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Healthcare needs, public policies and gender: the perspective of professional practices

Necessidades de saúde, políticas públicas e gênero: a perspectiva das práticas profissionais

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Abstract *This paper examines the relationship between public policies and professional practices with respect to healthcare needs. Taking a theoretical-conceptual approach, practices are defined as acts that are permeated by technical-scientific and socio-historical determinants for the social production of work, and the possibilities for cultural, ethical and political changes were analyzed in order to take critical action regarding gender inequalities. With comprehensive healthcare for men as the reference point, the relevance of a distinction between male and female needs, as partial and not necessarily convergent realities in (re)producing these inequalities, is examined. Likewise, professional practices are examined as partial and distinct realities of policies that establish non-immediate relationships. It is considered that the following are symbolic and practical obstacles to change: the reduction of needs through biomedical normalization; the culture of self-employment and approaches that individualize needs; the traditional gender-based culture that conserves unequal practices for men and women; and the lack of registration of rights as part of professional action. This requires proposals specifically geared to healthcare practices and male needs, in order to achieve greater convergence with policy reforms.*

Key words *Gender, Health practices, Health policy*

Resumo *Examina-se a relação entre políticas públicas e práticas dos profissionais, relativamente às necessidades de saúde. Em abordagem teórico-conceitual, as práticas são definidas como desempenhos permeados por determinantes técnico-científicos e sócio-históricos para a produção social de um trabalho, analisando-se suas possibilidades de mudanças culturais, éticas e políticas, para um agir crítico das desigualdades de gênero. Tomando-se a atenção integral à saúde dos homens, examina-se a relevância da distinção entre necessidades masculinas e femininas, enquanto realidades parciais não necessariamente convergentes na (re)produção daquelas desigualdades. Igualmente se examinam as práticas profissionais, como realidade parcial e distinta das políticas, estabelecendo relações não imediatas. Desenvolve-se que são obstáculos simbólicos e práticos para mudanças: a normalização biomédica redutora das necessidades, a cultura do trabalho autônomo e da abordagem individualizante das necessidades, a cultura tradicional de gênero conservando práticas desiguais para homens e mulheres e a ausência de inscrição dos direitos como parte do agir profissional. Isto exige propostas específicas às práticas de saúde e às necessidades masculinas para maior convergência com as reformas das políticas.*

Palavras-chave *Gênero, Práticas de saúde, Políticas de saúde*

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Introduction: putting healthcare needs in context

The topic of healthcare needs has for a long time been a thorny question in the field of Public Health, and in studies on access to services and care, on the quality of assistance and the practices of professionals, and even on health rights and the duties of the government in its public policies. It was an essential element in the planning of Public Health in the 1970s, linking the democratization of Brazil to health reform[1].

The study of needs made it possible to demonstrate the elitist nature of healthcare when the matter was treated in terms of ***needs satisfied and not satisfied*** by the health services which existed at the time. It gave rise to discussions on the transformative power of government, with recognition of the rights of citizens and of universal access to health services. The subsequent outcome (1980) was the major engagement with the question of Public Health represented by the setting up of the Unified Healthcare System (SUS), the democratic aims of which, although they have made progress, continue to be questioned to the present day[1-4].

But, at the time, the study of needs also led to criticism of the specialization of care, both in terms of professional practice and in terms of medical teaching. The debate revolved around two views. The first was one in which health needs were seen as illnesses which were ***reasonably common and scientifically fairly complex*** in certain sections of the population, so as to postulate a certain "inadequacy" in the training of doctors in the "real needs of the people," bearing in mind that such training concentrated (and still concentrates to a great extent) on the rare pathologies to be found in hospitals (the teaching hospital). Extra-mural education (outside the teaching hospital), as in proposals for community medicine, is the answer to the question of how to make training more suitable to the needs. The other view looked at needs on an individual basis, classifying them as ***felt and not felt***, the latter being connected to the epidemiological risk of becoming ill (potential needs). Thus, as an answer to this approach to needs from the ***individual*** viewpoint of the patient, beyond the discussion of demands presented in the health services, there was an advance towards preventive medicine in medical training[5].

Both approaches criticized the progressive loss of the clinical view of the patient as a bio-psycho-social whole, originating in the bio-medical reduction of the individual as a social being to an organism with pathologies, which also went back to preventive practices. And in the case of teaching, not only for doctors but for health professionals in general, the continuance of health needs as matters of training remained equally clear[6].

In the long period between the emergence of the concept of Public Health and the first decades of the 21st century, other interpretations were given to health needs. There was both a somewhat abstract theoretical-conceptual approach, in which needs were related to the social nature and historical development of human life in general and re-worked in terms of health in particular. This was also true on a more operational level, concerned with health services, in which needs formed part of policies and/or management programs for these services, in response to particular problems[7]. With regard to the first approach, recent publications[8-10] have pointed out the lack of more conceptual formulations, whilst, in relation to the second, even at the operational level of services, the subject is sometimes treated from the point of view of ***the population as a whole***, with the patient viewed in collective terms, or from the point of view of individual needs, such as in studies of the ***individualized*** demands of users[11].

There are also studies which distinguish between needs produced by the various structures of society (such as ***social construct***) and those considered to be ***natural*** to the human being[8,10,12], while others, from the social construct standpoint, contrast ***the point of view of users*** with that of ***the professionals***. This last category in turn subdivides into discussions on the quality of public policies and the management of services[2,4] or on the quality of practices[13-15].

Among this diversity of views, this article is a reflection of a conceptual nature. In my view of health needs I follow Mendes-Gonçalves[16], which has allowed me to focus on professional practices as the ***determining context for new needs***[13], allowing such professional practices to offer critical tensions to their (re)production in society. In addition, I record this reflection in the relationship between public policy and the health practices within the health services.

Methodology: the course of thought

This text is a theoretical essay. I have adopted the perspective of gender as it relates to the health of men, in line with what has been produced in the

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last decade on Public Health. Gender implies two lines of examination[17]: a relational dimension which leads to a view of men as they are linked to women and an explicit enquiry into the power inequalities between them, greater value being assigned to the male sphere in social questions, which has repercussions for the needs of men and of women[15]. The theory of gender affords an understanding of the socio-historical construction surrounding men and women with the aim of deconstructing it: it identifies the inequality in value, and shows the traditional ways of defining and dealing with men and women in social life, for a counter-cultural critique, in search of gender equality[17], for which reason I have adopted this reference point and have sought to distinguish the traditional construction of gender from criticisms of it.

The critical approach meets the principle of the comprehensive nature of public health policies and looks upon needs in an alternative way to the hegemonic mode of thinking of biomedical rationality[11,15,18-20]. In some way it also indicates that greater equality in comprehensive care does not lie in identical measures for men and women, because the construction of inequalities reflects a given conception of power in society. The critical approach assumes such a conception, so as to strike at the values which permit such a construction. For this purpose, a flexible critique must be possible; setting its shape as a historical possibility, even in the actual reproduction of society.

In this sense, from a methodological perspective, I have adopted the reference point of Bourdieu[21], for the study of the social agents in the reproduction of society, and that of Lefebvre[22], for the relationship between the different social classes in this reproduction, for whom the social forms a whole whose parts show themselves in a dynamic of affirmation and negation of the socio-historic characteristics of this whole. This is the notion of (re)production[22] as a reiteration which is, at the same time, a new production, generating tensions. Thus, even in social practices which conserve the social aspects, changes can be given impetus by social subjects that are the agents of these practices.

The reproduction of the social is therefore crystallization in structural terms, a re-working of social and cultural traditions. But it is an unstable crystallization, in that it brings innovations within conservation. Thus, where inequalities of gender are reproduced, this reproduction will not always and necessarily take the same form for men and women and the relationship between them, but will express converging and diverging aspects of greater value in male questions, as empirical studies have shown. It is the diversity of situations which will be found in studies. It does not deny, but clarifies, the many concrete expressions of social inequality of gender in specific contexts.

For example, studies have already shown that violent practices socialize boys in the formation of male identity, and also reveal that, although ideas of competitiveness and the use of physical force, which are the basis for portrayals of virility, may be a symbolic reference to male hegemony, not all men actually behave in a violent way, which shows the diversity of social practice in the same cultural frame of reference by gender[23].

It is therefore only to be expected that the field of health has been (re)producing gender inequality and contributing to its maintenance through patterns of attention directed towards men and women, which show both common and divergent aspects between them, as well as retaining, in a conflicting manner, the greater value reference in male questions. Cultural criticism, therefore, requests recognition of the areas of dominance (biomedical and gender-based) and of the escapes, which ought to be pursued in studies and research exploring this tension. This being so, in order to achieve comprehensive care for men and women, programs with similar adjustments will not be enough; but it also means that some projects and some practical measures can be similar, with the main basis for change being the value of these subjects to society, and therefore the difference in meanings with which they are included in the rationale for hegemonic and biomedical assistance in healthcare.

Pursuing the same line of reasoning, in relation to the perspective of proposed changes in Public Health, I take the field of policy and its management of services and the field of professional practice as partial dimensions of the health field forming a whole under tension. However, it is not automatic that questions of practice are identified and dealt with in policy, nor the reverse: policies are not directly reflected in the performance of professionals as soon as they are announced. As in various studies[3,14,24,25], I make a distinction between policy and practice in health as two separate, albeit related, questions. In relation to policy, practice maintains not only a certain independence, but an independence which will come into conflict with policy.

The reflections which follow will therefore consider how and why the aspect of gender per-

mits a conceptual enrichment of 'health needs,' as well as how to identify particular and concrete professional practice for comprehensive care for men and women, in order to achieve greater equality in public policy.

Health policies and practices: a distinction in order to think about health needs

This topic will answer the following questions: why make a distinction between health assistance, where health professionals take steps to respond to the needs and demands of health service users, and proposed steps set out in programs for healthcare derived from those announced in the official texts of public policies? Could it be the case that such steps by professionals are not responding to these policies?

Bearing in mind the methodological approach already described, the answer to the last question is: yes and no. As a result, the distinction is important precisely in order to highlight the conflicts between the two situations, conflicts which are not simply, as is often thought, systemic problems of lack of resources or limitations in mutual knowledge of each proposal, as if health professionals were simply unaware of the terms of the policy announced, its concepts and proposals for action. There is indeed a certain distance between policy and professional practice: the discrepancy between what appears in a plan as a proposal for (intended) action and the knowledge and actions actually taken in practice, on the operational side, in the area of services. In other words, the proposal as a ***plan*** is distinct from the proposal as ***technology***, i.e. the working knowledge of professional practice[26]. In addition to this distinction, there is also a distinction with regard to the set of actions which are feasible in the realm of policy and in the realm of professional practice.

Public policy is concerned with decision-making by government, which results from disputes between interest groups present in government[27]. The government decides between alternative responses to social questions, each of which represents gains or losses for different social groups, among them health professionals and medical scientists[25]. With regard to the choices represented by all those involved, the technical-scientific choice is not always the most highly valued[27], as it is for the health professional[25]. Scientific and technical knowledge is very different looked at from the area of policy and from the area of practice and health needs, and it will therefore be subject to different interpretation in these areas.

But the sphere of policy is already so closely linked to that of services, and the democratization of access to services and the recognition of human and social rights are now questions so pertinent to the preparation of specific healthcare programs, that it may even seem strange to seek to emphasize the distinction.

The fact is that this relationship between health policy and healthcare practice within the health services was a historical construction of Public Health, because, contrary to what might be thought at first sight, during the period of the emergence and the creation of this field (1970-80), the relationship was not clear between medical or hospital practice and health policies or even the central features of Brazilian society, such as the market economy and the capitalist social structure.

In the hegemonic mode of thought with regard to health, the presence of which is still felt in the field of medicine, the practice of health professionals was seen as independent from social, economic, political or cultural questions, and its quality seemed to be based exclusively on the technical-scientific dimension of knowledge. For this reason, a great effort was made to change the actual performance of professionals through educational reforms. These reforms were unaccompanied by policies towards the labor market or towards the formation and management of services, which would be unthinkable today, but which at the time meant the representation of the health professions (taking the profession of doctor as the central reference point) with autonomy in scientific and technical matters, as though, on the basis of their training, these professionals could change their practices and make them more ethical or democratic, in addition to ensuring higher technical standards[5].

A fundamentally important trend in Public Health, therefore, has been to ***politicize the field of health***, whether it is Public Health or Medicine. By 'politicize' is meant the reconnection of the private aspects of health to society, modeled on traditional epidemiology and bio-medicine, so as to show that technical practices are also, and above all, social practices[28], (re)producing the social pattern of private practice in the ***technical sphere of action***[25,28]***.***

This politicizing trend first of all turned its attention towards showing how much health was always compromised by the social context: by socio-economic inequalities, conflicts of interest and power struggles. In particular it challenged medical care, and showed it to be a part of the

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same economic and political complex as the pharmaceutical and equipment industries (the medical-industrial complex), also stressing the perverse relationship between the public and private sectors for the supply of services, in which the latter was financed and leveraged socially at the expense of the former, under a policy which was losing its public character of serving the common good in order to serve private interests: a private interests policy to underpin socio-economic inequality at the same time as it effectively broadened access to services.

Secondly, it introduced the subject of working conditions and the labor market (from salaries and working hours to the unequal distribution of professionals in Brazil, as well as their increasing specialization) and, more recently, the management of services, as determining factors for practices within the health services, thereby ceasing to view them as an exclusive product of the appropriation of the knowledge acquired during graduate training[25].

In this way politicization affects public health policy, by highlighting in a critical way the public character of the state, and demanding health reform as a social reform, with a view to the democratization of the state and a growing inclusion of human rights and social rights in health policies. It also affects the sphere of planning and management of services, introducing questions of critical planning and presenting healthcare models[29], which until today have been resisted[3]. There has also been a politicizing trend in professional practices, where the discussion was initially focused on human resources in health, then moved on to questions about professionals as the agents/subjects of technological and care modes of professional activity[30] and gaining new impetus today with the arguments about healthcare[31].

There has, however, been considerable difficulty in affecting professional practices, owing to cultural and political-ideological obstacles of great complexity[32,33], linked to the historical origins of such practices[25], which makes it appropriate to ponder specific questions of gender inequality[15]. In my view some of these obstacles consist in the failure to develop the distinction between health policy and professional practice, making communication between these areas more difficult.

The emergence of health planning and management as an instrument for social change was one of the results of the politicization of health on the basis of the setting up of a Public Health system[25], opening up a definitive dialogue between policy and the organization of service networks and the health system. This movement, however, lost sight of the problems surrounding the distinction, and with it reflections with regard to the capacity of the proposed changes. Nevertheless, the historical importance of the Public Health system[1] is undeniable, which now that it is well established, must, as a politicizing social movement, always remain active and revisit its own conquests in a critical way. By way of illustration I will cite two situations from conquests in the legal-political sphere, involving the enactment of laws and rules of great support to the ideal of gender equality, which proved to be inadequate to instill the same ideal in professional practice.

There is the law guaranteeing legal abortion in cases of rape, and the Maria da Penha law which criminalizes and imposes punishments for acts of domestic violence. How has professional practice reacted to these two legal enactments under which technical regulations have now been issued specifically concerned with the prevention of violence and the rehabilitation of victims in both cases? Have professionals broadened their interest in, and acceptance of, these situations? This does not seem to me to be the case in either situation, because although services have been properly planned and set up, trends to expand and also to reduce network services being noted, there are studies which not only show difficulties in implementing the law at the level of professional practice, but failures in performance based on beliefs, moral judgments and religious views of a strictly personal nature, but everywhere clothed with technical-scientific authority, which nowadays confers legitimacy on the authority of health professionals[34,35]. It is therefore necessary to broaden knowledge of the obstacles to the politicization of practices.

Gender: invisibility with regard to health needs in professional practice

What makes gender inequality visible is the politicization of technical-scientific intervention at the core of professional activity, which has been achieved by studies of the ***invisibility*** of such matters in professional practice[18,19,36]. This invisibility is the result of the bio-medical reduction of the body as the single approach to the needs assumed to be valid by the professionals. Thus, questions of gender only enter into health practice if this way of proceeding is criticized, in its various dimensions. One of them – the most common and well thought of – is based on the

technical successes inherent to such a reduction, where the critical alternative would be to cover them with ***practical successes***, thereby corresponding to the situation which takes into account the contingent aspects of the practical context in which technical intervention will occur. In this way, without dispensing with good solutions resulting from scientific-technical knowledge, the optimum professional performance would be represented by practical success as a way of living out technical success[33]. If such a change in technical perspective is not made, the visibility afforded to gender runs the risk of amounting to an ***ethical-political weakening of the concept***[17].

Such is the power of the prevailing professional culture, to give a preliminary notion of the difficulties of achieving reform within the context of professional practices, which is compatible with health policies based on greater gender equality. However, other dimensions must be considered in order to broaden our understanding of these practices, for which purpose I must examine the roots of this professional culture.

Social needs always represent the interconnection between society and the individual, because they are the recognition by the individual of needs which arise through living in society[16]. But if the need is responsible for discomfort (or suffering) in the face of a perception that 'something is lacking' or 'something is not working' to enable one to follow one's usual way of life, the trend which makes individuals seek a particular service and demand answers is based on the identification of existing services in society, and that, from its productive historical associations (such as the supply of solutions to certain needs), shows itself to be successful. For this reason, existing supplies which have been historically successful give rise to this demand trend on the part of individuals; a demand which is only "spontaneous" in the movement of the person seeking the service, but it is a search which is always socio-historically pre-determined.

Spontaneous demand for better health takes place where injuries are repaired so that the individual can live his normal life, or in preventing injuries or in the promotion of health (which does not play such a large part as injuries), and in all these situations the assistance of medical services is sought. This is because historically there is a recognition that these services will supply the best solution to these requirements to treat or avoid injury, because of the socio-historical hegemony of the ***language of illness***[15,19], which, as a ***medicalizing agent of needs***, extinguishes its origins in social life and because of social life, hence the social inequalities both in illness and in poorer health: ***Medicalization is a socio-historical marker which extinguishes the social nature of illness and medicine, reducing them to bio-medical questions and preventing the emergence of needs which do not encounter a discursive possibility in this language***[15].

In this sense, there will be obstacles to the recognition of human and social rights in the demands of service users, as well as to the recognition that to strive for these rights is a part of professional competence and that actions which achieve them in a more complete service should be included in their practice. This absence of questions with regard to the quality of care in terms of rights does not only concern gender, but also the Unified Health System (SUS) itself. In these terms it could be said that professionals ***disapprove of giving a complete service***: whereby disapprove means here that they are alienated from the social dimensions of their practices.

On occasions, professionals realize that questions of rights are involved. One example is domestic violence, a situation in which it has already been shown that professionals see a woman in a situation of violence and understand the consequences of her demands. Some also believe that violence is not good behavior and give importance to the maintenance of human rights. But they believe that intervention in these situations should preferably be the responsibility either of the woman herself, or of the government which represents society in general, or, when they relate rights to access to social benefits (such as retirement or sickness benefit), send such cases to the social welfare office.

For professionals, everything happens as though they did not have professional standards to be followed and as if problems connected with rights ought not to interfere with their ***own best practice***. I draw attention to this notion of best practice[19,33], because professionals associate it with an egalitarian approach (ethically not unequal) based on bio-medical standards, because these should be the same for each and every individual; best practice, therefore, means an ***ethical-political neutrality***, which is well demonstrated by the bio-medical approach. In their view, there would be no such neutrality if in their practice they took actions and made statements in support of rights, even in the case of those rights which have already been legally defined.

Seemingly curious, on the other hand, but responding to a controversial way of reproducing society in their practice, the historical success of bio-medicine being also modeled on the ***tech-***

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nical autonomy of professional practice, this practice is permeated by actions of a personal nature[25]. It is thus not uncommon, in specific medical assistance situations, to find the advice and guidance of the professionals trying to escape from bio-medical rules. These are actions of a moral nature, rooted in individual and personal values and beliefs (religious, aesthetic, etc.). This capacity of professional action to be influenced stems from its character as a ***morally dependent technical skill***, a quality of inter-subjective relationship which historically marks medical practice and extends to the health professions[25]. On the one hand, it represents the dependence of technical skill on the interpersonal relationship which is formed in the consulting room between the professional and his patient; technical skill is here dependent on a given ethic of interaction, which can be transformed, as it is currently, into an interaction which is mediated by technology. On the other hand, it represents a relationship of an interpersonal nature which is always overlaid by its technical-scientific nature, which culturally results in the professional assuming a moral authority based on his/her scientific authority. Some studies of gender and health[15,18,34,35] have emphasized this mixture of the scientific authority and the moral authority of professionals when they are dealing with cases of abortion, sexual violence, sexuality and sexual preference, including cases in which the religious beliefs of the professionals form the basis of a clinical decision, which is then followed by patients as though it was professional technical-scientific advice[15,34].

Obviously I do not raise such questions in order to suggest that professionals cannot have personal beliefs, but to stress that policy managers and formulators should take into account these characteristics of professional health practice.

Another specific feature of the historical success of professional practice in the field of health, which also represents an amplified (re)production of the conquests of the medical profession, concerns the ***individual consultation*** as the service which represents best professional practice. Its roots are to be found in the individualization of the ailing process (on a bio-medical basis and from which arises the notion of epidemiological risk and of risk behavior in preventative practices) and, most of all, in the individualization of treatment (care). The consequence of this characteristic is ***attendance as a series of individual consultations***. This emphasis on the individual conflicts with questions of a more social or collective nature, such as the perspectives of policies or rights. From such radical individualization, moreover, stems the notion of ***case***, which refers to the patient in medical language and with which all the commitment and responsibility of the professional is bound up. That means that the professional takes care decisions relating to the case, and his social responsibility as a professional appears to him to be limited to, and exhausted by, the case. He does not therefore see that his intervention also has potential consequences beyond the case, in the sense of repercussions for the collective whole, or for any human grouping (family, ethnic group, nation, society).

A third specific feature of professional practice which must be remembered lies in the historical magic-religious roots of medical practice and its related portrayal as a ***saving practice***, thereby constructing a social image of performance always subordinated to an ethic of salvation. The repositioning of medicine among sciences and technologies changes the center of belief, but preserves the image of the doctor-patient relationship linked to this ethic, which for this reason is not perceived as an interaction between equals, from the moral and ethical standpoint. Instead, the professional is viewed less as a technical-scientific agent and more as a donor, the bearer of some quasi-sacerdotal gift or vocation to serve others, and an altruistic, charitable and totally personal character was attributed to his professional conduct and performance, which is also in conflict with the principles of public policy based on citizenship rights and human rights. I must note here the conflict between this symbolism and the image derived from the fact that the professional is today increasingly an agent of technology, which from a practical point of view has been resolved in the day-to-day provision of services by a kind of split in professional practice. For matters which are easily reducible to the bio-medical plane, such practice operates by means of the automated procedures of standard programs, whether clinical or healthcare. However, for those matters which are not easily reducible to the bio-medical plane, as is the case with many socio-cultural questions, among them the question of gender, the professional has recourse to his personal moral judgment. This is because, precisely in the parts of his practice where public policy would like to introduce a different kind of attendance in a critical manner, one which seeks to secure rights and greater gender equality, there are the areas where tradition is recorded.

In traditional views of men and women, men are above all seen as the productive workers of

society, and when a man's body becomes sick it must be restored to health as quickly as possible, especially as far as his physical strength as a worker is concerned. In the case of women, professional practice pictures them in the domestic environment, having children and looking after the family, thereby reducing a woman's body to reproductive and caring functions, for which purpose medicalization has produced a variety of professional provisions and attendance services which might further these functions. The health field has therefore developed healthcare and emergency clinical and surgical services for the workers, with priority and preferential access being given to men. Care for women is geared to attention to the sexual body, to promote the reproductive body, and to educate women in family care, such as hygiene and pre-natal measures, and in child development, both of them basic factors in primary healthcare as basic units of the system. Thus, even while they are preoccupied with preventive care for men, professionals appeal to women and when there are men performing primary care services, it seems to the professionals that they should be attended with greater urgency, because they have to return to work, or they find it strange that they can take care of children, that they suffer mentally or that they wish to be present during the pre-natal procedure and the delivery by their partners. Moreover, the fact that measures for the restoration and protection of male sexual health have been reallocated to primary care units makes the professionals very uncomfortable, and they often approach such measures with the woman as intermediary in their relations with the man, or they believe that the traditional specialist in male health, the urologist, should be brought in for this type of care[15,20,36].

In essence, professional practices give rise to a body of specific questions with regard to health policies, and although they are connected with these policies, they demand other approaches in order that health needs are dealt with from a critical perspective, as proposed by the comprehensive care policy. It is necessary to think in terms of elements which are appropriate in this field, elements of a technological nature, it should be said, linked to the provision of assistance and care, which should not be confused with technicism. They are prescriptions which seek to meet needs and to provide answers in the light of an egalitarian view of men and women in the context of health services, seeking to re-order what tradition in bio-medicine and gender has constructed. This is not to be seen as a deconstruction of the earlier construction. It can only be perceived in terms of the openings produced by the conflicts, the cracks and the tensions which have affected the (re)production of these traditions on a daily basis, where the spokespersons will be the men and women who use the services. It will be through opening up to the different nature of their existences as men and women that the professionals will be able to identify the needs which are being satisfied or transformed into lesser needs. The managers and formulators of policy should encourage them and support them objectively in this direction.

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