeutic training and certification are undertaken by the different psychotherapy societies.

Research and publications

Almost all research in psychiatry is undertaken within academia, with a few excellent exceptions coming from private research institutes. The main areas of research are focused on basic matters, on clinical domains and on mental health policies and services. There is no national policy or specific funding for this specialty. A few groups are involved in international research networks.

The first national Portuguese morbidity study is currently being conducted.

There are three well established and regularly published Portuguese journals of psychiatry and mental health (*Saúde Mental*, *Acta Psiquiátrica* and *Psiquiatria Clínica*) and a few internet-based facilities for exchange of scientific and clinical material.

Workforce issues

The PMA, through its Colleges of Psychiatry and Child and Adolescent Psychiatry, defines and supervises good psychiatric practice in both the public and the private domains. This is done through an ethical committee (elected every 3 years). The elaboration of the training programme and the nomination of three of the five examiners for the final examination of trainees (the one that credits them with the title of specialist) are also responsibilities of the PMA.

Several meetings of all psychiatrists have been held under the auspices of the PMA in order to help it better represent their professional interests.

Non-governmental organisations (NGOs) are involved with mental health and some of them have government support; they are active in areas such as suicide prevention, family support and anti-stigma programmes.

The pharmaceutical industry gives financial support to help general practitioners attend psychiatric training courses and offers information and supportive programmes on mental health and psychiatry for patients and their families.

Human rights issues

Several anti-stigma campaigns, mostly promoted by NGOs, have been implemented. Patients' rights are guaranteed by legislation, especially that concerning persons who are thought to need compulsory treatment (ambulatory or in hospital). Legislation has now begun to be applied to employment facilities for those with mental illness.

Future developments

Despite a profusion of legislation in recent years, the landscape of psychiatric care in Portugal remains almost unchanged. Apart from a few areas where community care exists and works, the reforms required for the better rehabilitation and social inclusion of chronic psychiatric patients remain the same as they were 20 years ago.

Palha & Marques-Teixeira (2009) conducted a national survey of rehabilitation facilities and practices for chronic psychiatric patients, and concluded that the present scenario is very far from patients' needs. Pita Barros & de Almeida Simoes (2007) similarly concluded that 'in Portugal we are still far from offering to all the population access to essential mental healthcare'. The main reason for this is the distance between mental health practice and the contents of the laws and guidelines.

Pressure from the profession will transform the current legislation into real psychiatric practice. However, some of these measures are already conceptually and practically out of date. Before implementation, their adjustment to the cultural, financial and traditional characteristics of Portugal is mandatory, as will be some adjustment to account for the experience of other countries that have already evaluated their outcome.

Finally, a national research policy is being demanded by Portuguese psychiatrists in the hope that, in the near future, the results of the reforms can be clearly evaluated.

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