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Recognition Without Consolidation: Women's Health Governance and Lived Experience in Portugal

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Abstract

This article examines how gender shapes the framing, governance and lived experience of women's health within a national health system, and what this reveals about translating gender equality commitments into social policy practice. Using a convergent mixed-methods design, the study combines analysis of national policy documents and parliamentary debates in Portugal (2014–2024) with interviews with key actors (n = 13) and an exploratory national survey of women (n = 268). Across policy and political arenas, women's health is widely recognised within gender equality and rights-based discourse, yet remains weakly consolidated within mainstream health governance. Reproductive framings dominate, while life-course dimensions such as menopause, women's mental health and health literacy are under-articulated and weakly operationalised. Actor perspectives emphasise prevention, health literacy, communication and continuity of care, pointing to diffuse ownership and limited accountability. Survey respondents' accounts both reproduce and extend dominant framings, highlighting mental health, information needs, access barriers and the importance of accessible and trustworthy health information. Reported care experiences reveal a pattern of "respect without responsiveness", where positive interpersonal treatment coexists with organisational and communicative shortcomings. The article conceptualises this as a governance paradox of recognition without consolidation and shows how policy silences shape not only what becomes actionable within gendered health systems but also the informational conditions that support informed engagement with health and care. The findings have implications for designing life-course-oriented, communication-sensitive and accountability-anchored approaches to women's health governance.

Keywords: women's health; health governance; gender equity; health literacy; health communication; health system responsiveness

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Academic Editors: Ioanna Yfantidou and Stefanos Balaskas

Received: 14 June 2026
Revised: 14 August 2026
Accepted: 17 August 2026
Published: 18 August 2026

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1. Introduction

Women's health has gained prominence within international social policy agendas as a recognised dimension of equity and social justice. But the central policy challenge is no longer primarily one of recognition. It concerns translation: how gender equity commitments are converted into durable social policy, embedded in objectives, instruments, routines, and accountability. More fundamentally, this challenge signals how gender, as a structuring dimension of social and institutional life, shapes what is recognised, prioritised and made actionable within health systems. Across countries with universal health coverage, women's health may be highly visible in rhetoric while remaining

weakly stabilised as a coherent policy domain, with uneven implementation and limited monitoring [1,2].

At the same time, growing attention has been devoted to the role of communication, health literacy and informed engagement in reducing health inequalities and supporting healthier populations [3,4]. Access to healthcare services is insufficient if individuals lack the information, confidence or support needed to recognise symptoms, engage in preventive behaviours, navigate complex healthcare systems and make informed decisions throughout the life course [5–7]. These challenges may be particularly relevant in the context of women's health, where health needs are shaped not only by biological differences but also by social norms, care responsibilities, institutional arrangements and differential access to information and resources [8,9].

A persistent difficulty lies in how women's health is defined and governed. In many contexts, policy attention remains organised around reproductive and maternal priorities. While essential, this focus can marginalise life-course dimensions such as mental health, menopause, chronic conditions, prevention, and the social determinants shaping women's exposure to risk and their capacity to navigate care [8,9]. Narrow framings tend to produce fragmented programming, diffuse responsibility, and weak conversion of equality commitments into operational mechanisms capable of enduring over time [10,11]. They may also contribute to uneven information environments, limiting the visibility of certain health issues and constraining opportunities for awareness, prevention and early intervention [12,13]. These patterns are not gender-neutral but reflect historically embedded gendered assumptions about bodies, needs and legitimate areas of intervention within health policy [14,15].

Women's health frequently exhibits a paradox of recognition without consolidation. Equality commitments may be articulated in policy texts and political discourse, yet remain weakly operationalised through the absence of explicit ownership, measurable objectives, dedicated instruments, and monitoring arrangements [16,17]. The resulting limitations are not simply downstream implementation failures. They reflect upstream conditions in which women's health is insufficiently constituted as a governable policy domain, leaving life-course needs exposed to episodic attention and agenda volatility. From a gender studies perspective, this paradox highlights how institutional arrangements can reproduce gendered inequalities even in the presence of formal commitments to equality [18]. From a health communication perspective, it also raises questions about how policy priorities influence the production, dissemination and accessibility of information capable of supporting informed health behaviours and engagement with care [19].

Existing research has identified key dimensions of this problem, but often in parallel. Studies of gender mainstreaming and policy design show how equality language can coexist with policy instruments that lack clear objectives, implementation mechanisms and accountability arrangements [10,11]. Separately, research on women's healthcare experiences documents how institutional routines can generate care that is formally respectful yet insufficiently responsive to gendered trajectories and information needs [20–22]. A growing body of work has also highlighted the importance of health literacy, strategic communication and audience-centred approaches in enabling individuals to adopt preventive behaviours, access appropriate care and participate more actively in health-related decision-making [5,23,24]. Less common, however, are empirical studies that place these dimensions in structured dialogue, linking policy and parliamentary framings, governance actors' interpretations, communication and literacy challenges, and women's own reported understandings and experiences. Such integration is analytically important because it allows convergences, divergences and silences to be interpreted as social policy dynamics

rather than as isolated observations, and as expressions of how gendered power relations are embedded and reproduced across institutional levels.

We address this gap through a convergent mixed-methods study of women's health in Portugal. The case is analytically informative because formal commitments to gender equality are strong, yet women's health remains difficult to consolidate as a stable policy domain. We combine qualitative analysis of national programmatic policy documents and parliamentary debates from 2014 to 2024, interviews with key governance actors (n = 13), and a national survey of women (n = 268) including structured items and open-ended responses. Rather than seeking causal inference or population generalisation, we use cross-source comparison to identify patterns of framing, operationalisation and omission, and to interpret how these shape women's reported needs, health-related understandings and care experiences.

The analysis is guided by three research questions. RQ1 asks how women's health is conceptualised and operationalised within Portuguese health policy and political discourse. RQ2 examines how women conceptualise "women's health" and what needs and experiences they report in their interactions with health services. RQ3 explores what convergences, divergences and structural silences emerge across sources, and what they imply for strengthening gender equity, health literacy and responsiveness in health policy practice.

The paper makes three contributions. First, it develops the concept of "recognition without consolidation" to explain how gender equality commitments can be institutionally acknowledged yet remain weakly embedded in policy design and governance arrangements, limiting their durability and practical effects. Second, it advances an analytical approach that treats policy silences not as residual omissions but as indicators of how gendered priorities and exclusions are structured within policy frameworks, shaping what becomes governable, communicable and actionable. Third, by integrating women's perspectives, it shows how institutional framings are both reproduced and contested in lived experience, revealing a pattern of "respect without responsiveness" in which formally respectful care coexists with persistent gaps in communication, access, information and life-course sensitivity. These findings contribute not only to debates on gender and health governance but also to wider discussions on how communication environments, health literacy and citizen-centred approaches can support more responsive and equitable health systems.

2. Theoretical Framework

Health systems are not neutral policy arenas. They are historically embedded institutional arrangements that reflect prevailing norms, power relations and assumptions about bodies, illness and care. A substantial body of scholarship shows that modern medicine and health policy have developed within an androcentric paradigm, in which the male body has implicitly functioned as the normative reference for biomedical knowledge, clinical practice and policy design [14,25,26]. This legacy has contributed to the persistent marginalisation of women's health needs beyond reproduction and maternity, shaping both the production of knowledge and the organisation of services [26].

From a social policy perspective, androcentrism operates not only through clinical bias but through governance processes that structure recognition, prioritisation and resource allocation. Conditions that predominantly affect women, or present differently in women, have historically received less policy attention, contributing to delayed diagnosis, fragmented care pathways and uneven outcomes [20,25,27]. These patterns cannot be explained by biological difference alone. Rather, they reflect the interaction between sex-based factors and socially constructed gender norms that shape exposure to risk, access to resources and the interpretation of symptoms within institutional settings [2,8,28].

Conceptually, sex and gender are analytically distinct, although they operate through interacting pathways. Sex-related factors refer to biological attributes and processes that may influence susceptibility to disease, symptom presentation and responses to treatment, whereas gender encompasses socially constructed norms, roles, identities, relations and institutional arrangements that shape exposure to risk, access to resources, healthcare interactions and policy responses [25,28]. Distinguishing these dimensions is important to avoid treating biological differences and gendered inequalities as interchangeable. In this article, 'women's health' is used primarily as a policy and empirical category reflecting the terminology of the institutional sources examined and the population targeted by the survey. This does not imply that all health conditions commonly associated with women are exclusive to people who identify as women, nor that gendered health inequalities are experienced uniformly.

In policy terms, gender bias is reproduced through agendas and routines that privilege acute, event-based and biomedical interventions, while underplaying chronic conditions, mental health, prevention and socially mediated needs that disproportionately affect women [9,29].

Importantly, governance processes influence not only what services are provided but also what information is produced, disseminated and legitimised within health systems [12,13]. The visibility of particular health issues, the availability of accessible information and the capacity of individuals to recognise needs and seek support are shaped by institutional priorities and policy attention [4,6,30]. Consequently, conditions that receive limited policy recognition may also remain less visible within public communication, health education and awareness-raising efforts, reducing opportunities for prevention, early intervention and informed decision-making [17,22].

Feminist and gender-sensitive scholarship has been central in challenging the assumed neutrality of health systems and exposing the structural nature of gender inequalities in health. Rather than constituting a single theoretical tradition, this work converges on the analysis of power asymmetries, unequal access to resources and the differential valuation of health needs [25,26,31]. Within health policy analysis, these approaches have been particularly influential in problematising the reduction of women's health to reproductive functions and in advocating a life-course perspective that recognises mental health, chronic disease, menopause, ageing and social vulnerability as central policy concerns [32,33]. They have also highlighted how institutional routines and professional cultures shape diagnostic processes and patient–provider interactions, while legitimising women's lived experiences as relevant knowledge for policy design and evaluation [20,34]. A further contribution of this literature has been to emphasise the importance of knowledge, voice and participation in addressing gender inequalities in health [8,34,35]. Women's experiences are not simply outcomes of policy arrangements but constitute an important source of knowledge regarding unmet needs, barriers to care and the adequacy of existing services. Understanding how women interpret health information, identify priorities and navigate healthcare systems is therefore relevant not only for evaluating policy outcomes but also for informing more responsive and citizen-centred approaches to health governance [21,22].

Parallel developments in sex- and gender-sensitive medicine have sought to incorporate sex- and gender-related differences into biomedical research and clinical knowledge [34]. While this has contributed to correcting important knowledge gaps, translation into professional education, routine clinical practice, service organisation and health policy remains uneven [36]. From a governance perspective, greater recognition of sex- and gender-related differences is therefore necessary but insufficient: without complementary institutional mechanisms, gender equity commitments are unlikely to reshape routine practice or service configuration [37]. Equally important is the development of communication and educa-

tional strategies capable of translating knowledge into accessible information and supporting women's capacity to engage with prevention, care and decision-making throughout the life course [3,24].

Contemporary social policy research increasingly treats gender as a key social determinant of health, shaping trajectories through its interaction with labour markets, care responsibilities, income, education and institutional arrangements [8,9]. Intersectional approaches further show that women's health experiences are heterogeneous, produced through the cumulative effects of gender with age, socio-economic position, ethnicity and place [38]. For policy analysis, this has implications. On the one hand, ostensibly gender-neutral policies may generate unequal effects. On the other hand, treating "women" as a homogeneous category risks obscuring compounded forms of disadvantage and misdirecting policy responses. It also risks overlooking differences in access to information, health literacy and healthcare navigation capacities that may influence health-related behaviours and experiences across population groups [30,39].

Despite strong international commitments to gender equality in health [40,41], translation into effective policy practice remains uneven. Gender mainstreaming has often taken a symbolic or fragmented form, with gender considerations dispersed across programmes rather than embedded within core governance structures, budgets and accountability mechanisms [2,10,11]. As a result, rhetorical recognition frequently coexists with weak operationalisation.

In this study, operationalisation refers to the presence of concrete governance mechanisms through which policy commitments are translated into practice, including explicit objectives, indicators, institutional ownership, resource allocation and monitoring arrangements [42]. Where such mechanisms are absent, equality commitments remain vulnerable to episodic attention and agenda volatility. Equally important are policy silences. Drawing on problem-representation approaches [12], the systematic absence or marginalisation of issues such as menopause, cumulative life-course inequalities or women's mental health is treated here as analytically meaningful, signalling what is rendered governable, communicable and actionable within policy frameworks. Such silences may influence not only policy priorities but also the production of information, public awareness and the visibility of health needs within broader societal debates [13,17,26].

Finally, respectful interpersonal treatment in healthcare, while ethically essential, is insufficient to ensure gender equity in health outcomes. Scholarship on person-centred and equitable care shows that the absence of overt discrimination and the preservation of patients' dignity do not automatically translate into care that effectively responds to gendered needs across the life course [21]. In this context, responsiveness is understood as a system-level capacity shaped by institutional design, communication infrastructures and organisational priorities, rather than by individual professional attitudes alone [43]. Responsiveness therefore extends beyond clinical competence and encompasses the ability of health systems to communicate effectively, provide understandable information, support informed decision-making, adapt to users' circumstances, and recognise the diverse social contexts shaping individuals' interactions with care [44]. This distinction is central to interpreting women's reported experiences and linking them back to governance arrangements.

Building on these perspectives, the article adopts an integrated analytical framework that places policy framings, governance arrangements, actor interpretations and women's reported experiences into structured dialogue. Particular attention is given to how governance arrangements influence not only service provision but also the visibility of health issues, access to information, opportunities for prevention and the responsiveness of healthcare interactions. Convergences, divergences and silences across these sources

are interpreted as social policy dynamics that shape how gender equity commitments are stabilised, fragmented or constrained in practice.

3. Materials and Methods

3.1. Study Design

The study adopts a convergent mixed-methods design combining qualitative analysis of policy and political discourse with a cross-sectional exploratory survey of women residing in Portugal. This design enables structured comparison between institutional framings and governance arrangements in women's health and women's own conceptualisations, reported needs, access to information and healthcare experiences. Rather than seeking causal inference, the approach is oriented towards identifying convergences, divergences and recurring silences across sources, in order to interpret how gender equity commitments are translated (or constrained) within health-system governance.

3.2. Qualitative Data Sources and Corpus

3.2.1. Policy and Parliamentary Materials

A purposive corpus of national programmatic policy documents was assembled to capture formal orientations in health and equality governance. Included documents were the National Health Plan 2021–2030, the Strategic Plan 2024–2026, the National Strategy for Equality and Non-Discrimination 2018–2030, and the Priority Health Programmes. Documents were selected based on their formal programmatic status and relevance within the analytic period; materials primarily intended for communication or dissemination (e.g., press releases or briefings) were excluded.

Parliamentary discourse was analysed using records from the *Diários da Assembleia da República* (Series I and II) covering the period 2014–2024. Records were retrieved through a structured search using the keyword "*saúde da mulher*" ("women's health"). This deliberately narrow search strategy reflected the analytical objective of examining when and how women's health is explicitly constituted as a political and policy category in parliamentary discourse, rather than compiling all debates concerning individual conditions or services that may affect women. Condition-specific searches (e.g., menopause or endometriosis) might identify additional relevant debates but would address a broader and analytically distinct question in which those issues are not necessarily framed as components of women's health.

The initial search identified 88 pages across 70 parliamentary records. During the first screening stage, 18 pages were excluded because they contained duplicate content or only incidental references to women's health, leaving 70 pages for full-text assessment. A second screening assessed the substantive relevance of each record to the study objectives. Pages in which women's health was mentioned only tangentially, without substantive discussion of policy, governance or gender-related health issues, were excluded (n = 13). The final analytical corpus comprised 57 pages, which were subjected to thematic analysis. Parliamentary materials were analysed as indicators of agenda visibility, framing dynamics and political prioritisation rather than as a proxy for legislative activity or policy outputs. Accordingly, the 57-page corpus should be interpreted as representing the explicit parliamentary visibility and framing of women's health rather than an exhaustive corpus of all parliamentary activity concerning women-related health issues.

3.2.2. Interviews with Key Actors

Thirteen interviews were analysed, comprising nine women and four men, and combining six public-domain interviews from the podcast series "A Saúde das Mulheres em Portugal" with decision-makers and health managers, and seven semi-structured inter-

views conducted for this study with actors occupying governance and managerial roles in the health sector. Study-generated interviews were selected through purposive sampling to capture diversity in institutional position and responsibility. The study-generated interviews followed a semi-structured guide aligned with the conceptual framework, focusing on framings of women's health, gender equity and justice, governance arrangements, policy instruments, institutional capacity, communication and health literacy challenges, and conditions shaping implementation and agenda integration. They were conducted with informed consent and in accordance with the principles of the Declaration of Helsinki. All interviews were transcribed verbatim and analysed using shared analytic procedures to facilitate systematic comparison across sources.

The two interview corpora were not treated as methodologically interchangeable. The podcast interviews were public-domain conversations produced independently of the study, whereas the study-generated interviews were confidential semi-structured interviews conducted specifically around the research questions. Comparability was therefore established at the level of the analytical framework rather than the conditions of data production: both corpora were coded using the same thematic dimensions, while source provenance was retained throughout analysis and interpretation. Convergences were examined across corpora, whereas differences in emphasis were preserved rather than collapsed, recognising variation in prompting, depth and public/private context. The podcast material was thus used as a complementary source of actor perspectives rather than as a substitute for study-generated interviews.

3.2.3. Survey Design, Sampling and Data Collection

The survey targeted women aged 18 years or older residing in Portugal. Eligibility was communicated through the survey information, which explicitly identified adult women as the target population. The questionnaire did not separately collect sex assigned at birth or gender identity. Recruitment used non-probabilistic snowball sampling implemented at national level, with dissemination through social media and institutional communication channels and subsequent participant sharing. Participation was voluntary and anonymous. As a non-probabilistic sample, the survey was designed for exploratory pattern detection rather than statistical representativeness. Data were collected online between April and July 2025. A total of 408 individuals initiated the questionnaire; the final analytic sample comprises 268 completed questionnaires, excluding respondents who did not provide informed consent at the outset. The survey was fully anonymous and collected no directly identifiable personal data, in accordance with the principles of the Declaration of Helsinki and the General Data Protection Regulation.

The questionnaire was developed for this study based on the literature and research objectives and comprised 28 items organised into five domains: socioeconomic characteristics; self-reported health status; women's health conceptualisations and perceived needs; access to information and perceived knowledge; and experiences in healthcare services, including communication, respect for beliefs and values, perceptions of discrimination, perceived cultural competence and preferences regarding provider gender. Most items used closed-response formats (multiple choice or Likert-type scales). Two open-ended questions invited respondents to report three words/expressions spontaneously associated with the expression "women's health" and identify specific needs they considered insufficiently addressed.

A total of 268 women aged 18 years or older residing in Portugal participated in the survey. Table 1 summarises the sociodemographic and health characteristics of the respondents.

Table 1. Sociodemographic and health characteristics of survey respondents.

Characteristic	n	%
Age group (years)		
18–34	134	50.0
35–49	76	28.4
50–64	54	20.1
≥65	4	1.5
Marital status		
Single	137	51.1
Married	96	35.8
Other	35	13.1
Children		
No	156	58.2
Yes	112	41.8
Educational attainment		
Secondary education or below	78	29.1
Higher education	190	71.0
Employment status		
Employed	140	52.2
Student	95	35.4
Other	33	12.4
Area of residence		
Urban	114	42.5
Peri-urban	102	38.1
Rural	52	19.4
Monthly household income		
Prefer not to answer	59	22.0
Other income categories	209	78.0
Self-rated health		
Good or excellent	192	71.6
Fair, poor or very poor	76	28.4
Chronic condition		
Yes	74	27.6
No	194	72.4
Health service utilisation in previous 12 months		
No consultations	17	6.3
1–2 consultations	115	42.9
3–6 consultations	104	38.8
7–10 consultations	18	6.7
>10 consultations	13	4.9
Do not know	1	0.4

Table 1. *Cont.*

Characteristic	n	%
Assigned family doctor		
Yes	243	90.7
No	25	9.3

3.2.4. Data Analysis

Policy documents and parliamentary materials were analysed using structured qualitative document analysis guided by a coding framework [45]. Coding focused on framings of women's health; references to gender equality and mainstreaming; operational mechanisms (including targets, indicators and accountability arrangements); and governance dimensions such as institutional responsibilities and intersectoral coordination.

In addition to explicit content, the analysis treated absence as analytically meaningful. Drawing on problem representation approaches [12], "policy silences" were operationalised as issues that were either not mentioned at all or referenced only in residual or generic terms without translation into problem definitions, objectives, instruments or accountable responsibilities. To avoid over-interpretation of isolated omissions, an issue was considered a meaningful silence only when it was systematically weak or absent across the corpus, particularly in contrast with adjacent domains that were more fully specified. This contrastive logic supported interpretation of silence as a governance signal regarding what is rendered politically and administratively actionable. For example, menopause was classified as a meaningful policy silence because it was absent or only weakly articulated within the analysed institutional corpus and was not translated into explicit objectives, instruments, responsibilities or monitoring arrangements, despite its salience in other empirical sources. Sexual and reproductive health, by contrast, was not classified as a silence because it was explicitly represented in policy instruments and parliamentary debate through identifiable programmes, rights-based discussions and service-related measures. The distinction therefore rested not simply on frequency of mention, but on whether an issue was substantively constituted and operationalised as a policy object. Policy silence was therefore understood as a continuum of institutional visibility, ranging from near absence to episodic or weakly operationalised recognition, rather than as a binary distinction between presence and absence.

Interview transcripts were analysed using thematic analysis following [46], combining inductive coding with interpretation guided by the study's conceptual framework. Two researchers coded the material independently, with discrepancies resolved through discussion until stable categories and definitions were reached.

Open-ended survey responses were cleaned, read in full and coded into inductively derived categories emerging from the data, following established procedures for qualitative content analysis [47]. For the "three words/expressions" item, each word or expression was treated as a unit of analysis and assigned to a single category; for the "needs" item, responses were segmented where necessary to capture multiple needs within a single answer. Coding was performed independently by two researchers and reconciled through discussion.

Quantitative data were analysed in SPSS (v.30) using descriptive statistics (absolute and relative frequencies) to characterise respondents and summarise response distributions. Exploratory sociodemographic comparisons were also conducted to examine within-sample variation by age and educational attainment in respondents' conceptualisations and selected survey dimensions. Given the non-probabilistic sampling strategy, analyses were descriptive and exploratory in nature and were not intended to support inferential or

causal claims. Accordingly, survey findings should not be interpreted as representative of the Portuguese female population but rather as exploratory evidence of participants' experiences and perceptions.

Cross-source integration was conducted through structured comparative synthesis across qualitative and survey-based evidence. Analytic matrices [48] were used to align framings and governance mechanisms in policy and parliamentary discourse, actor-based interpretations from interviews, and respondents' conceptualisations, reported needs and healthcare experiences. Matrices were organised by analytical dimension (e.g., framings, governance mechanisms, health literacy, life-course issues and policy silences), allowing systematic comparison across data sources and supporting the identification of convergence, divergence and omission. Qualitative data management and coding were supported by NVivo. Table 2 summarises the study data sources, analytical approaches and their integration within the overall research design.

Table 2. Overview of data sources, analytical approach and integration.

Data Source	Sample/Material	Analytical Approach	Contribution
Policy documents	National health and gender equality policy documents	Qualitative document analysis	Policy framings and governance mechanisms
Parliamentary debates	*Diários da Assembleia da República* (2014–2024; 57-page analytical corpus)	Thematic analysis	Agenda visibility and political framing
Interviews	13 key actors (9 women; 4 men)	Reflexive thematic analysis	Governance actors' perspectives and policy priorities
Women's survey	N = 268	Descriptive statistics and qualitative content analysis	Respondents' reported experiences, needs and perceptions
Cross-source integration	All data sources	Analytical matrices	Cross-source synthesis of convergence, divergence and policy silences

4. Results

4.1. Policy and Political Framings of Women's Health

Across national programmatic instruments and parliamentary discourse, women's health is formally recognised as a matter of equity and rights, yet remains weakly consolidated as a coherent and operational policy domain. The analysis reveals a recurring configuration: explicit commitments to gender equality coexist with predominantly reproductive framings, fragmented programming, and limited translation into durable governance instruments, monitoring arrangements, or clearly designated responsibility.

At the level of formal policy orientation, core national instruments acknowledge gender as a determinant of health and recognise systematic differences between women and men across key indicators, including chronic disease prevalence and mental health. However, these differences are largely treated as contextual descriptors rather than as objects of targeted policy intervention. Women's health is addressed primarily as a transversal concern, without the definition of a dedicated strategic axis, explicit objectives, or instruments capable of anchoring action over time. Even in areas where gendered risks are clearly identified, such as gender-based violence or sexual and reproductive health, responses tend to be embedded within broader access or vulnerability frameworks rather than articulated as part of an integrated women's health strategy. Moreover, references to information provision, awareness-raising or health literacy are generally secondary to

clinical and organisational concerns, suggesting a limited emphasis on communication as a policy instrument for promoting women's health across the life course.

A similar pattern emerges in medium-term strategic planning. While policy documents emphasise sex and gender-disaggregated data, professional training, and sensitivity to violence against women, these orientations remain largely programmatic. The absence of operational targets, earmarked resources, or systematic monitoring limits their capacity to reshape priorities or routines within the health system. Taken together, national planning instruments reflect growing alignment with international equality frameworks, but weak specification of the governance mechanisms required for implementation. This includes limited attention to how information, education and public communication strategies might contribute to prevention, early intervention and women's capacity to engage with their own health needs.

The National Strategy for Equality and Non-Discrimination reinforces this dynamic. Although it provides a comprehensive equality framework and incorporates health across several action plans, it adopts a horizontal gender mainstreaming logic. As a result, women's health is not articulated as a sector-specific policy domain within the health system, and responsibilities for implementation remain diffuse. The lack of alignment between equality strategies and health-sector governance instruments constitutes a structural constraint on consolidation.

Priority Health Programmes further illustrate the sectoral character of women's health policy. Several initiatives are directly relevant to women, most notably cancer screening and sexual and reproductive health measures. However, these actions are organised around specific diseases or life stages and do not amount to a life-course-oriented women's health strategy with explicit equity objectives, indicators, or accountability. Women's health thus continues to be addressed through vertical programmes rather than through an integrated policy vision.

Parliamentary debates largely mirror these institutional framings. Women's health gains political visibility mainly through three interconnected clusters: access pressures in the health system, public health strategies, and sexual and reproductive rights. Discussions of access frequently foreground primary care shortages, pregnancy-related trajectories, and organisational fragilities within the National Health Service, framing women's health predominantly in rights-based terms while rarely interrogating the broader policy architecture that produces persistent inequalities. Reproductive and perinatal care dominates political attention, reflecting legitimate concerns regarding quality and safety but also narrowing the political imagination of women's health. As a result, prevention, mental health, menopause, ageing, and cumulative life-course inequalities remain marginal, while issues such as voluntary termination of pregnancy and family planning retain high political salience and ideological contestation. This configuration reinforces women's health as a terrain of episodic visibility rather than stable policy consolidation. Similarly, comparatively limited attention is devoted to communication, health literacy and public awareness as policy tools capable of supporting informed decision-making and preventive health behaviours among women.

Across both policy documents and parliamentary debates, silences are equally revealing. Women's mental health, menopause, chronic conditions with disproportionate burdens among women, cumulative life-course disadvantage, and the interaction between gender and social determinants receive limited and uneven articulation. Menstrual health occupies a somewhat different position: it appears episodically in political discourse, including in relation to menstrual products, but is not developed as part of a sustained life-course policy framework. These patterns of absence and limited visibility contrast with the broader concerns expressed by actors and women themselves, as shown in the following sections.

4.2. Actor Perspectives on Women's Health Governance

Across both the public-domain podcast interviews and the study-generated interviews with key actors, women's health is consistently framed as a legitimate policy concern requiring greater institutional recognition, yet one that remains insufficiently anchored within Portuguese health governance. Actor accounts converge around three core ideas: women's health continues to be reduced to reproductive and maternal framings; prevention, health literacy and communication are recognised as essential but under-delivered system functions; and persistent structural barriers, particularly organisational, territorial and service-related, constrain equitable access and continuity of care.

A first cross-cutting theme concerns the need to give women's health explicit and accountable institutional recognition within mainstream health policy, rather than relying solely on diffuse transversal commitments. In the interviews, this emerges as the most salient category, combining recognition of biological and socially patterned differences with repeated references to the limited visibility of women's health within national instruments. Interviewees link the absence of clear institutional anchoring within flagship planning frameworks to weak policy traction, uneven prioritisation and limited capacity to sustain action beyond episodic initiatives.

A second shared axis relates to prevention, health literacy and communication. In the podcast corpus, the most prominent thematic domain centres on strengthening women's capacity to identify risk, interpret symptoms and engage in preventive behaviours, alongside calls for improved public communication strategies. Study interviews similarly emphasise prevention and education, often articulated through a contrast between a system perceived as comparatively effective in treatment but weaker in primary prevention and structured outreach. Across sources, women's health literacy is framed both as an individual resource and as a governance responsibility requiring institutional investment in accessible, targeted information and preventive pathways.

Third, actor narratives broaden the health agenda beyond reproductive health by emphasising chronic conditions with gendered patterns, though unevenly across sources. The podcasts foreground chronic and cardiovascular conditions and innovation in screening, while study interviews place greater emphasis on maternal and sexual and reproductive health, mental health, and the neglect of conditions such as endometriosis. Together, these accounts suggest that actor framings extend beyond maternity but remain uneven, with some life-course domains receiving limited explicit attention despite being acknowledged as relevant.

A fourth area of convergence concerns structural barriers to access and service adequacy. In the podcast corpus, barriers are articulated both as general inequities in care and as concrete service fragilities, particularly geographic variation in primary care availability. Study interviews add operational specificity, highlighting territorial disparities in outreach, limited "women-friendly" service organisation, difficulties in accessing primary care, especially during pregnancy, and constraints associated with resources and weak articulation across levels of care. Access is thus framed not as an individual problem, but as an outcome shaped by service configuration, workforce availability and organisational responsiveness.

Actors also emphasise governance mechanisms for agenda-setting and implementation, particularly through partnerships and multilevel collaboration. Interviewees recurrently stress the importance of engaging a wider network of actors, including schools, municipalities and community organisations, signalling a preference for multisectoral approaches to prevention and outreach. References to international experiences appear less as prescriptions than as illustrations that alternative governance arrangements are feasible.

Finally, a smaller but analytically meaningful theme concerns the integration of gender in research and clinical practice. In the podcast material, this appears with low fre-

quency but high conceptual salience, particularly regarding innovation and women's under-representation in clinical research. Although less prominent in the study interviews, it aligns with broader calls for evidence-informed policy and gender-sensitive clinical pathways.

Table 3 summarises the main themes identified across the interview material and their contribution to understanding women's health governance.

Table 3. Main themes identified in interviews.

Theme	Illustrative Synthesis	Illustrative Quotation
Recognition of women's health	Women's health is recognised as relevant but remains weakly institutionalised within mainstream health policy.	"The National Health Plan itself [. . .] does not contain a specific chapter on women's health."
Prevention	Prevention remains comparatively underdeveloped within a health system strongly oriented towards treatment.	"In Portugal, we are very good at treating disease. When it comes to preventing disease, we still have a considerable way to go."
Health literacy	Limited knowledge and information can constrain women's engagement with prevention and screening.	"It is related to the fact that women do not know that they need to undergo screening."
Structural barriers	Territorial and organisational inequalities continue to produce uneven access to care and prevention.	"There are territories in Portugal where invitations [for screening] are reasonably systematic. In others, we do not even invite women."
Governance	Multilevel governance and stronger involvement of local actors can support policy implementation.	"This model of Local Health Units is enabling greater involvement of local authorities in policy, in the implementation of health policies and in the functioning of organisations."
Research	Gender-sensitive evidence is needed to identify and respond to conditions that disproportionately affect women.	"We need to move towards more in-depth research, with more results on identifying diseases that affect women more than men."

Note: All illustrative quotations are drawn from the study-generated interviews. Interviews were conducted in Portuguese, and quotations were translated into English by the authors. Ellipses and square brackets indicate minor omissions or clarifications made for readability without altering meaning.

4.3. Women's Conceptualisations of "Women's Health"

Across the lexical units associated with the "three words/expressions" item (N = 791 valid lexical units after data cleaning), respondents' conceptualisations concentrate around a limited set of dominant semantic fields. The most frequent associations relate to reproductive health and reproductive or life-course processes, including gynaecological and intimate health, fertility, pregnancy, menstrual cycles and menopause. These terms account for the largest share of coded units, indicating that reproductive processes and life-course transitions remain central reference points in how respondents conceptualise women's health. Rather than appearing as isolated biological events, these dimensions are often expressed as ongoing conditions requiring monitoring, care and professional follow-up.

Mental health and emotional well-being constitute the second most salient domain. Respondents refer not only to mental health as an abstract category, but also to specific conditions (such as anxiety or depression), emotional states, psychosocial strain and the need for psychological support.

Although less frequent than reproductive references, these associations indicate respondents' recognition of the interdependence between psychological and physical di-

mensions of health. Preventive orientations also feature prominently in respondents' conceptualisations. Lexical units related to prevention, screening, routine examinations, healthy behaviours and self-care suggest an understanding of women's health as a proactive and continuous process. Health is framed less as an episodic response to illness and more as an ongoing process, involving vigilance, anticipation and regular interaction with health services.

References to physical health conditions and disease emerge with lower frequency but notable specificity, particularly in relation to oncological conditions and chronic or metabolic diseases. These associations indicate recognition of disease-related risks that disproportionately or distinctively affect women, especially in later stages of the life course. In contrast, some domains appear comparatively marginal in respondents' spontaneous conceptualisations, including identity-based descriptors, specific non-gynaecological clinical specialties, and general or ambiguous references to health.

A further, smaller cluster of lexical units frames women's health in relational, social and institutional terms. References to rights, respect, equality, autonomy, access to services and the role of health institutions indicate that, for some respondents, women's health is understood not only as a bodily condition but also as shaped by interactions with health systems and broader social arrangements.

Analysis of the open-ended item on perceived needs (N = 332 analytically distinct units following segmentation of multi-issue responses) reinforces and deepens these patterns. The most frequently identified needs concern access to health services, including the availability of services and professionals, financial barriers, waiting times and, to a lesser extent, geographic accessibility. These needs are articulated in concrete terms, reflecting practical constraints encountered in everyday interactions with health services, particularly in relation to gynaecological care, pregnancy follow-up and specialist consultations.

Literacy, education and the dissemination of information emerge as another central area of need. Respondents highlight the importance of clear, accessible and trustworthy information about women's health, as well as education and awareness-raising initiatives targeting different life stages. These responses suggest that information gaps are perceived as a significant obstacle to informed decision-making and effective health management.

Menopause and healthy ageing form a distinct category of perceived needs, encompassing requests for information, preparation and support during menopausal transition, as well as broader concerns with ageing-related health. Although less frequent than access or literacy-related needs, the internal coherence of this category indicates its salience for a subset of respondents.

Mental health-related needs are also reported, including access to psychological support and recognition of mental health conditions as part of women's health. Additional needs, expressed with lower frequency, relate to reproductive health and related life-course processes, quality and organisation of services (including humanised care and cultural competence), prevention and screening, pregnancy and maternity support, respect and autonomy in clinical encounters, research and knowledge production on women's health, and experiences of violence, abuse and stigma.

Finally, a non-negligible proportion of responses reflect uncertainty or difficulty in identifying specific needs, expressed through statements of lack of knowledge or indifference. These responses constitute a distinct analytical category and point to heterogeneity in awareness, engagement or perceived relevance of women's health as a policy and care domain.

Overall, the results show that respondents conceptualise 'women's health' as a multidimensional construct, centred on reproductive health and life-course processes such as

menstruation and menopause but extending to mental health, prevention, access to care, information and interaction with health services.

Exploratory sociodemographic comparisons further suggest that these conceptualisations were not uniform across the sample. Age-related variation was particularly visible: younger respondents more frequently referred to fertility, maternity and mental health, whereas older respondents more frequently associated women's health with menopause, disease and institutional or sociocultural barriers. Educational attainment did not show the same pattern in relation to spontaneous conceptualisations, although differences by education emerged in other survey dimensions, including perceived access to health information and the types of health needs identified. Given the non-probabilistic sample and the exploratory nature of these comparisons, these patterns are interpreted as within-sample variation rather than as population-level differences.

4.4. Reported Needs, Barriers, and Experiences in Healthcare

The experiences reported by survey respondents suggest a pattern combining generally positive interpersonal interactions with persistent structural, communicative and organisational shortcomings. Although a majority reported no direct gender-based discrimination, respondents also identified gaps related to communication practices, cultural responsiveness and the visibility of gender-specific considerations in routine care (Table 4).

Table 4. Summary of women's reported healthcare experiences.

Indicator	Main Result
Respect for beliefs and values	67.5% reported that their individual beliefs and values were respected most of the time or always.
Cultural responsiveness	72.4% reported that professionals rarely or never asked about cultural factors.
Communication difficulties	35.4% reported difficulties sometimes; 33.6% rarely.
Gender discrimination	60.4% selected 'never'; 39.6% reported having felt discriminated against because they were women at least rarely.
Cultural discrimination	79.5% reported never having felt discriminated against because of their ethnicity or beliefs.
Gender competence	39.9% considered professionals prepared; 40.7% were unsure.
Preference for female professional	39.2% expressed a preference for female healthcare professionals.

Around two-thirds of respondents (67.5%) reported that their individual beliefs and values were respected most of the time or always. Conversely, nearly one-third did not report this level of consistency, indicating that consistently respectful care was not universal. By contrast, active enquiry about cultural factors that might influence treatment appeared considerably weaker. In the survey, these factors were operationalised through examples such as religious beliefs or traditional practices, and most respondents reported that health professionals rarely or never asked about them. This pattern suggests limited proactive engagement with the cultural factors explicitly measured in the survey.

Communication also emerged as a central dimension of healthcare quality. Although communication difficulties were reported by some respondents, there was near-universal agreement regarding the importance of receiving information in clear and accessible language, highlighting communication as a core component of person-centred and gender-sensitive care (Table 4).

Reported experiences of direct interpersonal discrimination present a more complex picture. Although 60.4% reported never having felt discriminated against because they

were women, 39.6% reported having felt discriminated against because they were women at least rarely, indicating that perceived gender-based discrimination in healthcare was reported by a substantial minority. These findings concern perceived discrimination in interpersonal healthcare encounters and should not be interpreted as evidence that structural gender discrimination is absent. Gender inequities may also operate through less visible institutional mechanisms, including professional training, service organisation, communication practices, resource allocation and the relative prioritisation of different health needs. Reports of discrimination related to ethnicity or beliefs were less frequent, although these findings should be interpreted cautiously as respondents' perceptions of direct interpersonal discrimination, particularly because the survey did not collect ethnicity, race, nationality or migration background and therefore cannot assess how such experiences vary across population groups.

Perceptions of professional preparedness were notably uncertain: only 39.9% considered healthcare professionals prepared to address gender differences, while 40.7% were unsure. This suggests that gender-sensitive competence is not clearly visible to a substantial proportion of service users. In addition, 39.2% expressed a preference for a female healthcare professional. This finding indicates that provider gender is relevant to a substantial proportion of respondents, although the survey did not investigate the reasons underlying this preference. Taken together, these findings indicate that women's healthcare experiences are characterised by generally respectful interpersonal interactions coexisting with persistent shortcomings in communication, cultural responsiveness and the explicit integration of gender-sensitive approaches. The relatively limited reporting of direct interpersonal discrimination should not obscure more subtle but consequential limitations in organisational responsiveness to women's diverse needs across the life course.

These results indicate that women's healthcare experiences are characterised by positive interpersonal experiences alongside a substantial minority reporting perceived gender-based discrimination, alongside persistent shortcomings in access, communication, cultural responsiveness and the explicit integration of gender-sensitive approaches. These patterns highlight the importance of distinguishing interpersonal experiences from broader structural mechanisms through which gender inequalities may be reproduced within healthcare.

4.5. Cross-Source Synthesis

To facilitate comparison across the different sources of evidence, Table 5 summarises the principal findings emerging from policy documents, parliamentary debates, interviews and women's survey data, highlighting areas of convergence, divergence and limited policy attention.

Table 5. Cross-source synthesis of the main findings.

Analytical Theme	Policy Documents	Parliamentary Debates	Interviews	Women's Survey	Cross-Source Synthesis
Women's health framing	Predominantly reproductive and maternal	Focus on reproductive rights and access	Broader life-course perspective	Broad understanding including prevention, wellbeing and mental health	Convergence: Women's health is recognised across all sources. Gap: Institutional framings remain predominantly reproductive.
Mental health	Limited policy attention	Rarely discussed	Identified as a priority	Frequently identified as an unmet need	Convergence: Recognised as an important dimension of women's health by actors and survey respondents. Gap: Limited policy and parliamentary attention.

Table 5. *Cont.*

Analytical Theme	Policy Documents	Parliamentary Debates	Interviews	Women's Survey	Cross-Source Synthesis
Menopause	Weakly addressed	Not identified in the analysed corpus	Recognised as a neglected issue	Recurrent concern and information need	Divergence: Prominent in interviews and respondents' accounts but weakly visible within the analysed institutional sources.
Health literacy and communication	Limited operationalisation	Occasional references	Strong emphasis on information and communication	Strong demand for accessible and trustworthy information	Convergence: All sources acknowledge its importance. Gap: Limited translation into concrete policy action.
Governance and accountability	Fragmented responsibilities	Political recognition with limited operationalisation	Need for clearer institutional leadership	Reflected indirectly through reported healthcare experiences	Convergence: Women's health is recognised as a governance issue. Gap: Weak institutional coordination and accountability mechanisms.
Healthcare experiences	Not explicitly addressed	Not explicitly addressed	Communication and organisational barriers highlighted	Respectful interpersonal care coexisting with limited responsiveness	Divergence: Women's lived experiences highlight organisational shortcomings that receive little institutional attention.

Legend: Policy documents = national health and gender equality policy documents; Parliamentary debates = Diários da Assembleia da República (2014–2024).

5. Discussion

The findings position women's health in Portugal as a gendered policy object that is widely recognised yet weakly stabilised. Across policy documents, parliamentary debates, actor perspectives and survey respondents' accounts, women's health is repeatedly anchored in equity and rights-based language. However, recognition is only partially translated into a consolidated policy domain with clear ownership, operational instruments and sustained accountability. The resulting limitations are not best understood as downstream implementation failure alone, but as an upstream governance condition in which women's health is insufficiently constituted as durable and actionable over time.

5.1. Recognition Without Consolidation: Governance Alignment and Misalignment

A first and central convergence across policy framings and actor perspectives concerns fragmentation and the predominance of reproductive and maternal framings. National planning instruments and parliamentary discourse cluster around maternity, perinatal care and sexual and reproductive rights, while broader life-course dimensions remain comparatively residual. Actor accounts echo this diagnosis, treating reproductive health as necessary but insufficient and linking its dominance to weak agenda traction and episodic policy action. Governance-relevant effects arise when this framing effectively delineates what counts as "women's health" for planning, resourcing and service configuration, a pattern widely documented in comparative analyses of gender and health policy [8,10].

This convergence reflects a shared problem representation [12] in which women's health is rendered governable through framings that prioritise reproductive risk, access and rights. Life-course issues that are less easily translated into discrete programmes, biomedical categories or performance logics, such as menopause, cumulative mental health burdens, prevention and chronic conditions with disproportionate burdens among women, remain weakly problematised as policy objects. This mirrors long-standing critiques of androcentric governance arrangements that privilege acute, event-based interventions over chronic and socially mediated needs [14,25,26], and is consistent with this study's findings, where these domains appear as systematic marginalities rather than isolated omissions.

A second convergence concerns weak operationalisation. Policy documents acknowledge gender as a determinant of health and refer to disaggregated data, professional training and sensitivity to violence, yet rarely translate these commitments into dedicated strategic axes, measurable objectives, resourcing or monitoring arrangements. Actor perspectives align closely with this reading, explicitly linking policy invisibility to limited traction and diffuse responsibility. From a governance perspective, this supports interpretations of gender mainstreaming as symbolic or fragmented, in which equality is articulated as a transversal principle with dispersed obligations rather than embedded within mainstream health governance through clear responsibilities and enforceable expectations [2,10,11].

At the same time, analytically revealing divergences expose institutional incentives. Parliamentary debates remain comparatively narrow in practice, clustering around politically salient and ideologically contested issues, particularly sexual and reproductive rights. Actor perspectives advance a broader agenda centred on prevention, health literacy, communication and continuity of care. This divergence reflects a well-documented tension between political arenas, which privilege visibility, conflict and moral contestation, and governance or service arenas, which foreground system functions essential to equity but less amenable to political mobilisation [22].

A further divergence concerns ownership. Equality strategies adopt a horizontal mainstreaming logic that disperses women's health across plans without generating sector-specific custodianship within health governance. Actor narratives, by contrast, call for clearer institutional anchoring while also emphasising multisectoral collaboration. This points to a recurrent governance tension identified in gender policy research: without a designated centre of responsibility, collaboration risks amplifying diffusion rather than consolidating accountability [10,11]. The issue is therefore not whether intersectoral engagement is desirable, but how it is configured so that it complements, rather than substitutes for, institutional ownership and durable policy capacity.

Importantly, such consolidation should not be understood as the creation of a segregated women's-health policy silo. Doing so could reproduce the very marginalisation that gender-sensitive policy seeks to address, particularly if reproductive health becomes institutionally separated as a "women's issue" while mainstream health policy continues to operate through implicitly gender-neutral or male-normative assumptions. Rather, consolidation requires gender-responsive objectives, responsibilities and accountability mechanisms to be embedded within mainstream health governance, while maintaining sufficiently explicit institutional ownership to prevent women's health needs from being diluted through diffuse mainstreaming. The policy challenge is therefore to combine integration with accountability: women's health should be part of mainstream health policy, but not rendered institutionally invisible within it.

5.2. Policy Silences and Life-Course Limits

If convergence and divergence reveal how women's health is framed and governed, policy silences expose the boundaries of what becomes actionable. The uneven visibility of mental health, menopause, chronic conditions with disproportionate burdens among women and other life-course concerns is analytically significant not simply because these issues receive limited attention, but because weak recognition constrains their constitution as durable policy objects with defined objectives, responsibilities and mechanisms of action [10–12]. These patterns are not uniform: some issues, such as menstrual health, appear episodically in political discourse without becoming part of a sustained life-course policy framework. Policy silence is therefore better understood as a continuum of institu-

tional visibility and operationalisation rather than as a binary distinction between presence and absence.

This pattern is consistent with critiques of androcentrism in health systems, whereby women's health continues to be institutionally framed primarily through reproduction while prevention, chronic conditions with disproportionate burdens among women, and broader life-course needs receive comparatively limited or fragmented policy attention [8,9,14,15,25,26]. The Portuguese case illustrates how these dynamics become visible across policy documents, parliamentary discourse and actor perspectives, suggesting that formal commitments to gender equality are not consistently translated into operational priorities or accountability mechanisms [2,10,11].

Menopause provides a clear illustration of these life-course limits. Although women frequently identified it as an important transition requiring information and support, it remains only weakly articulated in policy and parliamentary arenas and receives limited attention from governance actors. This suggests a persistent difficulty in translating life-course processes, shaped by cumulative social, occupational and health inequalities, into stable policy priorities with defined ownership, objectives and monitoring [8,38,42]. Consequently, issues that remain weakly problematised are more likely to receive episodic political attention than sustained institutional commitment, reinforcing the broader governance challenge identified in this study.

The contrast with other life-course and chronic health needs is also instructive. Actor accounts draw attention to conditions with substantial female prevalence, including rheumatic and autoimmune conditions, while menstrual health appears only intermittently in political debate. Together, these patterns suggest that policy silence is better understood as a continuum of institutional visibility—from near absence to episodic recognition- rather than as a simple binary distinction between presence and absence.

5.3. Women's Perspectives: Internalisation, Expansion and Navigation

Survey respondents' conceptualisations of 'women's health' offer a critical lens through which to assess how institutional framings are reproduced but also extended in everyday understandings. While spontaneous associations largely mirror dominant reproductive framings and references to life-course processes such as menstruation and menopause, respondents' accounts situate these concerns within broader trajectories involving mental health, prevention, access, information and continuity of care. This suggests that institutional agendas and public discourse may contribute to shaping what is readily recognised as women's health [1,2], while respondents' priorities simultaneously expose dimensions that remain less visible within formal policy and service logics. The resulting tension is not simply between narrower and broader definitions of women's health, but between event-focused institutional framings and lived understandings organised around cumulative needs, navigation and continuity across the life course [8,9,38,40,41].

An important implication is that fragmented policy arrangements may shift greater responsibility towards individuals. Where women's health is addressed through dispersed programmes and limited institutional coordination, service users may be required to navigate multiple services, information sources and life-course transitions with relatively little systemic support. This illustrates how governance arrangements can shape not only service provision but also the everyday work involved in coordinating care and making informed health decisions [2,8].

Information needs are particularly significant in this context. Respondents consistently identified accessible and trustworthy information as essential for engaging with prevention and healthcare, reinforcing health literacy as an outcome produced through institutional communication as well as individual capabilities [3]. These findings highlight the impor-

tance of strengthening gender-sensitive communication and information pathways as part of a broader life-course approach to women's health.

5.4. Respect Without Responsiveness: Experiences as Governance Signals

Women's reported healthcare experiences provide a more complex picture of how gender equity commitments and their weak operationalisation are enacted in routine care. Around two-thirds of respondents reported that their individual beliefs and values were respected most of the time or always, indicating that positive interpersonal experiences were common but not universal. At the same time, 39.6% reported having felt discriminated against because they were women to at least some degree, indicating that perceived gender-based discrimination was reported by a substantial minority. These findings coexist with communication difficulties and limited proactive enquiry into the cultural factors specifically measured in the survey, such as religious beliefs and traditional practices. Taken together, the findings suggest neither pervasive overt discrimination nor uniformly respectful and responsive care, but heterogeneous experiences situated within broader organisational and institutional conditions.

This distinction between respectful treatment and responsive care is analytically central. Respect constitutes an ethical baseline, but it does not in itself imply institutional capacity to adapt information, pathways and service routines to gendered needs over time. Equally, the absence of perceived discrimination in an individual clinical encounter cannot be taken as evidence that structural gender bias is absent. Such bias may operate through professional knowledge and training, service configuration, communication infrastructures, resource allocation and the institutional prioritisation of particular health needs, even where individual professionals behave respectfully. In person-centred and responsiveness frameworks, these limitations are therefore better understood as properties of organisational design and institutional priorities rather than solely as individual professional failings [21,43]. The Portuguese pattern points to uneven institutional embedding of responsiveness within routine care.

Responses concerning professionals' preparedness to address gender differences reinforce this interpretation. Only 39.9% of respondents considered healthcare professionals prepared to address gender differences, while 40.7% were unsure. Rather than indicating simply a lack of knowledge among service users, this substantial uncertainty suggests that gender-sensitive competence is not clearly visible as a recognisable dimension of routine care. Gender competence may therefore remain weakly embedded or insufficiently communicated through clinical practices and service pathways. This finding is consistent with broader critiques of androcentric health systems, in which overt discriminatory behaviour may be absent while gender bias persists through standardised, biomedical and event-focused models of care [14,25,26,29].

Provider gender was also relevant to a substantial minority of respondents, with 39.2% expressing a preference for a female healthcare professional. The survey did not investigate the reasons underlying this preference and it should therefore not be interpreted as direct evidence of discomfort with male professionals. Nevertheless, the finding indicates that provider gender forms part of the healthcare experience for a meaningful proportion of respondents and merits further investigation.

Taken together, these findings suggest that women's healthcare experiences provide an important signal of how governance arrangements are translated into everyday clinical practice. The reported experiences suggest neither uniformly discriminatory encounters nor uniformly responsive care. Instead, positive interpersonal experiences coexist with a substantial minority reporting gender-based discrimination, considerable uncertainty regarding professional gender competence, communication limitations and uneven attention

to women's broader circumstances and life-course needs. This combination reinforces the distinction between interpersonal conduct and systemic responsiveness: gender equity depends not only on how individual professionals behave, but also on how knowledge, services, communication and accountability are institutionally organised.

5.5. From Policy Recognition to Behavioural Empowerment

The findings suggest that strengthening women's health requires attention not only to governance arrangements but also to the informational and communication environments that enable women to understand health needs, navigate healthcare systems and engage with prevention and care. Across data sources, prevention, health literacy and communication emerged as recurring priorities. Governance actors emphasised shortcomings in education, outreach and public communication, while women consistently identified access to clear, accessible and trustworthy information as one of their most important unmet needs.

This convergence positions health literacy not simply as an individual attribute but as an outcome shaped by institutional arrangements and communication practices. Contemporary scholarship increasingly recognises that individuals' ability to make informed health decisions depends not only on personal capacities but also on the accessibility, relevance and quality of available information [3,6]. The present findings reinforce this perspective by showing that communication gaps are particularly relevant in areas such as prevention, mental health, menopause and other life-course health needs that remain weakly institutionalised.

These results have important policy implications. Strengthening women's health requires sustained investment in communication strategies, health literacy initiatives and gender-sensitive information pathways alongside improvements in governance and service organisation. Such measures would support informed decision-making, facilitate engagement with prevention and contribute to more responsive care across the life course.

6. Conclusions

This article shows that women's health in Portugal is not marginal to policy, but remains insufficiently consolidated within mainstream health governance as an explicit and accountable dimension of gender equity. Across policy documents, parliamentary debate, actor perspectives and survey respondents' accounts, gender equality is consistently recognised, yet only weakly institutionalised within stable governance arrangements. The core limitation lies less in the absence of commitment than in the absence of durable institutional anchoring, operational instruments and accountability mechanisms capable of sustaining action across the life course.

Bringing institutional framings and lived experiences into dialogue clarifies how this configuration shapes what becomes actionable within gendered health systems. Policy and political attention remain centred on reproductive and event-based priorities, while prevention, mental health, menopause, chronic conditions with disproportionate burdens among women and continuity of care receive more limited or fragmented attention. Survey respondents' reported healthcare experiences similarly reveal a mixed picture: positive interpersonal experiences are common, but not universal, while a substantial minority report perceived gender-based discrimination and many respondents remain uncertain about professionals' preparedness to address gender differences. These findings reinforce the distinction between interpersonal respect and system responsiveness. Organisational routines, professional knowledge, communication infrastructures and policy priorities can reproduce gender inequities even in the absence of overt discriminatory behaviour. Governance arrangements therefore shape not only service provision, but also the informational

and organisational environments through which women understand health needs, access support and engage with prevention and care.

The analysis reorients debates in gender studies on health and inequality towards questions of policy architecture and the institutional production of gendered inequalities. Treating women's health solely as a diffuse transversal concern can disperse responsibility and weaken accountability; however, consolidation should not imply removing women's health from mainstream policy into a separate institutional silo. The central challenge is instead to combine mainstreaming with explicit ownership: gender-responsive objectives, responsibilities, instruments and monitoring must be embedded within health-system governance in ways that preserve accountability and sustained policy capacity. This includes strengthening the communication and health literacy dimensions of gender-responsive health policy, particularly in areas that remain weakly visible within institutional agendas despite their salience in respondents' reported experiences and priorities. Such efforts are important not only for improving access to information but also for supporting preventive behaviours, informed health decisions and sustained engagement with care across the life course.

These conclusions should be interpreted in light of the study design. The survey was based on a non-probabilistic sample and included a relatively high proportion of younger respondents and respondents with higher education, which may have influenced how participants articulated health needs, healthcare experiences and health literacy. Consequently, the survey findings are not intended to be representative of Portuguese women but rather to provide exploratory insights into the experiences and perceptions of the participants. Exploratory sociodemographic comparisons indicate some within-sample variation, but these should not be interpreted as population-level differences. The survey explicitly targeted adult women but did not separately collect sex assigned at birth or gender identity; consequently, the study cannot examine whether experiences differ between cisgender, transgender or other gender-diverse participants. The survey also did not collect ethnicity, race, nationality or migration background, preventing intersectional analysis of healthcare experiences across racialised or minoritised groups. Findings concerning discrimination related to ethnicity or beliefs must therefore be interpreted with particular caution. The actor material also combines study-generated interviews with public-domain accounts that differ in their conditions of production; comparability was therefore established at the level of the analytical framework rather than by assuming equivalence between the two sources, and source provenance was retained throughout analysis and interpretation. The deliberately narrow parliamentary search strategy captures the explicit political framing of 'women's health' but may not identify condition-specific debates conducted under different terminology. Finally, there is a modest temporal offset between the institutional corpus, which covers policy and parliamentary materials up to 2024, and the survey conducted in 2025; the cross-source synthesis should therefore not be interpreted as a strictly contemporaneous comparison. Within these boundaries, the study develops an integrated interpretation through structured comparison across multiple data sources, focusing on patterns of institutionalisation, framing and agenda formation rather than population estimates or evaluations of individual health services.

Author Contributions: Conceptualization, G.S. and M.P.; methodology, G.S., M.B., M.A.S. and M.P.; formal analysis, G.S., M.B., M.A.S. and M.P.; investigation, G.S., M.B., M.A.S., A.F. and M.P.; writing—original draft preparation, G.S., M.B., M.A.S., A.F. and M.P.; writing—review and editing, G.S. and A.F.; supervision, G.S. and M.P. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study involved non-interventional social science research with adult participants and posed minimal risk. All study procedures complied with the principles of the Declaration of Helsinki and with the General Data Protection Regulation (EU Regulation 2016/679). Procedures were in accordance with the rules of the Ethics and Deontology Council of the University of Aveiro (Portugal), which were reviewed and approved by PARECER 02-DCSPT-M/2025.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data is available upon request to corresponding author.

Acknowledgments: The authors would like to thank UID/04058—Research Unit on Governance, Competitiveness and Public Policies (GOVCOPP), financed by national funds through FCT—Foundation for Science and Technology.

Conflicts of Interest: The authors declare no conflicts of interest.

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