

Introducing the gender perspective in national essential drug programmes

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Abbreviations

IUD	intrauterine device
IMF	International Monetary Fund
MSF	Médecins sans Frontières
STI	sexually-transmitted infection
SAP	structural adjustment programme
GDP	gross domestic product
UNDP	United Nations Development Programme
AIDS	acquired immune deficiency syndrome
PHC	primary health care
UNICEF	United Nations Children's Fund

Foreword

Medicine is one of the first responses to illness. Probably since time immemorial, human beings have had an ontological need for a mediator - the physician - and a mediating substance - medicine - to drive away illness, a sign of death. Medicines have always had a price, be it spiritual or material. No doubt, it is man's ethnocentric naivety, associated with the still vivid image of the "noble savage", which leads him to believe that traditional medicine was free. Through a system of barter or monetary exchange - cowries or dollars - medicine that promises to heal brings with it hope to which society affixes a price tag. "...the peasant slowly leaves the commercial district and, walking along the stream, returns to the highlands of Paklarev. On the one hand, in his breast he feels a nagging pain; on the other, in his pocket, Mordo's (the name of the traditional healer) powder wrapped in blue paper. And, throughout his body, another pain, a pain caused by regret at having thrown away his money, doubt and the fear of having been fooled. He walks towards the sunset, with an air of absent-mindedness and despair, for there is no creature more distraught and pathetic than a sick peasant." (Andric, 1987).

Moreover, and as a confirmation of the above, "medicines constitute the largest portion of the health budget of individuals and households. A study conducted in Mali revealed that households allocate 80% of their health budget to modern drugs as opposed to 13% to traditional medicine.... In Côte d'Ivoire and Pakistan, over 90% of household medical expenses are on drugs. Medicines or traditional products represent 62% of the cost of complete treatment in Burkina Faso." (WHO, 1997).

Yet, in the many volumes written on health and medicines, there is only a limited number of studies on the access women and/or men have to medicines. However, we talk of access of the "population" or a specific group, most often women and children, to health care. Obviously, health care implies the use of drugs but the one does not cover the other. Drugs are concrete objects as opposed to the abstract notion of health: to speak vaguely of persons or of the population, without distinction of gender, and of their insertion into health systems, is, in a certain manner, a way of removing the human aspect and keeping "suffering at a distance" (Boltanski, 1993). It is possible and indeed necessary to conduct these studies in order to deal with the problems of disease and treatment in their totality.

Nevertheless, as advances are made, they clash - an apparent contradiction - with the need to deepen and explore relations between the general and the particular. Medical anthropology has offered some answers but they remain inadequate. The various health specialists and experts in the social sciences should collaborate better to decipher the overlapping and positive or negative interrelations between patients and disease and patients and health care providers, in order to interpret them and take them into consideration. If indeed "individuals are unique and references are general" (Hours, 1995), then references

should also abide by the law of individualisation and search for the basis of human diversity.

It is within this two-tiered approach that WHO seeks to introduce the gender perspective in essential drugs and medicines programmes within countries, which begs the question, why?

The main objective of this document is to provide a conceptual framework in order to explain the situation of women and men with regard to health, and more specifically, drugs. However, although this study focuses on drugs, at the same time drugs receive minimum attention from a purely nominalist point of view. Indeed:

- If practices related to disease, and by extension, the use of drugs, are indissociable "from an articulated symbolic system" and that "the discourses which support them espouse general theories which organize the symbols whereby we envisage society as a whole" (Augé, 1986);
- If the role of drugs in health is fundamental but there is a limited amount of data on the use women and men put them to;

then, it appears that the only relevant method of treating the social subject is to comprehend, above all, the overall cultural, social and economic context in which drugs are used and, based on that understanding, reasonably formulate working hypotheses.

The health problems encountered by women will not be outlined again. Rather, in an effort to go beyond the fashionable use of the term "gender", the facts will be re-organized. In this way, while recognizing the legitimacy and necessity of current, immediate, future and sector-wide measures, the intention is to show that use of the gender concept, in fact, leads to a reconsideration of action to be taken, in the medium and long term, within the framework of a truly holistic approach. "It is not information which we lack. What we lack is the courage to understand what we know and to learn lessons from it". (Lindqvist, 1999).

The gender concept

Gender, in its narrowest sense, means socially constructed sex, be it female or male. It was in the 1970's that American and English feminists started using the terms "gender" and "gender relations". Hence the transition was made from "study of the differences between the sexes... to relations between the sexes both in the sense of social relations and conceptual relations". (Hurtig, Kail and Rouch, 1991). The word "gender" was to develop at a remarkable pace in the early 1980's (Nairobi Conference, 1985) in English-speaking and Latin American countries and also within all international organizations; its usage would be facilitated by the holding of a succession of important conferences such as the Cairo Conference (1994) and the Beijing Conference (1995) during which the term definitively established itself. Yet if one were to contemplate the subversive nature of the gender concept, one would wonder why the term became such a catch word. A number of reservations need to be made and it should be noted that, all too often, the word is used simply as a synonym for woman, or the female sex. Such improper usage consists precisely of disguising or erasing to some extent the word "sex". It can therefore be reasonably assumed that it is this watered-down, almost "dulled" meaning of the word which, by removing much of its epistemological and ideological force, vindicates its excessive use.

This is why it is important to outline the most fundamental implications of the definition provided above, for they will guide and set the tone for this work.

The gender concept implies:

- A rejection of the underlying biological distinction in the word "sex" and in the expression "sexual inequality", which appears as "an ideological alibi for maintaining domination, the alibi of nature". (Hurtig, Kail and Rouch, 1991). Women are no more part of nature and no less part of culture than men;
- Grouping together all the differences identified between men and women, be they individual differences, differences in social roles or cultural representations, i.e., the grouping together of all that is variable and socially determined;
- The non-homogenous nature of the category of women, which is transcended by differences of class, ethnicity and age;
- The basic asymmetry and hierarchy between both groups, sexes and genders - one of them dominating and the other dominated - which is the basis of male power;
- The overriding need, regardless of the problem, to consider men in relation to women, whether these relations are complementary or conflictual. It is within these gender relations that power intervenes, in its most virulent or subtle forms, and that it needs to be clarified in order to understand the

complexity of the situation. Further and more detailed reference will be made to the fact that gender relations are power relations, and this is one of the determining factors in women's access to health and medicines.

Gender implies knowledge of the difference between the sexes, yet that knowledge is also a way of organizing the world and is inseparable from the social organization of those differences. Knowledge, much like power, which is one of its pillars, is neither determined nor finite; it is variable and subject to countless changes. The same is true of complementarity and opposition between the sexes which can change and come about through changes in society.

Gender is therefore an essentially dynamic concept which brings into question the apparent immutability of social roles. Despite these advances in theory, women continue to be placed, implicitly, in the category of nature - instinct, sentiment, irrationality - while men, on the contrary, are placed in the category of culture - reflection, abstraction of a mental system. A recent example illustrates well the commonness of this type of stereotype. On April 16, 1999, a reporter with France Inter was reporting on a group of refugees as follows: "...crying women, starving children, humiliated men...." The choice of words, even if unintentional, was not innocent.

Two points should be made on this unequal structure in which gender relations are played off, namely:

- This quasi-universal inequality and subordination has been able to endure for all these centuries only because each and every society has designed the kind of education that produced freely consenting cultural submission in women. "Habit, which has such a great influence on all things in us has, above all, the power to teach us to serve and, as is told of Mithridates, who accustomed himself to poison, the power to teach us to swallow the venom of servitude without finding it bitter." (La Boétie).
- The social construction of this submission which goes by the name of nature (feminine nature) is so fine-tuned that, for example, women such as peasants and urban street traders in the informal sector, who do 10- to 12-hour days of unpaid reproductive and productive work, state in census surveys that they are housewives, i.e., they are classified as unproductive according to the list of categories. Yet it is common knowledge that their work, in fact, increasingly ensures the family's survival. Excision is another example that shows how freely submissive women accept genital mutilation and suffering in order to keep up with social traditions and symbols. Yet it should not be forgotten that men too, from a tender age, are trained to be dominant and will exercise that domination just as "naturally" as women submit to it. Submission should be considered as a logical agent of cultural order. This is how social order is constructed and reproduced through perpetuated values and representations still very much prevalent today and why the ideological dismantling of that order is far from being a reality.
- Doubtless, women are subordinated, submissive, more or less marginalized, depending on their country, from the economic, legal, religious and political spheres. Nevertheless, one should be wary of holding them up as victims, and victims alone, regardless of what form of violence the oppressive social

regime inflicts on them. They know and have always known how to defend themselves, invent answers and strategies which give them some leeway for negotiation and relative freedom. What is remarkable is that women, faced with difficult situations and in charge of the daily survival of children and the elderly, do not lose hope; instead, they fight, find new answers, invent new solutions, group together with other women better to organize their daily struggle in the form of nurseries, alternative day-care centres, new family structures (e.g. sisters, mothers and daughters) and new economic activities such as organizing garbage collection. In response to the crises they face and the socio-economic changes which accentuate their exclusion, they seek an answer not in tradition, but rather, in modernity. Obviously, not all women react that way, but a great many of them do. On the contrary, many men faced with a situation that undermines their authority such as unemployment or an accident in the workplace far too often adopt an escapist attitude, seeking refuge in alcohol, violence or abandonment. Indeed, in times of adversity women, who were educated to be subservient, fight and resist, even at the cost of great suffering, while men, who were educated to be dominant, do not know how to react in situations which deprive them of their "natural authority". The problem is serious enough, even if studies on the subject are still few and far between, to warrant some measure of concern from several development organizations. They need to ask themselves more and more frequently how to make men assume their responsibility.

Gender and health relations

Science has, to the present day, been marked by an "andropocentric" bias which is now widely acknowledged. When, in describing social phenomena, gender relations necessarily consider women, they complicate the analysis. In fact, "the operative categories as regards both the definition and identification of scientific problems and the spontaneous perception of human activity have to be questioned: the workplace versus the family, political as synonymous with partisan and, more generally, the equations of female/reproduction/private domain and male/production/public domain" (Defossez, Fassin and Viveros, 1992).

In our forward, we stated that there was as little data on the access women have to medicines as for men; the same cannot be said for health-related data, however. In this area, on the contrary, there is a large number of medical and sociological studies on women and health, the overwhelming majority of which is devoted to the reproductive health of women. At a first glance, that focus would seem to be justified. After all, is not reproduction an absolute imperative for any group of human beings just as it is for all animal species?

However, the correctness of this reasoning should not conceal the fact that the overwhelming emphasis placed on the reproductive health of women also leads to dual inequality in gender relations.

Fertility

The first inequality resides in the biological and then symbolic fact of reproduction and motherhood. In all societies, the reproductive difference between men and women has always been a question of power. Culture, society and religion have always wanted to control women's fertility, not only through rules and customs, such as excision, for example, but also through very elaborate thought systems which "justify" the inferiority of women by their so-called "immersion" into nature. This is a poignant paradox: motherhood, presented as "an instant bestowal of femininity" (Mathieu, 1985) implies that women produce the very fabric of society while remaining excluded from society. Motherhood represents an essential reality which men have always wanted to master, for it is linked to kinship, or in other words, social order. The devaluation of women's natural capacity to have children has therefore coupled, in the interests of social efficiency, with the over-valuation of motherhood on a purely rhetorical level, thus reinforcing women's sense of family duties, responsibility and dedication. Not only do women accept this, they also demand it, for it is their only source of positive identity in the eyes of society. To achieve social recognition, women have to be mothers, and this notion persists in most societies. It is "the social exercise of motherhood" (Tabet, 1995) for which women have been educated which explains why they internalize the uplifting belief that they alone are responsible for children, both biologically and socially.

The second inequality lies in the fact that control over fertility is exercised not only within each family in any given society but also, more generally, globally in the form of population policies.

This double imposition of male power attests to the difficulty experienced and time it took (roughly 30 years) for women to have the notion of reproductive rights recognized. The Cairo Conference (1994) declared in its Programme of Action that women should be able to "make choices, without discrimination, coercion or violence" with the aim of attaining "the highest possible level of reproductive and sexual health". The social complexity of the decision to procreate and the power relations which may come into play have finally been recognized. Yet that resolution was voted in by 179 countries and rejected by 23. One year later, the Beijing Conference confirmed the right of women to "exercise control over issues related to their sexuality". That was the first international recognition of the right to sexuality without violence. If indeed Arlette Poloni was justified in writing that "the major international conferences are essential places for the ultimate crystallization and consecration of a utopian ideal world order" (Poloni, 1995), then it would be reasonable to think that previous distortions are not likely to cease. Consider the 1979 Convention on the Elimination of all Forms of Discrimination against Women which is still very far from being respected even in those countries that ratified it.

This new international instrument should, nevertheless, pave the way for more effective efforts if the problems which have been identified and condemned are heeded, namely:

- The quasi exclusive focus on the reproductive health of women, notably in family planning or "safe motherhood " programmes which fail to take into account other aspects of health; women patients who are monitored for contraception are not treated for numerous gynaecological disorders, notably in Egypt (Zurayk et al., 1994). "The family planning programme in Indonesia is getting accolades while maternal mortality remains at a rate of 390 per 100,000 births" (Gautier, it would seem).
- Maternal mortality (500,000 deaths per year) is 30 times higher in developing countries and resources to diminish that mortality rate whose causes are multiple and known, are still little used even though, according to WHO, it would imply the implementation of a comprehensive strategy, which seems relatively simple. Is it not rather the more or less unthinking absence of political will, so necessary for mobilizing resources to save the lives of women, particularly poor women who are valued so little within society?
- Moreover, 500 million couples would like to be able to resort to family planning but do not have access to it (Euréka, 1997) and many women abandon contraceptive measures because of complications such as bleeding, uterine contractions and incontinence which are rarely ever taken seriously by health care providers.
- Every year, there are over 20 million abortions (a highly under-estimated figure) giving rise to 700,000 deaths for various reasons such as lack of access to family planning, unaffordable or ill-suited contraceptives (only one size of IUD, for example), depleted stocks and lack of information. Another cause is

the introduction of a family planning programme which does not take into account an overly hostile religious context, a patriarchal context so strong that it obliges women to obtain their husband's consent to go to family planning centres (difficult for married women, impossible for single women, widows or an increasing number of adolescents who fall pregnant) and an economic context so devastating that women, and also couples, prefer, particularly in rural areas, to have several children. In contrast, certain Asian countries authorize the destruction of female fetuses detected by amniocentesis.

- Training and information targeting women alone, even though the importance of men in the decision-making process and their interest in the issue are well-known.
- Finally, between 60 and 80 million persons suffer either temporarily or permanently from sterility caused most frequently by STIs. Most times, programmes geared at preventing the meteoric spread of STIs and AIDS target women, most of whom, precisely because of male domination and sexual dominance (referred to above), are not in a position of independence to impose the necessary precautions on their partners. Yet sterility represents for men, but even more for women, a personal and social drama which can lead to the rejection and abandonment of women.

The inconsistencies of this scenario would disappear if one were to analyse the situation in the light of a double rationale referring, on the one hand, to the observation about male authority (family, religion, state) devaluing women and controlling their fertility and on the other, the imposition of birth policies in countries which do not entirely want to impose them, but which do so because of financial and strategic interests and only secondly, in an effort to improve women's health. Whatever the reason, whether it be because they are subject to cultural or religious customs or because of two, often contradictory legal systems (the national and the traditional), women are still far from being able fully to enjoy their reproductive rights, despite their international recognition.

Malnutrition

Nutrition is of special significance for women from as early as childhood. "Indeed, poor nutrition can have cumulated effects from one generation to another throughout the different stages of a woman's life. Protein-energy malnutrition and micro-nutrient deficiencies at different stages of her life can be a factor in morbidity and mortality due to various infections or chronic illnesses" (WHO, 1994) or tropical diseases such as malaria and leishmaniasis. Worldwide, 43% of women and 51% of pregnant women are anaemic. In developing countries, 56% of pregnant women are anaemic and this figure can reach as high as 88% in India. These deficiencies can increase the rate of abortions, haemorrhaging during childbirth, miscarriages, birth defects, low birth weights and infant or child mortality.

A number of causes, including poverty, affect women more than men as is illustrated below:

- First of all, cultural factors, such as dietary prohibitions, which forbid women, from an early age and throughout their life, to eat certain foods such as eggs and certain types of meat, or custom which dictates that women should serve more copious helpings, particularly of sauce and meat, of dishes prepared for men and young boys.
- Apart from these reasons, there is another, more important cause not very often associated with nutrition: radical changes in production systems within developing countries and, above all, the disintegration of female agricultural production systems. Although women have almost never had access to property, custom did allow their husbands to grant them the usufruct of one or more parcels of land where they could grow vegetables, legumes and grains for household and commercial use. Those crops, essential in maintaining a balanced and varied diet, have always been rather contemptuously designated as mere "condiments" for sauces. Colonisation and, subsequently, development projects imposed land-intensive export crops which pushed back land used by women to the less fertile outlying areas of the village and reduced their surface area. The heads of development projects, convinced of the universal nature of the Western model of the single family budget, refused to recognize either that husband and wife kept their finances separate or that the nutritional and financial contribution made by women was anything more than free family labour. This was done with the blessing of peasants who did not wish their wives to be financially independent and is therefore a system of dual male power. Yet, studies all show that men, unlike women, spend more on themselves than on their family. These economic contradictions, strongly condemned in the 1980's (Bisilliat, 1985), still persist and are compounded by economic crises and structural adjustment policies which oblige women, more than ever, to try to find ways of satisfying their needs and those of their children. Deprived of land title, they could not obtain loans which would enable them to purchase the necessary inputs to achieve higher crop yields or to undertake income-earning activities. In this context, gender relations and power relations forced peasant women into rising poverty. Use of the word "gender" by a number of development agencies, although it does make room for some meagre advances, does not really change the situation in any meaningful way. Women remain largely absent from decision-making structures although it has been recognized that the food crisis may only be overcome with their contribution in food crops.

Mental health

Rural women have to cultivate men's fields, their own fields, fetch water, firewood, transform produce into family meals or for sale, look after the children and tend to them when they are sick, which represents 12- to 14-hour work days. Urban women have the same household responsibilities which are classified as "unproductive" because they are "natural". In addition, they have poorly paid activities in the informal sector, meaning that their work day is equally long. The physical fatigue is tremendous but the emotional fatigue caused by stress when faced with difficult situations, anxiety and frustration at not being able to succeed should also be mentioned. Another parameter accentuating this nervous fatigue should be taken into consideration: living in such an unstable situation (eviction, no food, sick children, heavy or unstable work) that it is impossible to plan ahead, sometimes even from one day to the next. This fatigue is one of the results of empowerment and of the financial responsibility assumed by women for their children. Finally, the prevalence of violence - domestic or other - and rape, on which statistics are now starting to emerge, only make the burden of fatigue heavier and more unbearable. This leads to depression. It is not surprising, therefore, in these circumstances, that women are the biggest consumers of tranquillisers.

Overburdened schedules have a tremendous impact on women's health. They often cannot find the time to go, along with their children, to a health centre or hospital where the rigid opening hours do not always coincide with their free time and where the queues are far too often never-ending. In addition, in rural areas transport is rare, even non-existent and in urban areas, buses and timetables are often designed with workers in mind (Coutras, 1992). Because certain health services such as antenatal care, family planning and immunization are not integrated and are offered on different days (Kitts and Hatcher Roberts, 1996), women find that they waste an enormous amount of time which could have been spent working and that, no doubt, can act as a deterrent.

Power: the common denominator of gender relations and health systems

The previous pages have shown some of the consequences of the central role of male power and its manifestations on women's health. Yet there are other forms of power at stake, even within health systems, and their effects are cumulative.

This paper has drawn much inspiration from Didier Fassin's 1992 analysis, which was based on his study in Dakar. The concept of power, closely linked to knowledge in the area of health, goes far beyond the narrow conception of politics in the sense that it "covers all representations and practices through which an individual or group enters into a power relationship with others. It may be political, religious, economic, magic or healing power, among others. Power, therefore, puts the social construct in its entirety and social structures on terms of inequality into play..." This theory is confirmed by Glick (1967) who considers power as the main, universal principle for defining medical systems. In its interaction with physicians, traditional healers and religious sects (some of which have powerful networks for distributing arms, drugs and even medicines), health continues to be a stake in politics. This implies clientele connections which facilitate enrichment and influence. The increasing power over the mind and body consolidates the symbolic capital of the actors on the stage of the health system, whatever their role in the hierarchy (nursing assistant, hospital director or drug-trade executive) and their political capital. The "participation of the population in community health" also abides by this same rule. In fact, members of local committees (the titles may change but the reality is the same) are local personalities or district representatives, nearly always men, who seek to exercise or strengthen their authority over a rural or urban area. To do so, access to strategic positions - regardless of their importance - leads to or reinforces political representation. Similarly, the arrival on the scene of traditional healers and midwives in scientific and modern health systems increases their legitimacy and popularity and that of those who support them before the people. Nevertheless, it would be erroneous to deduce that patients, despite being in a dominated position, remain absolutely helpless. Alone or in groups - and in this respect women's groups are significant - they express their solidarity while attempting to make the best of available health care facilities, thereby perpetuating the social link which is ever so important for community life.

From this perspective of power, the importation of the Western biomedical model only serves to highlight the disparities among the social classes and, furthermore, the difference in treatment given to patients depending on their social background. These disparities are significantly widened on the basis of the patient's sex.

Most physicians believe that lower-class patients are ignorant, careless, do not do as they are told and go to see traditional healers. In short, they lack intelligence. It is therefore not at all surprising that the medical relationship between physicians

belonging to the dominant class and their patients (the others) is unbalanced and smacks of paternalism, disdain or indifference. "In the minds of certain physicians or other personnel, there is an often unexpressed notion that taking the patient's social and/or cultural context into consideration is "something extra", even a luxury, which cannot always be offered to the patient in medical emergencies" (Bonnet, 1990). Since better quality medical relationships imply that medical personnel recognize the dignity of their patients, it is normal that the context described above of power/knowledge does not allow for such relationships in the majority of cases.

In addition to physical deficiencies such as lack of equipment, drugs, antiseptics, medical and paramedical personnel (Viveros, 1990), there are also irregular relationships which affect women in particular since they are the least considered in society. Many studies have condemned bad treatment, impoliteness, brutality and disrespect meted out to women by doctors and perhaps even more by auxiliary personnel who adopt the mannerisms of their superiors by believing that they have been invested with some measure of their power. "... they treated me so bad, so bad... I came back home and never went back." Or "...the students were there, they undressed me, they touched me. I am scared to go back." (Bonino, 1994). As another female researcher wrote, there is a great chance that a woman who has been badly treated in a health centre will never go back.

Gender relations and medicines

WHO introduced the concept of essential drugs and medicines as early as 1975 and implemented its Action Programme on Essential Drugs in 1981. Nevertheless, it is estimated that one-third of the world's population still does not have access to essential drugs and medicines and that figure reaches over 50% in the most disadvantaged regions of Africa and Asia (WHO, 1998). Seventy-five per cent of that population is composed of women and children. "This year (1998), in developing countries there will be over 40 million deaths, of which one-third will be under 5-year olds. Ten million of those deaths are the result of acute respiratory infections, diarrhoeic diseases, tuberculosis and malaria, for which safe and inexpensive essential drugs and medicines capable of saving lives are available. With a simple preparation of iron folate, the rate of maternal and infant mortality due to anaemia in pregnant women can be reduced...." (WHO, 1998). Yet the reality, according to the same document, is that "medicines are unavailable, too expensive, used incorrectly and of mediocre quality".

Statistics and data

How can one react to this situation when very few statistics are available to offer guidance on what should and should not be done? Despite the forceful demands made over and over at major international conferences (1975, 1980, 1985, 1994 and 1995), gender-specific statistics in the area of health remain limited when compared with other areas. Each time a problem requires serious reflection, all that is available are "incomplete" data for one or the other sex. From this perspective, figures on aspects of the reproductive life of women are insufficient to paint a true picture. Would it not be useful, and indeed enlightening, if comparisons were possible? Certainly, at least from the medical and sociological standpoint and even more from the perspective of analysis of both sexes.

Statistics are, in fact, an ideological sound box; including women in statistics would mean granting them precise, irrefutable recognition, something which has been avoided for over 20 years, despite vociferous demands for that very recognition. After all, aren't mathematics the male-dominated domain par excellence?

What Stella Chungong (unedited) wrote on Africa has already been mentioned and deserves to be extended globally to include both sexes: "There is an absolute penury of information among African women about how to use drugs..." Yet some information is nevertheless available:

- The impact of physical and biological differences between men and women on the epidemiology and aetiology of diseases is virtually unknown, "research on health having often been conducted by male subjects who assume that the results are valid for men and women" (Kitts and Hatcher Roberts, 1996). Women react differently to treatment and their bodies

metabolise medicines in a different way. In short, as Donna Stewart of the University of Toronto wittingly pointed out, "women are not just men without menstrual cycles" (Priest, 1994).

- There are also gender-related differences which are cultural, not biological, the consequences of which have not yet been studied. For instance, from the perspective of occupational medicine which almost exclusively concerns men, the consequences of women's working conditions on their health (meticulous, repetitive tasks, carrying heavy loads such as water and wood, inhaling fumes from prolonged cooking of foods, etc.) remain largely unknown. Another example is women's tolerance level of suffering which is much higher than men's. They are more used to being devalued and not paying attention to their bodies, which holds them back from consulting a physician as quickly. "Women tend to suffer in silence...the threshold of illness recognized by society on the illness-health continuum is so high for women that they endure so much in order not to disrupt household organization." (Okojie, 1994). Moreover, it is well-known that men are treated more easily, spend more on their health and also, that physicians take their complaints, even light ones, into consideration more than women's. For example, Smyke (1991) shows that when men and women describe the same psychological or psychosomatic symptoms, physicians tend to have tests run for men and renew a prescription for mild tranquillisers, if they have already been prescribed, for women.

Indeed, most conclusive research deals with population and family planning, the object of which (and there is consensus on this) is not a better understanding of women's basic health needs but to contain the rate of demographic growth. The exclusive focus on reproductive health or anti-birth policies have been justified in the name of better levels of development, although they have not really made any impact on development. They have also been hailed as embracing women's rights and reproductive health "for a better life for future generations" (Dupâquier, 1999). It should be highlighted that all these efforts are made within the moralising and conservative context of the family in its narrowest sense. The number of pregnant teenagers who do not have the right to use contraceptives and who have abortions with a high mortality rate - after all, it's their fault - as the Republicans of the USA claim - illustrate that health and well-being are applied in a strangely restrictive manner to women. Between 38 and 68% of the women who seek treatment for complications as a result of abortions in hospitals in the Congo, Kenya, Liberia, Mali, Nigeria and Zaire are under 20 years of age. Women's needs are judged secondary because they are perceived, above all, as mothers or future mothers while "men's health is never defined in the family or paternal context" (Rathgeber and Vlassof, 1993). "Women are supposed to take care of others, not to be taken care of".

The role of women in providing health care

According to the World Bank (1993), women, although they are not recognized as health care workers, are in fact responsible for between 70 and 80% of all health care provided in developing countries. They therefore have a unique position as care providers for the family and the community. Yet is it not surprising that the World Bank - or any other organization for that matter - affirms at the same time the need for empowerment of women on the one hand, and on the other, their complete responsibility for health? It should be underscored that this responsibility is not shared by men, which poses another significant problem. This attitude masks perhaps, once again, the implicit idea that women take care of their sick children because that is just an extension of their physiological role, i.e., it is "their nature".

The use of this term, as well as of the terms "provider, manager, consumer, head of medical supplies" reveals some measure of confusion. How could women, whose subordinate role in society has already been described, suddenly be responsible for between 70 and 80% of health care? In this context, what is the meaning of the notion of responsibility? True women perform these tasks, there is no doubt about that, but under what conditions? Caring for children, for example, without having the right to go and see a physician, or not being able to consult one because the physician is too far away, or not having enough money to afford a visit or medicines is definitely a responsibility, and an immense one at that. Yet it is a mitigated responsibility and therefore, an incorrect usage of the term. The reference made to that reality, accepted and repeated like an incantation, should be examined closely in order to uncover the profound, gender-based inequalities which it conceals and uses as a weapon. Several hypotheses may explain the statistics mentioned above, namely:

- Women from varying social backgrounds with different hierarchical responsibilities are grouped together.
- Male health care accounts for between 20 and 30%, the rest represents health care for children and women for which women have complete responsibility, and in which men are totally disinterested (this is contradicted by many observations).
- The State is aware of the unfaltering responsibility women have for the health of their children; by recognizing that responsibility officially, the State may relieve itself of its duties and obligations (as has already been highlighted by many women researchers).
- Or, more likely, the reality is a blend of the three hypotheses above, whose blurred, unclear limits give rise to approximations and avoid addressing the irrefutable complexity of the problems.

Women as consumers of medicines

In order to come to grips more closely with the relationship between women and medicines, reference will be made to sparse data from various regions of the world. They bring to the forefront problems which, it can be safely assumed, are identical throughout the developing world, although certain terms may vary for they correspond to similar structural situations as illustrated below:

- There are too few pharmacies and too few pharmacists per capita; in Bolivia, there is one public or private pharmacy per 4,000 inhabitants; there are 0.4 pharmacists per 10 000 inhabitants in Nigeria, 0.1 in Mali and Swaziland and 2.3 in South Africa (these figures are broken down by gender in the African countries cited above but not for other African countries or for the rest of the world).
- The national lists of essential drugs and medicines, defined by level of health institution, do not always match the needs of the population. For example, in Cochabamba, the list of a health post does not include pills, diaphragms or male condoms. They only have one size of intrauterine device. In Mali, a few years ago a gynaecologist in a hospital complained that diaphragms came only in large sizes and did not suit a large number of women.
- The main trends in improper use of medicines and its dangers have been identified; they are: abuse of antibiotics and injections, under-utilization of effective products and use of dangerous and ineffective products. Prescriptions are often uselessly long and make it difficult for the patient to follow the doctor's orders. In fact, it is very likely that the patient will not buy all the drugs prescribed (instead arbitrarily choosing which ones to buy) or will stop the treatment early.
- Widespread corruption allows notably physicians, nurses and medical assistants within the public system to sell, at a higher price, medicines which should be distributed free of charge or at affordable prices.
- Essential drugs and medicines are oftentimes more expensive at public health facilities than at private ones.
- There is a strong tendency towards self-medication and traditional medicine, particularly among women. In fact, the relationship between symptoms, diagnosis (poorly trained physicians, self-diagnosis), prescription (corruption and clientele problems) and the purchase of medicines cannot be established with accuracy, far less from a gender perspective.

It would be interesting to go back to the concept of women's empowerment which was discussed earlier to attempt to formulate the model(s) in which women may exercise their choice. Moreover, this would allow for a distinction between the person taking care of the patient and the one making the decision; the two are not always one and the same and do not always take into consideration the notion of responsibility as illustrated below:

- Who decides to seek treatment or to treat whom, depending on the type and nature of disease?

Assuming that it is a woman:

- Does she decide on her own to seek treatment?
- Does she decide with her husband (or any other male or female member of the paternal or maternal family)?
- Does she decide on her own which medical system to use - modern or traditional? What are the reasons behind that choice: medical, sociological, religious or economic reasons including, apart from the price of the visit and medicines, time needed, transport, but more importantly, possible financial assistance (more or less complete) from the husband or father? On this point, a number of studies have shown that women are increasingly forced to pay for health care and schooling.
- How are the costs shared? Are they the complete or partial responsibility of the woman, and in the latter case, with whose assistance?

Finding the answers to these questions would no doubt improve understanding of gender relations applied to the field of essential drugs and medicines.

Poverty, women and medicines

"We are still faced with formidable challenges", stated Dr Gro Harlem Brundtland, Director-General of WHO. "They are linked, above all, to nagging poverty. The imbalances are striking". (WHO, 1998).

People in developing countries account for over 90% of illness and have access to a mere 10% of all resources allocated to health.

Over 5 billion persons in the world - three quarters of humanity - are poor and 70% of all persons living in absolute poverty are women. Sixty-two per cent of those women live in countries or regions with a GDP of less than \$1000 and in which, throughout the 1980's, annual growth of GDP was under \$10 or, in many cases, negative. In 1984, the income of women in Argentina dropped to 50% to of that of men (United Nations, 1991). As a result, 30% of women in the world are heads of household. This state of affairs has been developing hand-in-hand with rising poverty among women (Khoury, 1996).

The main reasons why there are poor women in rural areas were described above. Poor women exist in urban areas because they are unqualified and confined to the informal sector, which is highly varied but very unified in that incomes are very low. Both situations imply overburdened schedules and difficult, even dangerous working conditions. Poor women in urban areas also live in unsanitary housing conditions, notably due to poor ventilation (which causes respiratory illnesses in children) and have an inadequate and unsatisfactory water supply.

Poverty is on the rise for a number of reasons, some of which are always cited such as globalization, economic crises and structural adjustment programmes (SAPs). These programmes, designed to better integrate national economies into the world market economy, have a negative effect on women for they "reinforce for many of them unequal gender relations, while increasing their economic vulnerability and work load". Jayati Ghosh's (1998) comments on the effects of SAPs on women in India is valid (studies throughout the world confirm them) for all countries. He writes "access to basic amenities such as food, clothing and housing... access to education and vocational training, which would allow women to abandon unskilled, low-productivity jobs, access to reproductive necessities and schooling for children, and to health care and other social services ... control over the allocation of resources.... Each of these areas is affected negatively by cuts in government spending in the form of stabilization measures, but also by the State's withdrawal ... and by greater dependence on markets". Cuts in social budgets not only have direct negative effects on women's living and working conditions, but also, ipso facto, on the quality of health, nutrition and education of their children. They also oblige women to enter the workplace for economic reasons. "In this context, there is no cause to sing the praises of having more women in the workplace, which is sometimes attributed to liberalization policies" linked, in fact, to working conditions bordering on exploitation and to lower family income, since men often lose their jobs at the same time.

In Asia (Eviota, 1998), real salary and income levels dropped at the same time that prices rose, which forced women to increase their activities in the informal sector in order to buy less abundant and less wholesome food. "During periods of structural adjustment, malnutrition and infant mortality rates rose, as did the number of unsafe pregnancies and underweight babies". The consequences of SAPs on the environment should also be highlighted to the extent that export policies have required the construction of large-scale infrastructure and industrial projects "responsible for the displacement of rural communities and which often, once they are operational, release toxic chemicals into their surroundings". Yet again, it should be underscored that these kinds of policies force countries whose main source of revenue is agriculture, to produce more and more export-oriented crops. After all, only by exporting more can the balance of payments be improved, and this to the detriment of food crops cultivated by women. Women peasants too have to buy foodstuffs between harvests, at the market price, that is, at increasingly higher prices.

In Zimbabwe, SAPs were implemented in 1991. One year later, maternity costs rose. In the main hospital in Harare, the deposit for covering delivery, a room and anaesthetic rose from Z\$140 to Z\$500. "As a man once told us, I earn Z\$300 a month. How can I take my wife to the maternity ward for Z\$500?" (Kanji and Jazdowska, 1998). There is no lack of examples of impoverishment which have affected men and to a greater extent women since SAPs were put in place to satisfy the dictates of liberalism. Many, notably UNICEF, have appealed to the IMF and the World Bank to carry out their reforms with "a human face". However, although the expression is now in use, the results are not very encouraging.

Much like the term "gender", the "human face" expression is much used but little is actually done. "It is as though social policies were used as first-aid kits to treat those who have been wounded and hit by the ostracism imposed by an economic model whose exclusive aim is economic growth, not fairness. Social policies are used to compensate damage caused by economic policy. Some are wondering whether recent investments in health made by international development banks will have the same consequences" (Antezana and Velasquez, 1996). The ravages of neo-liberal dogma are being felt all the time.

Purchasing medicines and gender relations

The objectives of the WHO Essential Drugs Programme, designed with the aim of tending to the health needs of as many persons as possible, are equal access to essential drugs, quality and the rational use of medicines. Introduced almost 25 years ago, this concept "has still not yielded all the expected results - proof that technical and economic reasoning cannot always vouchsafe economic viability". One of the Programme's main assets, particularly with regard to equality, lies in the price of generic drugs, which are between 50 and 70% lower than the same drugs sold under a brand name. Equity implies that everyone has financial access to medicines. Sometimes, governments finance, in part or in whole, essential drugs and medicines to enable poor citizens to obtain them more easily, but that does not mean that they can actually purchase them.

The problem remains an unjust and brutal one as described below:

- It is the poorest, most destitute persons who, for the reasons explained above, include women and children, who need to buy medicines. Furthermore, when they fall sick, the household's resources are often further drained. For those that are unfamiliar with poverty, it is almost impossible to imagine these concrete implications. If buying matches is difficult, what can be said of medicines?
- This is the group that can least defend itself against the abuses and distortions noted above. Women are particularly affected because they are not considered in society as women, as poor and as illiterate. It should be noted that an estimated 62% of women in least-developed countries are illiterate. This problem is compounded by the effects of economic crises, resulting in lower numbers of girls registered at schools because they have to help their mothers at home.
- Community-based systems may be considered as a possible means of assistance. Yet, given the power relations described above, these systems have proved to be far from efficient.
- Primary health care (PHC) programmes have also been suggested, but some wonder "whether these have become primary health care for the poor or selective health care which contributes to the medicalization of under-developed countries" (Thébaud, 1986). By formulating a more selective strategy, which no longer targets the overall problem of health, but a number of priority diseases, "so-called selective primary health care runs the risk of

regression in the formulation of relevant health policy for the Third World" (Grodos, 1991). The Bamako Initiative, launched in 1987 by UNICEF to make PHC accessible to all, can also be cited. To accomplish its goal, the Initiative's main focus was on supplying essential drugs and medicines in peripheral structures where they are sold above their cost price. The funds earned (consultations also have to be paid for) and managed by communities should cover operating costs and replenish stocks. Community involvement at all levels, recommended by the Alma-Ata Conference, is by all means laudable. Yet on examining the process of selecting and training agents and their position within the system, it was found "that they are often used to allow for greater professional intervention, which has difficulty getting to the grassroots, especially since they do not represent a genuine opportunity for work based on community dynamics and in collaboration with the communities" (Corin, 1985). These distortions can often be explained by the inadequate involvement of women throughout the process.

In light of these facts, one can understand why women resort in massive numbers to self-medication and purchase traditional or Western medicines within the private or public system or on the parallel, illicit market. It should be highlighted that women, even poor women with little or no education whatsoever, are brilliant managers. In their particular conditions and depending on the season, they manage, in the interest of their family's survival, their desire to take care of their children, their time, transport, their husbands' authority and their finances. For example, 75% of households resort to self-medication in Benin, 94% in Togo, 86.4% in Nigeria and 55.6% in Burkina Faso (Chungong, unedited). These overwhelming figures lead one to think that these persons act not out of negligence or ignorance, but simply because they have no alternative.

Self-medication

Self-medication, which can have positive aspects, is inevitably associated with one of the objectives of the Essential Drugs Programme, namely the rational use of drugs. This objective is jeopardised both in the private and public sectors by lengthy prescriptions (sometimes 5 to 6 medicines), antibiotic and injection abuse, "advice" given by peddlers, expired drugs, etc. It is also threatened by a lack of drugs and qualified personnel. There are also other causes such as non-compliance with the treatment regime, which is due to ignorance and the desire to take control of one's own life by refusing certain side effects of medicines or stopping the treatment once symptoms disappear.

Self-medication is also linked to a number of perceptions about certain diseases. For instance, in Nigeria, the percentage of mothers who were familiar with oral rehydration therapy rose from 6 to 47%. However, only 9.5% of those very women deal with diarrhoea using this technique (Jinadu et al., 1988). "It is not rare to encounter nutritional rehabilitation facilitators whose children are seriously malnourished; the facilitator has a certain knowledge but cannot apply it to her daily life, either because her living conditions do not allow it, or because this knowledge brings about a major contradiction with previously acquired knowledge" (Bonnet, 1990). The important question is whether acquisition of new knowledge leads invariably to new behaviour.

Close to one-third of the world's population still does not have regular access to the most basic essential drugs and medicines. Yet 30 to 40 drugs would be enough to treat between 80 and 90% of patients in any given health centre. The situation of pharmaceuticals in the world is inextricably linked to the international health situation, which, itself, depends on the socio-economic situation. "The economic regression of many developing countries in the 1980's went hand-in-hand with a degradation of the social infrastructure.... If, in the coming years, the public system of medical supplies weakens and collapses... communities will be forced to find solutions themselves to their health problems (and, to do that) by resorting to the private sector and informal markets which, under no circumstances, can replace the public sector". Health sector officials are discussing how to implement health reforms, including reforms to the pharmaceutical sector, which can improve the current and future situation. How is it possible to overturn the automatism that assumes the market to be the sole satisfactory response to all problems? It is common knowledge that "an approach which espouses the allocation of social resources solely in market terms leads to inequity because markets cannot solve the problems of redistribution... in cases where social objectives are given lower priority than economic objectives, if equity is the aim, policy must be shaped by the "visible hand" of the government" (Madrid, Velasquez and Fefer, 1998).

The authors of the document cited above insist that reform has to be "dramatic" and characterised by "a parting with old ways of thinking, planning and functioning". It is from this decidedly innovative perspective that one can attempt to make recommendations and propose measures in order to introduce the gender concept into essential drug programmes. In that way, equal access can be achieved as well as the rational use of drugs.

Proposed policy and research

Given the distortions and prejudices at play in gender relations, which place women in a position of social, cultural and economic inferiority compared with men, the focus of these proposals and recommendations will be placed on women in an attempt to redress the imbalance. The following proposals are two-tiered: they seek to 1) strengthen the autonomy of women and 2) provide them with indispensable new knowledge.

According to WHO, health is not merely the absence of illness. It is also, and perhaps even more importantly, a state of physical, mental and social well-being which, as has been illustrated, varies greatly between men and women. The definition of health, if it is to be taken seriously, necessarily includes gender equality and, consequently, a heuristic approach towards that difference, on both the political and the medical levels; admittedly, such an approach is far removed from one that focuses exclusively on reproductive health.

Without wishing to overstate our case, introducing the gender perspective into essential drugs policy is a decision based on extremely innovative, even revolutionary thinking which should not be underestimated. That implies, from the very outset, a decidedly holistic implementation in which WHO cannot be the single actor. Indeed, the organization should be able to take the initiative, legitimately, in the face of all its other partners.

Proposals will be classified in the following categories: general policy, pragmatic policies and institutional, biomedical and socio-cultural research.

General policy

- Take the necessary measures at the international and national levels, for a number of health- and drug-related statistics to be broken down by sex. This type of data is absolutely necessary to validate knowledge either by country or for comparative purposes. These data cannot be ignored either from a scientific perspective or in the current context of globalization.
- Attempt to woo partners - be they international, regional, national or non-governmental - with whom WHO can maintain working relations. This may take the form of fixed or non-fixed structures, such as workshops, which ensure that women are represented within different organs in keeping with the principle of parity which has been reaffirmed by the new Director-General of WHO. This need for equality should also be respected in the various on-the-field structures, such as communal committees, for example. Indeed, women must be allowed to participate by expressing their points of view and their needs at all levels of policy formulation and the implementation of health sector reform in general, and essential drugs policy in particular. This implies, moreover, establishing mechanisms which allow

for a top-down and bottom-up circulation of information. The current situation whereby women act on the lowest rung of the ladder, without their voices being heard at the local or macro-economic level has to stop if the aim is truly to ensure a more equitable sharing of male dominance and power. Furthermore, and this condition is important, women should be included not only in focus groups, they should be involved in large numbers to overcome the "cultural deafness" with which men protect their power.

- The poor health of women and men is not only due to clinical causes. It is compounded by all the problems linked to access to medicines, appalling living conditions and endemic poverty. A number of examples were given of the interrelated nature of the factors which, in some cases, account for problems specific to women and their relationship with medicines. Even if resolving this situation may seem an impossible task, an attempt must be made. Before making proposals, we should point out that there are many who vociferously criticize the lack of coordination and collaboration in the field, among international donors on the one hand and between donors and local decision-makers on the other. There is no point in analysing the reasons for such compartmentalisation, whose first victims are the target populations. It should merely be noted that the project approach, which is also unanimously called into question, only serves seriously to reinforce those distortions and pave the way for the misappropriation of funds and corruption.

These proposals, obviously, are just a first step towards coordinated action which must be implemented.

Pragmatic policies

- Much has been written about the system of financing drugs and much thought has been devoted to the central issue of equitable distribution. The resolution on "the revised drug strategy" adopted by consensus on 22 May 1999 at the fifty-second World Health Assembly demonstrates WHO's will to monitor and analyse the consequences of trade agreements for the pharmaceutical sector and public health, thereby giving priority to health over the economy (Resolution WHA52.19). Many experiments have been conducted in an attempt to put in place alternative solutions. Women need to be incorporated into those as soon as possible. Furthermore, it would be preferable to design, in collaboration with women in the field, some of their proposed solutions. These might be alternative solutions or adaptations of what is already in place. As the main purchasers of medicines for themselves and their children (men, it would appear, take care of themselves), there is no doubt that women can come up with realistic proposals. While it is true that they have little or no money, it is equally true that they have every wish to treat their sick children. They also know how to be resourceful in difficult situations and it has been proven that they repay their debts better than men do. The widely-used system of "tontines" in Africa can be examined from that perspective as well as the system of women's co-operatives.

- The rational use of drugs depends mainly on proper information. Several experiments have shown that, among disadvantaged, often illiterate populations, messages broadcast on the air waves and simple posters are the most effective means of communication. It would be wise to promote information campaigns geared more specifically to women who spend long hours in health centres, which, unfortunately, can very rarely offer something to listen to or read. However, these messages should be carefully thought out, because "the receiver does not passively receive the meaning; he/she reconstructs it based on context, constraints and multiple strategies. Interactions and incessant negotiations operate around a message. The grassroots social actor, as deprived or dominated as he/she may be, is never a recipient who only has a choice between submission and revolt" (de Sardan, 1990). Given that women are the primary users of medicines, that women are poor but know, because they are obliged to, how to manage their budget, they would certainly be interested in hearing well-prepared information on the financial and medical advantages of essential drugs and try to make the most of it. On another level, women often form groups or associations which can constitute target groups and why not pressure groups? Including women in the design and elaboration phases of projects can only lead to greater efficiency. It would be, therefore, very important to design, in collaboration with women's groups, a number of information/awareness campaigns, test them and compare their results with those of campaigns designed without women's collaboration.

Institutional research

The widely-condemned problems of stockouts and lack of certain drugs, sometimes some of the most commonly used ones, reduce the confidence of patients in the medical system, undermine their health and drive them towards parallel, illicit systems in order to find substitute products. Huge efforts have been made to improve national purchasing systems but it appears that the distribution system between the central point and local outlets is not so efficient, particularly in the public system. The following measures must therefore be taken, among others:

- Better knowledge of the process of selecting essential drugs and medicines at each institutional level in the health system.
- Recording the frequency of stockouts per type of drug and in particular, those which are necessary for women and children, the places where they occur most frequently and the reasons for such occurrences.
- Draw up a list of drugs intended for use by women and children which are rarely or never bought and analyse the reasons.
- Evaluations were carried out (WHO, Le Point, 1998-1999) in the 34 countries that have established fee-for-service systems and in the 17 sub-Saharan countries which use community working-capital funds; it is almost certain that these evaluations failed to take the gender variable into consideration. However, it may be possible to retrieve specific information from the data

collected. If not, if this type of evaluation is repeated, this new variable will have to be included. Looking through the publications, it is clear that there are several evaluation and analysis tools to which the gender variable could be added. Precious time could be saved and dedicated to creating a relevant data bank. One of the major problems is the political will needed to rationalize and standardize, from the gender standpoint, a number of already-existing mechanisms at lower costs.

All these measures could but contribute to the much demanded improvement and refinement of pharmaceutical statistics.

On another level, the possibility of reviewing national drug policies should be considered in order to examine how women can be involved in the design, formulation and implementation phases and to take the necessary measures for such mainstreaming.

Biomedical research

Generally, there are no studies on the impact of the physical and biological differences between men and women on the epidemiology and aetiology of diseases, taking also into consideration the effect of socio-economic factors such as location, conditions, working environment, etc. The "male bias" in research on disease and drugs, which assumes that the results are valid for both sexes, has already been mentioned. Yet it is a well-known fact, to cite but a few examples, that drugs are metabolised differently in men and women and tropical diseases have different effects depending on the sex of the patient. The following measures should therefore be taken:

- These distortions should be corrected by systematically including women in current and future research into the effects of drugs.
- Moreover, there is a lack of data on the effects of the menstrual cycle on the metabolism and pharmacokinetics of drugs, as well as on the effects of menopause.
- Not only is new research required from the gender perspective, using appropriate methodologies, techniques and instruments, these should also be applied to current research to save time.
- Finally, interdisciplinary work should be encouraged whenever possible in order to analyse the interrelations of medical results with the socio-cultural environment.

Sociological research

In this connection, there is a need for extensive research and an exhaustive list cannot be provided here. However, a basic guide is given below:

Applied research

Le Point (WHO, 1998-1999) cites a number of experiments and initiatives, namely: decentralization (which, in our opinion, makes it possible to quantify drug needs in terms of environment and season); the system of replenishing supplies in a Ghanaian dispensary; a research group on essential drugs and medicines within Médecins sans Frontières (MSF), present in 50 countries and in contact with a variety of populations, particularly refugees; reforms in the health sector in Pakistan; community-based treatment in Mali; the provincial system of group purchases in Thailand; the sole distributor system in two Provinces of South Africa; reform of the essential drugs policy in Guatemala and improved quality of care in communal health posts in the Province of Haiphong in Vietnam. This list is by no means exhaustive. However, it does demonstrate a strong desire for innovation and a wealth of experience which is clearly defined and which draws on qualified, dedicated and relatively readily available personnel. In all of these cases, and depending on their specificities, questionnaires or survey forms can be drawn up to collect fundamental, significant data which would be an additional contribution to certain aspects of the relationship between women and drugs as follows:

- Decision-making system (see above)
- Access to drugs:
 - availability in health institutions
 - geographical accessibility (length of time spent in transport and costs involved)
 - affordability.

Other aspects can also be taken into consideration, such as:

- Interrelation between rational or non-rational use and the educational and socio-economic level of women;
- Clash or compatibility between women's schedules and opening hours of health centres, dispensaries and consequences;
- Role of women and women's groups in local decision-making structures.

Other simple parameters can be added depending on the country, region and experience, etc.

Basic research

Within the framework of gender relations, it would be interesting to conduct a dual comparative study (men-women/three countries with different cultural, religious, sociological, economic, political and historical situations) on the rational use of drugs which is necessary to ensure the success of any essential drugs policy.

First of all, are there any specificities, among men and women, in the use of drugs? If so they should be described and studied, not just from an economic angle, which is certainly fundamental, but also in their symbolic context.

Men have the right to "mobility" of word which allows them to speak in public in a discursive, innovative way while women are culturally starved of this type of voice. This opposition covers the public/private dichotomy so widely used in analysing gender relations: the forum, the man's domain versus the house, the woman's domain. That implies that the dominant party can dominate knowledge while the dominated party cannot.

Moreover, it has been found that it can be quite difficult to apply new knowledge. These difficulties may be partly explained by the different disease classification systems of traditional and Western culture, but also by ignorance of how cognitive structures integrate and even accumulate often conflicting knowledge, based on a purely medical reality in one case, and a socio-religious one in another. However, whether these difficulties are harder to overcome for women than for men is a matter for speculation.

Does this very schematic cognitive pattern lead to changes in the behaviour of men and women regarding diseases and their treatment, diseases whose symbolic meaning lies in a vision of the world shared by the two sexes?

Of course, research has to deal with similar disease structures, even if their aetiology varies from one society to another.

Conclusion

Introducing the gender concept in essential drugs policy, as with any other global policy, is difficult but possible.

"Introduction of the feminist vision blurs, doubtless obscures the apparent clarity of the discourse hitherto offered by science, but this new complexity, enshrined in the new theoretical framework of the gender concept should constitute a challenge rather than a pretext to give up.... Changes, developments can only be apprehended by taking into account the interaction of a multitude of parties which should henceforth include men and women.... The gender concept represents a radical theoretical transformation in the sense that it imposes "a revelation of the past as being ideological". It implies a cognitive break which, while accepting the universality of knowledge in social practice, challenges its existence in the elaboration and practice of knowledge" (Bisilliat, 1996).

Therefore, the frame of reference in which drug policy and action have so far been formulated must be changed. Dualism needs to take the place of the monism of the past. The modest proposals made here are in line with this thinking. That should widen understanding which, make no doubt about it, will certainly help in bringing essential drugs policies closer to the objective of equality.

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