



Newsletter

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*From the Desk of Rosie Tong &
Laura Shanner, Network Coordinators*

Hello, FAB Members!

Welcome to a new year, welcome to new members, and greetings from some new faces in familiar places! On January 1, Rosie Tong and Laura Shanner (that is, "we") assumed the duties of co-coordinators of the Network following your vote of confidence last fall. We also would like to welcome some new members on the Advisory Board—the full list of names and contact addresses is included on p. 23 of this newsletter. Both of us are delighted to help steer FAB into a new century, and we feel tremendous excitement at the momentum FAB has built in just a few years. We would like to express our deepest gratitude to our predecessors, Anne Donchin, Becky Holmes, and Gwen Anderson, who guided FAB through its early years; we have been given a legacy of commitment and dynamism that makes our new job so much easier. As both of us have relocated within the past year to new jobs and new cities, we would like to bring everyone up to date on where we are and what we are doing, and to introduce ourselves to those whom we have not yet had the pleasure of meeting.

Laura is an Associate Professor in the John Dossetor Health Ethics Centre and the Department of Public Health Sciences at the University of Alberta (Canada). I am American by birth and upbringing, but gradually evolving into a true Canadian. I think I have always been a boundary-crosser: my Ph.D. in philosophy at Georgetown University (U.S.) included clinical internships, technology assessment, and interviews with infertility patients and clinicians. I then taught for five years at the Philosophy Department and Joint Centre for Bioethics at the University of Toronto, where I coordinated the undergraduate bioethics degree programs and helped steer the Graduate Collaborative Program in Bioethics.

The different expectations for research, grants and teaching in a medical faculty are new challenges for a philosopher, but the move is also an odd sort of homecoming: my under-

graduate biology major/chemistry minor originally aimed at a medical career before I found my calling in feminist ethics and health policy. My new home offers me many wonderful opportunities for collaborative research in relational and care ethics, aboriginal health issues, international human rights, rural health care, and ethics in public health. My current primary research project focuses on the metaphysics of the maternal-fetal relationship, with applications to legal and medical pregnancy interventions. I'm teaching two graduate courses in health ethics, one a new venture in public health ethics, law, and policy. I am also continuing work on a project for Health Canada (the federal department of health) on the ethics of embryo donation, and working with two local ethics committees.

The greatest advantage of the move and career upheaval is the opportunity at last to live with my husband (a mathematics professor) after 3½ years of commuting across continents and oceans to see each other. We finally landed jobs in the same city, and I've learned from this difficult experience just how far we still have to go to integrate work with personal and family lives in our society. As a result, I feel a renewed commitment not just to theoretical feminist bioethics, but to genuine and global change in women's (and men's) lives.

Rosie is the Distinguished Professor in Health Care Ethics at the Center for Professional and Applied Ethics at the department of Philosophy at the University of North Carolina at Charlotte (U.S.). I received my Ph.D. from Temple University in philosophy and taught for

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over twenty years, first at Williams College in Massachusetts and then at Davidson College in North Carolina. Although I enjoyed teaching 18-22 year-olds, I wanted to break out of the world of private education and enter the public domain. Currently I am teaching a very heterogenous group of students. Every day poses new challenges as I learn how to communicate with young and old, rich and poor, experienced and inexperienced people of every race and ethnic group imaginable and from a wide variety of walks of life. My new position permits me to devote considerable time to research and public service. I am an active member of two hospital ethics committees, several statewide task forces on managed care and long-term care, several faculty groups pursuing grants in the area of institutional and organizational ethics, several feminist theory and practice groups, and several citizen-oriented groups that seek to educate the general public about issues in health care. At present, I am teaching an undergraduate bioethics course and a graduate course on healthcare ethics and law. Next year I will teach a course on feminist ethics and one on complementary/alternative/integrative medicine.

My research areas are feminist theory, feminist ethics and bioethics, women's health issues, anything and everything related to reproduction and genetics, institutional and organizational ethics, and integrative medicine. Recently I have become very interested in "globalizing" everything I do. I realize how myopic my vision has been and I want to spend the next ten years of my life learning how to think globally. After that I want to retire, travel the globe with my husband, and watch my two sons' antics. It is an honor to serve FAB. I want us to enter the new millennium full force. If we work together, there is no way anyone can prevent us from increasing women's freedom and well-being worldwide.

It is our hope and commitment that the 21st century will see feminist approaches become the norm. In order to help that happen, our goals for FAB in 1999-2001 include the following:

- ❖ We want to increase international representation in FAB, especially by outreach to feminists in countries with developing economies.

- ❖ Our strategy for increasing membership in FAB is to aim for quality rather than quantity. Allies are always embraced; we are concerned, however, that mere interest rather than commitment—or worse, sabotage by opponents to our commitments—will dilute the credibility and strength of FAB's presence.

- ❖ We would like to use our listserv, newsletter, and website to promote sharing of information about who will be presenting at upcoming conferences or panels, and to encourage attendance and mutual support at

such meetings.

- ❖ We want to encourage greater attendance by FAB members at relevant conferences and other formats to raise the profile of feminist approaches.

- ❖ We hope to find funding sources that will allow members with limited resources to travel and participate in conferences more frequently. Any volunteers (preferably from several countries) to head up a funding and grants committee?

- ❖ The 3rd international FAB conference will be held in London, UK in September 2000. Further information is detailed elsewhere in the newsletter. The two previous FAB conferences have been extremely well done, and we look forward to yet another spectacular forum. Please join the planning committees to make this conference the best it can be!

- ❖ Our website has relocated from its original home at Georgetown to Rosie's site at UNCC. As the new site becomes fully operational and updated, we plan to add links to the personal and institutional web pages of members, enable sharing of course syllabi, post papers to the web, and use the technology to create a genuinely interactive network.

- ❖ Several other changes are afoot with practical matters related to communication, membership, etc. that will make it easier and more efficient to keep in touch with each other. Details follow under other headings in the newsletter.

We both look forward to working with all of you in the next couple of years as FAB grows stronger. With great enthusiasm and our very best wishes,

Rosie Tong and Laura Shanner

American Medical Women's Association (AMWA) member Diane Shrier, MD, and her daughter Lydia Shrier, MD, are seeking help with a new project. "We are interested in identifying mother-daughter physician pairs (including medical students) for a study we are doing entitled *Mother-Daughter Physicians: Generation to Generation*." If you are a member of such a pair or know someone who is, please send the names/addresses/phone/fax/e-mail to:
Diane Shrier, fax: 202-965-2942, e-mail: diane.shrier.med.64@aya.yale.edu
or her daughter Lydia Shrier, e-mail: shrier@al.tch.harvard.edu.

Upcoming Conferences

FAB 2000 NEEDS YOU!

Rosie Tong

The 3rd International Feminist Approaches to Bioethics Conference is coming up in late September, 2000. As in previous years, the FAB conference will be held in conjunction with the International Association of Bioethics Conference at Imperial College in London, U.K. The FAB Conference (Sept. 19-20) will precede the IAB Conference (Sept. 21-24). The first two FAB conferences have been widely praised for their high quality, and we are looking forward to making the third time a charm!

We therefore call upon all FAB members—and especially those in the UK—to get involved in laying the groundwork for this international forum. At present we are looking for people in the UK who would be willing to lead on-site coordination efforts.

The Network Coordinators, Rosie Tong and Laura Shanner, are the official coordinators for the conference. Both will have opportunities to speak with Alastair Campbell, President of the IAB, in upcoming months. Hilde Lindemann Nelson, Susana Sommer, Anne Donchin, Gwen Anderson, Hilary Rose and Ailsa McLaren have already volunteered for the Program Committee along with the coordinators (thank you!). In addition there will be an on-site coordination team whose members will be announced in the next Newsletter.

The suggested theme is “Feminist Bioethics at the Turn of the Century,” and we hope to push the boundaries of feminist scholarship in the call for papers and keynote presentations. We very much want the program to reflect the rich diversity of FAB. We value the contributions of all FAB members including those who view themselves as activists first and academicians second, if at all. Finally, it is important that no one or two countries dominate the program. For all these reasons, we encourage as many people as possible to submit papers (information on p. 26).

Suggestions and assistance with arrangements, publicity, funding, keynote speaker suggestions, etc. are always appreciated—please feel free to contact Rosie and/or Laura at any time.

ASBH PROGRAM SHAPING UP

Hilde Lindemann Nelson

Plans for the ASBH Second Annual Meeting, to be held at Philadelphia's Wyndham Franklin Plaza Hotel 28-31 October 1999, are well underway. Jeremy Sugarman and I, the co-chairs of this year's Program Committee, are delighted to report that, thanks to the efforts of Mary Faith Marshall and an amazingly hardworking committee, a number of key elements are already in place, including a keynote lecture by the distinguished British philosopher Onora O'Neill. Other plans, such as the exciting plenary lectures to be given by leaders in bioethics, are very close to completion.

An array of preconference symposia, scheduled for the morning of Thursday, 28 October, are firmly set. FAB members Maggie Little and Sue Rubin, the Program Committee members responsible for arranging these, have done a superb job in lining up sessions on topics that will be of genuine, practical use to ASBH members. Submissions for presentations, panel sessions, workshops, and posters are now under review. ASBH Headquarters reports that 218 members managed to meet the 1 March deadline.

Once everything is in place, the meeting brochure will be printed. ASBH members can expect to receive this in late July. In addition to the program, the brochure will contain a meeting registration form (which will also be available on the ASBH web site in early August). The FAB Affinity Group time slot will appear in the brochure, so be sure to look for it.

If the titles of the presentations that were submitted are any indication, this year's meeting promises to be an exceptionally lively and interesting one. The Program Committee is doing its best to make it so, and we certainly hope you're planning to come.



Reports From FAB2: Emerging

Anne Donchin, Project Director, Indiana University

From its inception in 1992, FAB has aimed to truly internationalize bioethics: to rectify the sweeping disregard of women's health care issues within mainstream bioethics literature and build a nonhierarchical, nonelitist, geographically diverse, grassroots movement with a collaborative structure that is open to all—academics and professionals, health care activists, and concerned groups in all fields. Since our organization at the inaugural IAB Congress in Amsterdam (1992), we have been expanding our international scope, first in Buenos Aires (1994), and then through our own conferences in San Francisco (FAB1, 1996) and Japan (FAB2, 1998).

Twenty-seven of the fifty-eight participants presenting papers at FAB2 live and work in developing countries. A generous grant from the Ford Foundation's Human Development and Reproductive Health Unit provided full funding for fifteen of them.¹ Their presence significantly strengthened our ties with feminist health care scholars and activists in regions where there had been little or no prior FAB presence, particularly the Philippines, Brazil, and South Africa.

FAB members in industrialized countries benefited immeasurably from face to face meetings with our sisters who are wrestling with grassroots issues of poverty and injustice. Some of the indigenous problems they addressed

at the conference and summarize in the following essays reflect concerns already familiar to Western feminists (though they are far more pervasive than we'd realized until now): the predominance of bioethical principles that seldom reach far enough to encompass the pressing health care needs of marginalized social groups, the use of medical institutions as instruments of social control, and objectifying barriers dividing the life worlds of provider and patient. But even in the face of such profound barriers, the feminists whose essays you will read here have imaginatively developed strategies that empower local communities to meet their own distinctive needs. We publish these essays in the hope that they will energize all our struggles and advance international collaboration among FAB members across the globe.

¹ All of us who reaped the rewards of the event are immensely grateful for the foresight of Marjorie Muecke, Ford Program Officer, and Nikki Jones, longstanding FAB member and former Ford Program Officer in the Philippines, both for their original suggestions and vital help throughout the gestation of the project. Our appreciation also to the IAB organizing committee in Japan (Darryl Macer, in particular) which provided resources and set up local arrangements, without which it would not have been possible for FAB to mount such a gathering.

Apartheid and Population Control: Health Professional Accountability in South Africa

*Jeanette de Gruchy & Laurel Baldwin-Ragaven,
The Health and Human Rights Project,¹
Cape Town, South Africa*

The development of contraceptive and reproductive technologies has been a major step towards increasing the control that women can exercise over their reproductive and sexual lives. However, this "potentially liberating technology"² is vulnerable to abuse, particularly in the context of political repression. This abuse for political purposes can be seen clearly in the population control project of apartheid South Africa.³

Apartheid denied the majority of South Africans their fundamental human rights. Profound injustice extended to the health sector, where apartheid distorted and corrupted health services and health professional training.⁴ With regard to reproductive health services, the state used its family planning programme to implement a policy of population control, which did not focus on improving the health status of women. Scientists and health professionals were integrally involved in the development and implementation of the apartheid "family planning" programme. Their role in these programmes designed primarily for population control raises challenging ethical questions. We present three specific examples where health professionals actively subjugated, and might continue to subjugate, professional ethics and human rights principles in providing for the reproductive health of women.

Voices in Feminist Bioethics

The military project to develop an anti-fertility vaccine

The South African Truth and Reconciliation Commission (TRC) heard evidence that “the most important project of the early stages of South Africa’s secret biological warfare programme” was work done by scientists of the South African Defence Force (SADF) to develop an anti-fertility vaccine which “could have been used clandestinely on black people.”⁵ Giving evidence before the TRC, Dr. Goosen, a veterinarian and pathologist, said that:

I thought we were involved in a war for our survival. [The surgeon-general had] said it was our most important task as there were “too many blacks”...We believed at the time, this was legitimate. If we developed an anti-fertility vaccine, we would have curbed the birth rate, there would be less starving kids.⁶

Female Sterilisation

Parallel to its extensive promotion of reversible contraception, the apartheid state also embarked on a major programme of female surgical sterilisation. Here too, the potential for abuse by health care workers was enormous. A doctor recalled how he observed surgeons-in-training sterilising patients during appendectomies without their knowledge, and how surgeons regularly manipulated fallopian tubes with the intention of causing adhesions and subsequent infertility.⁷ These practices were commonly known. In 1987, the Deputy Director of Family Planning, Ms. Stockton, admitted that “there is the problem of doctors in provincial hospitals doing sterilisations when they do a caesar.” As explanation, she suggested that “it is partly a problem of enthusiasm for a cause...noting that the white population is well below replacement and that ‘we’ are a minority group in the country’.”⁸

Depo-provera: the “fourth stage” of labour

Medicine describes three stages to labour. In South Africa, the automatic administration of an injectable progestogen during childbirth has resulted in depo-provera being known as “the fourth stage of labour.” “Many women do not give informed consent for the injection, and women who try to refuse are often given a hard time.”⁹

While we acknowledge that health professional complicity with the government’s population policy is a complex issue, this in no way absolves the relationships cultivated between the state and the health professions to achieve population targets.

Klugman articulates the problem clearly:

When providers of contraception are absolutely certain that stopping a woman from having another child will be a major contribution towards the national good, there is a serious ethical problem, especially when the majority of the nation have had no say in the formulation of the policy in the first place.¹⁰

We discuss some of the ethical inconsistencies, highlighted in the above examples, which pose real challenges to the health sector.

First, there was ideological congruency between those most powerful in the health professions—predominantly “white” male doctors—and the politicians and administrators of the apartheid state. If we understand medicine itself as an institution of social control, we can see how easily those with medical training could have and indeed did serve the purposes of the apartheid state. Apartheid, patriarchy and medicine asserted control of women’s bodies.

Additionally, this veneer of professionalism is used to cover the close partnership between “science” and a repressive state. With the biochemical warfare programme, for instance, it was “because doctors were running the programme [that] it was generally assumed that the programme was ethical and above board.”^{11 12}

Lastly, many health professionals held a Malthusian conviction (many continue to do so) that *population growth* per se is the root problem of social ills, that “family planning” is the answer, and that their involvement in family planning programmes is part of their duty in the “fight against poverty.”¹³ However the promotion of contraception alone as the answer to socio-economic ills does more to regulate women’s reproduction and control their social behaviour, than respond to their reproductive health needs and redress social inequities.

Racist and sexist constructions of “black” women as incompetent in decision-making can lead to health professionals believing that they have a right to sterilise without consent to reduce the number of “starving kids,” or to reduce the rate of HIV. In an alarming contemporary example, a recent physician’s letter to the *South African Medical Journal* suggests that any policy to curb the rates of mother-to-child transmission of HIV should include consideration of termination of pregnancy “either voluntarily or by law” as well as “an Act of Parliament...to the effect that all HIV-infected women in their reproductive years should be sterilised.”¹⁴ We are greatly concerned to find eugenics discourse in a medical journal, as well as certain inputs at the recent

Tsukuba Roundtable and IAB conferences in Japan which appeared to be unapologetically eugenic in their ideological thrust.

In conclusion, we welcome recent important legislative and policy developments in South Africa, such as the Choice on Termination of Pregnancy Act (1997) and the White Paper on Population Policy (July 1998). However, given the history of health professional collusion with apartheid patriarchy, where the rights of “black” women particularly were abrogated, what guarantee is there now that South African health professionals will begin to adopt women-centred practice styles and redress power imbalances in previous applications of apartheid health legislation and reproductive policy? What transformation is required in the health sector for nascent reproductive rights to realise comprehensive health care for women?

The role players involved in the health sector—individual health professionals, professional organisations, the statutory councils, state services, training institutions, organisations in civil society and the private sector—all need to engage in far-reaching interventions which affirm their commitment to social transformation. There is much work to be done in challenging the racist and sexist constructions of the health profession in order to truly develop a culture of respect for human rights in the South African health sector.

Note: The racial terminology used in this paper employs categories legislated by the apartheid state. We submit that “race” is a social construct that serves particular political purposes, and in no way do we suggest that “races” exist as essential groupings.

¹ The Health and Human Rights Project is a joint initiative of the Department of Community Health, University of Cape Town and The Trauma Centre for Survivors of Violence and Torture, Cape Town. The authors, both medical doctors, are Research Fellows with the Project. Address correspondence to: Health and Human Rights Project, PO Box 13124, Woodstock, South Africa 7915. E-mail: hhrp@trauma.org.za or laurel@trauma.org.za. Fax: 27-21-462-3143.

² Zwi, A. “The political abuse of medicine and the challenge of opposing it,” *Social Science and Medicine*, 25, no. 6 (1987): 650.

³ Brown, B. B. “Facing the ‘black peril’: the politics of population control in South Africa,” *Journal of Southern African Studies*, 13, no. 3 (April 1987): 256-273; A. Zwi. “The political abuse of medicine,” 650; B. Klugman. “The politics of contraception in South Africa,” *Women’s Studies International Forum*, 13, no. 3 (1990): 261-271; B. Klugman. “Balancing means and ends - population policy in South Africa,” *Reproductive Health Matters*, no.1 (May 1993): 44-57; H. Rees. “Contraception: more complex than just a method?” *Agenda*, no.27 (1995): 27-36.

⁴ Gruchy, J. de, London, L., Baldwin-Ragaven, L., Lewin, S., and the Health and Human Rights Project Support Group. “The difficult road to truth and reconciliation - the health sector takes its first steps,” *South African Medical Journal*, 88 no.8 (August 1998): 976.

⁵ Thornycroft, P. & Sole, S. “SADF used chimps in project to curb black fertility,” *The Sunday Independent* (19 April 1998): 1-2.

⁶ Thornycroft, P., and Sole, S. “SADF chimps,” 1-2.

⁷ Doctor at Medical Research Council, Interview by HHRP. Cape Town, 22 July, 1998.

⁸ Klugman. “The politics of contraception,” 265.

⁹ Rees, H. “Women and reproductive rights,” in *Putting Women on the Agenda*, S. Bazilli, ed. Johannesburg, Ravan Press, 210.

¹⁰ Klugman. “The politics of contraception,” 264.

¹¹ We note that no action has as yet been instituted against these doctors by the Health Professions Council. This once again confirms our belief that the Council colludes with the abuses of its health professionals.

¹² Sidley, P. “Doctors involved in South Africa’s biological warfare programme,” *British Medical Journal*, no.316 (20 June, 1998): 1852.

¹³ Dr. Esther Sapire, former chairman [sic] and later president of the Planned Parenthood Association of South Africa, as well the head of the Family Planning Unit at Groote Schuur Hospital over a twenty-year period, from 1976 to 1996, Interview by HHRP. Cape Town, August, 1998.

¹⁴ van de Wal, B. W. “Preventing perinatal vertical HIV transmission in South Africa,” *South African Medical Journal*, 88, no.10, (October 1998): 1283.



New Reproductive Technologies and Their Dilemmas

Susana E. Sommer

Universidad de Buenos Aires, Argentina

Headlines like: *Septuplets fight for their life* or *A Christmas present* where a couple offers as a present six frozen embryos that they are not going to use, show us what is happening in assisted reproduction and how these new developments pose various questions. They also shows how in vitro fertilization (IVF) offers “solutions” that place new duties on apparently happy infertile women, compelling them to pursue technological solutions to childlessness.

In Argentina, assisted reproduction began in 1984, and the first such birth there was in 1985. In Latin America there are 64 centers devoted to the new reproductive technologies. Argentina has 17 private institutions that account for 21% of Latin America’s IVF births (no public institution is involved in these techniques). Brazil has 23 centers that provide 30% of Latin American assisted reproduction. (Sommer, 1998)

These institutions must have the technical approval of the Latin American Network of Sterility and Fertility, as well as of their local branch. Every five years the centers are checked to determine their success rates. According to the last report, the pregnancy rate averaged 12% per treatment cycle. It was not possible to obtain information on the number of children born in each center.

Most new techniques are quickly applied in

Argentina, and donor insemination, egg donation, IVF, GIFT and ICSI are currently used. Sperm banks (there are four or five) follow the norms of the American Fertility Society. There is no regulation of embryo freezing. Each institute has its own rules; sometimes frozen embryos are kept for five years. The couple may use them or offer them to other infertile women for "prenatal adoption." "Prenatal grandmothers" have come into being too—women who gestate their daughter's children.

In our country, assisted reproduction still operates in a legal vacuum, although discussions about regulation have been underway since 1990. Two antagonistic and powerful lobbies, the Church and the medical establishment, cannot agree on the status of the embryos. Needless to say, this discussion is related to the lack of legal abortion in our country.

We cannot forget that accomplishments in reproduction are intimately related to studies of development and embryogenesis, as well as other puzzles that worry scientists. Laboratory manipulation of ova, sperm and embryos, an impossibility until a few years ago, will in the near future enable researchers to understand fertilization, contraconception and many other questions related to reproduction, including the risks of fertility-enhancing drugs. Rossing et al (1994) have tried to evaluate whether ovulation-inducing drugs enhance the risk of having ovarian tumors. Results suggest that the risk is increased after twelve or more stimulations. Perhaps we have arrived at the time to discuss what counts as a reasonable number (if any) of treatments to undertake.

Another pending issue is whether IVF and other reproductive technologies contribute to serious illness or other difficulties for children born through these methods. Cynthia B. Cohen (1996) points out that Australia is the only country that has gathered statistics and follow-up data on the development of these children. The effect of freezing embryos was studied in rats by Dulioust et al (1995) in France. Although the evidence is not totally conclusive, rats show some retardation in certain morphophysiological as well as behavioral characteristics, but the authors point out that they are not able to evaluate the effect of freezing on subsequent generations. Experts such as Wagner and Stephenson (1993) suggest that, as long as there is not enough available information, any new technology should be considered experimental and should be used accordingly. It is very important to distinguish whether one is receiving a proven therapy or is involved in research. (ten Have, 1995)

Unresolved issues about the risks of treatment raise questions about whether healthy fertile women should submit to treatment to accommodate infertile partners and also whether postmenopausal women should seek to erase physiological barriers to conception. One wonders whether access to these techniques gives

women greater freedom or puts new pressures and burdens on them.

Feminists are worried about the risks for women who use these techniques, and the pressure put on infertile women to do everything possible to have children. New reproductive technologies provide a very good example of the issues that arise where autonomy is not understood relationally in a full sense that acknowledges power relationships. (Sherwin, 1998) Infertile women who give informed consent to fertility treatments are not making a choice that is fully autonomous as long as they do not have full equality and must make decisions about pursuing these treatments under the influence of social or familial pressures.

Cohen, Cynthia B. "Give me children or I shall die!" New Reproductive Technologies and Harm to Children," *Hastings Center Report*, 26 (1996): 9

Dulioust, E., K. Toyama, M.C. Busnel, et al. "Long-term effects of embryo freezing in mice," *Proc. Natl. Acad. Sci. USA*, 92 (1995): 589-593.

Rossing, Mary Anne, J. R. Daling et al. "Ovarian tumor in a cohort of infertile women," *N. Engl. J. Med.*, 331, no. 12 (1994): 771-776.

Sherwin, Susan. "A relational approach to autonomy in health care" in *The Politics of Women's Health*, S. Sherwin, ed. Temple University Press, Philadelphia, 1998.

Sommer, Susana E. Nuevas formas de procreación en *Género y Salud Reproductiva en América Latina*, compilado por Lucila Scavone, Ed. Lur (Eulac/GTV), Costa Rica, 1998.

ten Have, Henk A.M.J. "Medical Technology Assessment and Ethics: Ambivalent Relations," *Hastings Center Report*, 25, no. 5 (1995): 13-19.

Wagner, Marsden & Patricia Stephenson. *Tough choices: in vitro fertilization and the reproductive technologies*. Temple University Press, Philadelphia, 1993.



Aids, Research and Developing Countries: Compassion for Whom?

Florencia Luna

University of Buenos Aires, Argentina

I have been working on assessing HIV trials in developing countries, trying to enrich the debate by drawing on my own experience in another developing country, Argentina. Although my focus is on AZT trials in Sub-Saharan Africa, these analyses might be usefully applied to other research in developing countries.

Issues inherent in arguments favoring the use of placebos include: the value of research, the scientific rationale that regards placebo-controlled trials as the gold standard, the utilitarian calculus that favors fast

results, and financial and socioeconomic considerations. Another argument is the so-called “standard practice argument,”¹ which points out that no treatment at all is available for women in many of the countries in which the trials are being run and therefore any treatment is better than none. It subtly implies that, while not beneficial, such treatments are not harmful and do not cause any damage that would not occur “naturally.”²

This argument merits two comments. In the first place, the standard-practice argument mixes two different contexts: research and the “real life situation,” and it fails to note moral obligations involved in research. The two contexts cannot be so readily conflated. Policies or health finances of a country cannot be altered, but researchers do have certain obligations toward the people involved in clinical trials.

Secondly, one might challenge the previous vision of the situation of the women participating in these trials. We should consider the effort involved for those women: they have to leave their work or their other children with another person in order to make periodic visits to the hospital; they have to travel to get to the hospital; they will medicalize their pregnancy, an unusual behavior for such a population, etc. Such efforts, which, as many local scientists have pointed out, are not part of usual health care behavior, deserve both respect and appraisal. Instead of treating these women as if they are receiving typical health treatment or even an equitable share of what their society is able to afford, researchers should evaluate what these women’s “extraordinary” efforts actually deserve.

Are there other reasons, peculiar to developing countries, for protecting research subjects, particularly women? First, in Argentina, physicians and researchers in public institutions are not well paid. In order to earn a relatively decent salary, they generally supplement their work with private practice or by simultaneous positions in different hospitals. It is informally known that, in many cases, industry pays extra money to researchers and research physicians; they even pay per subject enrolled in a study (which may raise doubts as to the adequate selection of certain research subjects). In these cases, money is not delivered to the institution or allocated transparently, but goes directly into the researchers’ pocket.

Second, most research is done in public hospitals and not in private clinics. This means that the population available is typically the *most vulnerable*—illiterate women with scarce resources and no other access to health care. In general this population feels gratitude for what is offered and will not dare to question anything; how could they? Behavior towards them is paternalistic;³ and they may be in a desperate socioeconomic situation, willing to accept almost anything. And if the country is a Catholic one (as is mine), research done with the goal of benefitting the

fetus must be accepted, because of the importance given to fetuses and to the reproductive role of women. If your physician is conducting clinical research and you are in a vulnerable position with nearly no other options for treatment, it is difficult to refuse participation.

Thirdly, there is a general lack of respect for persons. In countries where death is common (we have a long history of dictatorships, murders, and violations of human rights), the tendency to disrespect persons is widespread.

Some of the factors I have described may also apply to other developed countries. Also, many countries have very poor mechanisms to control or punish wrongful doing or corruption. The cumulative effect of all these elements should be carefully considered when formulating safeguards for research subjects.

I do not believe these variables invalidate the conduct of any trial in such places. I am not arguing here for a rigid vision of research where no changes may be introduced and where no socioeconomic factors are to be taken into account. Developing countries are in need of research, not only for humanitarian but also for scientific reasons. But what I would not endorse is pursuing the fastest and easiest route by overriding the rights of poor and uneducated women; instead, we should search for better and less rigid designs. This might prove more difficult but it is more compassionate and just.

¹ This argument has not been explicitly formulated by researchers, but it can be inferred from criticisms. A version of this argument states that, in such countries, trials are morally acceptable because women cannot have access to any treatment. A counterargument points out that many developed countries also have populations in miserable conditions, so minorities in misery or vulnerable conditions could also be exposed to major risks. This position, however, resembles the justification of the Tuskegee study, which is not endorsed by researchers.

² Deborah Zion, criticizing this argument, points out its disturbing implications: “... that it is ethically acceptable to exploit the suffering of vulnerable populations even though the means to alleviate it are known, because if no trial at all were offered the women in question would have passed on the infection to their children anyway.” Zion, Deborah. “Ethical considerations of clinical trials to prevent vertical transmission of HIV in developing countries,” *Nature Medicine*, 4, no. 1 (January 1998): 11.

³ Luna, Florencia. “Paternalism and the argument from illiteracy,” *Bioethics*, 9, no. 3/4 (July 1995): 283-290.



Feminist Bioethics: The Emergence of Difference

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The first two decades in the emergence and consolidation of bioethics were marked by the predominance of the principlist theory, originally developed by James Childress and Tom Beauchamp in *Principles of Biomedical Ethics*, the book which became the “bible” of bioethical studies. The principlist theory offered the possibility of resolving moral dilemmas in bioethics based on four principles which its critics described as an “ethical checklist.”¹

The principlist theory had tremendous impact in the United States. The theory’s influence was also enormous in countries such as Brazil where, today, despite being subject to critique, the majority of Brazilian bioethicists still refer to principlism as “the” bioethical theory. The persistent influence of the principlist theory in countries of peripheral bioethics is due to delay in access to recent bioethical debate and, more importantly, to the seductive instrumentalism of the principlist theory.²

Critiques of the principlist theory were accompanied, not coincidentally, by a re-examination of the assumptions of bioethics as a discipline. Feminist bioethics formally arose in the 1990s, with the publication of the first books which interrelated feminism and bioethics.³ Earlier, in the 1980s, a number of scattered studies on the topic were published, though debate focused on feminine ethics theories, most notably Carol Gilligan’s book, *In A Different Voice*.

Other than the influence of Gilligan’s work, bioethics traditionally kept its distance from gender and feminist ethical studies. Susan Wolf considers this neither coincidental nor the result of an underrepresentation of women in research (women bioethicists have been present since the beginning of bioethics, though in fewer numbers than men). According to Wolf, the resistance within bioethics to admitting feminist ethical studies was due to the “deep structure” of the discipline characterized by:

...a historical preference for abstract rules and principles that disregarded individual differences and contexts; embraced liberal individualism that obscured the importance of groups; *the structure of bioethics as a field frequently serving government, medical schools, hospitals, and health professionals in a way that may have discouraged attention to the views of people lacking power inside and outside those institutions*; and the frequent

isolation of bioethics from major trends within the academy, including feminism, critical race theory, and post-modernism . (1996 p. 14)⁴

Wolf’s analysis critiques the assumption that the principles of the principlist theory are universal; second, it indicates the limits of liberal ideology which holds individualism and, consequently, the principle of autonomy as the highest of values; third—and for us perhaps most importantly—it recognizes that the structure of bioethics preserves the interests of the socially advantaged, thereby constituting a “bioethics for the privileged;” (1996 p.18) and, finally, it testifies to the neglect within bioethics of critical studies. That said, it is clear that feminist ethical studies, or even gender theory, demand more than inclusion in the agenda of bioethics. In fact, feminist bioethics demands a reorganization of the discipline’s “deep structure” or, better put, of its nature. In their markedly critical analysis, bioethical feminist studies proposes a revision of basic bioethics assumptions and upsets the status quo of the discipline.

The post-Gilligan phase was marked by analyses critical of the assumption of a universal or generalizable ethics which characterized studies in bioethics. Feminist bioethics is one strand in contemporary moral philosophy which seeks to understand and grasp the moral differences between parties in moral conflict and hence shares common ground with those ethical theories which accept moral pluralism. On the other hand, it also challenges principles of relativism and nihilism. As Susan Sherwin argues, a distinction should be made between respecting difference and universal tolerance, particularly when the latter is used to defend perverse practices on the grounds that culture justifies itself.⁵ Hence feminist bioethics suggests a sociogenesis critical of the discipline: displacing traditional ethics from its supra-regulating role in the resolution of conflicts, on the one hand, and refusing to recognize the nihilist principle of “everything goes,” on the other.

Like Sherwin, we hold that, if this critical movement does not bear fruit, principlism will serve to maintain the dominant order which protects those whom Wolf appropriately termed “privileged” and will fail to safeguard the dignity and integrity of moral subjects caught in ethical conflict. According to Wolf, if the principle of autonomy—treasured in the feminist movement, as well as in bioethics—is not applied in a context of equality between the parties in conflict, it may be transformed into a weapon against those whom it seeks to protect. Or, as Sherwin argues, (1992, p.53) it could be transformed into a senseless concept since the reference to individuals decontextualized from their social biography is empty. Consequently, we believe that feminist bioethics, like other bioethical theories underpinned by moral pluralism, proposes a subversion of the moral order. In its absence, bioethics will continue

to serve the interests of the “privileged” rather than the oppressed.

Throughout this article feminist bioethics has been referred to in the singular, but we recognize that both feminist bioethics and traditional bioethics are not monolithic. On the contrary, there are a variety of strong feminist theories in bioethics. What unites them, however, is the concern with difference and focus on unequal relations. What defines feminist bioethics is its search for changes in social relations characterized by human domination and by subordination which impedes the exercise of freedom.

¹ Gert, Bernard; Culver, Charles; & Clouser, Danner. “Principlism,” in *Bioethics: A Return to Fundamentals*. New York: Oxford Press. 1997. pp. 71-92; Clouser, Danner & Gert, Bernard. “A Critique of Principlism,” in *Journal of Medicine and Philosophy* 15, no. 2 (1990): 230-242.

² For a definition of the concepts of central and peripheral bioethics, see Garrafa, Volnei; Diniz, Debora & Guilhem, Dirce. “O Idioma Bioético: Seus Dialeto e Idioleto,” in *Cadernos de Saúde Pública*. in press. 1998.

³ See Sherwin, Susan. *No Longer Patient: Feminist Ethics & Health Care*. Philadelphia: Temple University Press. 1992; Tong, Rosemarie. “Feminist Approaches to Bioethics,” in *Feminism & Bioethics: Beyond Reproduction*, Susan Wolf, ed. Oxford: Oxford Press, 1996, 67-94.

⁴ Wolf, Susan, ed. *Feminism and Bioethics: Beyond Reproduction*. New York, Oxford University Press, 1996.

⁵ A classic example frequently cited by feminist bioethicists and which suggests the imposition of limits on cultural difference is that of female genital mutilation, a ritual suffered by women in Africa and elsewhere (Sherwin. op. cit. 1992. p. 61).



A Glimpse of the Ethical Terrain in Philippine Hospitals

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The health sector in developing countries like the Philippines is weak, fragile and vulnerable to financial pressures and the vagaries of national budget priorities. Health care ranks only 10th in the allocation of the national budget of the Philippines. The affordability of health care and growth in health expenditures and medical costs are continuing problems which are aggravated by the growing privatization of health services.

In this context, the delivery and quality of health care services in public hospitals leaves much to be desired. Lack of resources (e.g., beds and blood supply), congestion, deteriorating equipment and

over-utilized facilities are typical features. In such a setting, the practice of ethics is mediated by scarce resources, overburdened doctors/hospital staff and the immediate health care needs of patients. In effect, discussions about ethical issues of concern to patients and medical/health care practitioners are often set aside by doctors and staff for the more urgent needs of patients/clients.

Mechanisms to promote ethical conduct and decision-making in hospitals include the establishment of ethics committees. In Philippine hospitals, ethics committees are generally not fully developed or well-functioning. They are basically reactive and ad-hoc in nature, so what exists are informal structures and mechanisms as well as processes of negotiation and decision making. Some committees also function more for the protection of the institution than the protection of the interests and rights of patients.

Medical treatment of patients and doctor-patient relationships are still governed by the norms of authority and paternalism. Of ethical concern in the delivery of health care in hospitals is the arrogant and impersonal attitudes of doctors. In a Catholic country like the Philippines, vulnerable clients such as women who seek treatment for the consequences of abortion have to contend with the unsympathetic and moralistic attitudes of doctors, interns and staff. Consider this case:

A young woman has an unwanted pregnancy and so aborts the baby by having a foley-bag catheter inserted into her cervix for twenty-four hours. During this period, she is given Amoxicillin 500 mg three times a day, is subjected to abdominal massage, and eventually has some bleeding. A day later the foley bag catheter is deflated and removed from the cervical canal. She develops very malodorous vaginal discharge, fever and severe crampy pains. She self-medicates with paracetamol for the fever and, with the increasing frequency and intensity of the uterine contractions, the child is aborted.

At the emergency room, the very harried over-worked doctor interviews and examines this young woman who presents with the classic signs and symptoms of an induced septic abortion: malodorous vaginal discharge, fever, chills, and a badly bruised dead fetus. The resident doctor, within hearing distance of other people accompanying the young woman and other patients, asks the woman if she has had an induced abortion. The woman responds with an emphatic “NO!” For some reason the resident is obsessed with finding out if the patient indeed had an induced abortion and spends some time asking her. The more he insists, the more she denies.

He threatens that if she does not admit having had an induced abortion she might die. He finally decides to treat her with antibiotics and starts her on intravenous fluid with oxytocin to contract the uterus and he

schedules her for a curettage to remove whatever is left of the placenta in the uterus. This procedure is customarily done with intravenous painkillers. The young doctor then performs the curettage *without any painkillers*. So the curettage is a “howling” success (the patient howls every time her uterus is scraped by the curette). The doctor’s reason? To teach the woman not to commit another abortion. She is using supplies of the public hospital which other patients need.

This case clearly demonstrates how women can be at the mercy of doctors, nurses or staff who are not sensitized to ethical and gender concerns. Another area that is replete with ethical issues and where gender sensitivity is also needed is the treatment of victims of sexual abuse or violence. Cases that spell breach of ethical standards and renunciation of professional responsibility also commonly occur. A recent case is particularly notable: a private teaching hospital discharged a pregnant HIV-positive woman 10 hours after she had been admitted because the hospital claims it did not have the facilities, staff and equipment to handle her delivery.

Other unethical practices abound in hospitals, such as not admitting patients if a deposit or down payment is not given (despite a law that prohibits this), or discharging patients if they cannot afford to pay.

Tales of greed, abuse of power and neglect have also been reported. There are doctors who engage in self-referral in ordering laboratory tests, diagnostic procedures or treatment for patients, and those who resort to overcharging of fees and selling of (sample and expired) pharmaceuticals. Unnecessary procedures are also common, such as inducing a Caesarian section so that a higher charge is obtained.

There is apparently a lack of understanding of what ethics is among health care professionals and workers and, therefore, a glaring need for ethics education. Health care providers must be knowledgeable about the principles, issues and methodologies in ethics as well as the mechanisms that foster ethical practice and decision making. More importantly, ethics education must be informed by the perspectives of gender, culture and poverty to enable health care givers to be more responsible and humane in their practice. The establishment of hospital ethics committees as a more formal and structured mechanism and venue to respond to these concerns is all the more imperative.



Poverty, Gender And Reproduction: Understanding the Terrain of Women’s Lives

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How do international commitments on women’s health, like those expressed at the International Conference on Population and Development (ICPD), blend with women’s realities in the field?

The ICPD provision on reproductive health and rights states that “Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. In all matters relating to the reproductive system and to its function states should take appropriate measures to ensure...universal access to health care services, including those related to reproductive health care...”

I remember the women I was privileged to interact with during my field research in a rural community in the Philippines. Women whose life experiences speak of a blatant absence of good health and well-being. Women whose existences have been marked by family obligations and domestic roles in situations of material poverty. And women whose life stories reveal inadequate access to health care. And yet we make big pronouncements about “everyone’s right to the enjoyment of the highest attainable standard of physical and mental health...”

How do we deal with underlying issues (e.g., women’s health, gender concerns, poverty) that are not necessarily on the table of concerns when health care is being discussed? How do we appropriate issues such as the absence of gender-responsive health care facilities, women’s inability to prioritize their personal health because of urgent family concerns reflective of material poverty, in the schema of health care management that may spell a difference in women’s lives?

Back in the community where I am immersed, the experiences of women form a context which may eventually challenge health care professionals. The women of this fishing village are inheritors of generational poverty. They were raised in the village by parents who are also poor. Due to the unstable livelihood of their husbands, these women, with children ranging from four to nine, hardly meet their basic needs (e.g., food, shelter, education of their children). Money is hard to secure and P 50 (US\$ 1.25) means big money to them. If they can earn that much for a week of work (e.g., gathering seaweeds, shells) then they are lucky.

These women participated in a micro-credit project in the hope of alleviating their economic situation. The credit from the project allowed women to pursue

alternative livelihoods (e.g., fish vending, piggery, fishing). However, they have to stretch their daily time just to meet project commitments and juggle their domestic tasks—cooking, taking care of the kids, washing clothes, etc.

While women earned additional income for the household, they have to deal with some personal costs. Physical fatigue was common, and some women faced extreme health consequences. One woman had a miscarriage that led to extreme depression which made her stay in the hospital several times. Another woman experienced half-body paralysis; still another woman did not notice that she was pregnant until her sixth month when she could hardly manage heavy manual labor. Another woman died due to miscarriage in her seventh month of pregnancy while she was doing paid laundry, household tasks, and project concerns.

While these are isolated cases of health problems, my study points out that women's personal health is the neglected aspect of their lives. They bear their pains and prioritize the concerns for daily survival so that their children and husbands can be secure. It is not surprising that women's health—especially their reproductive health—suffers the most amidst situations of poverty and unequal gender relations. Women's perception of familial obligation, imbibing the ideology of domesticity, underscores the gender role of life-long domesticity. Added to women's problems is inadequate access to health care: often they have to travel forty kilometers to the city to be able to access adequate health services.

Thus, for Nita, the woman who died, health service was too far and too late to save her life. She left seven young kids who will eventually inherit her fate should poverty, gender and health care problems continue to persist. And in a country like the Philippines, where there is a macro-economy of underdevelopment, women's health and children's futures will always be negotiated within class inequities unless transformative mechanisms are instituted to prioritize basic health and welfare services.

And so, the challenge for health care professionals remains. There is a need to broaden the ethics of health care to include a deeper understanding of women and their place in the social ecology of family survival and terrain of economic underdevelopment. And while women continue to be victims of inadequate health care and poverty, the greater challenge lies in motivating gender-responsive health care professionals imbued with commitment to serve the far-flung underprivileged communities in the rural areas, where their services are of utmost significance. Eventually, we may be able to develop at the grassroots level women who are adequately informed of their health and rights so we can weave a better tomorrow for the next generation.

Social Development Organizations: Their Ethical Dilemma

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Philippine Partnership for the Development of Human Resources in Rural Areas

The downfall of the late Philippine dictator, Ferdinand Marcos, brought about the installation of the first woman President of the Republic. During her term, the former President Corazon Aquino cultivated the spirit of democracy and encouraged the formation of non-government organizations (NGOs) and civil societies. NGOs exist to fill the gap between government organizations and the local communities in the delivery of basic services and to develop processes to capacitate and empower the latter.

With the strong influence of its past colonizers, the Philippines is still characterized by a patriarchal system. The Spaniards conquered the Philippines with a sword in one hand and a cross in the other. The country's economy as well as its people's spirituality were controlled by the Spanish soldier-colonizers and Catholic missionaries who introduced their patriarchal civilization. The missionaries transplanted Roman Catholicism and its misogyny into native culture. Men begun to dominate civil society and the state more systematically, and men's dominance was endorsed by forces in the labor market which controlled women's lives.

As a reflection of patriarchal influence today, most NGOs are dominated and directed by males whose main interests are rehabilitation of the environment and development of farming and fishing technologies. They have little sensitivity to gender power disparities and the consequences of unequal power relations. Records show that in the Visayas Region, 67% of the NGOs are headed by males. This means that for every woman NGO head, there are two men. Barely 6% of them have initiatives that respond to gender and reproductive health issues.

Inspired by the belief that development does not only mean trees on the hillsides, hedgerows along farm contours, animals raised in pens and latrines in every home, but also the well-being of the women and men who plant the trees and raise the animals, participatory action research was done in some upland barangays of Cebu City by Mag-uugmad Foundation, Inc. Trained in gender sensitivity and oriented to reproductive health, local research teams devised their own research tools to generate information about gender, reproductive health, and the community. They generated data from an equal number of women and men respondents and later analyzed them.

Another group of women and men volunteers composed the community planning team. They utilized the research findings to make comprehensive village

development plans. The planners looked at the relation between the different community issues and problems, including women's situation in gender relations.

The comprehensive research undertaken in Barangay Lupa, an upland village in Cebu, shows that, in contrast with men, women spend much time working and have very limited time for rest and recreation. They do most of the housework and manage the animals. The research also shows that decision-making in the home is largely controlled by men. This, plus the burden of work, deprives women of participation in community activities, leadership positions and engagement in income-generating endeavors. Further, the research revealed that women suffer from different forms of violence (battery, rape, incest, emotional, psychological and economic abuse, neglect and abandonment) and a wide range of reproductive health problems such as difficult deliveries, absence of breastmilk, beri-beri, unsafe abortion, anemia and "bughat" (a very common health problem among women associated with childbirth which is unexplained by medical doctors).

The research proved to be an effective method to expose community issues, and the process became a venue for women and men to bring their issues and plans to the local government, to government agencies responsible for providing basic services, as well as to non-government organizations. But should these organizations respond to these problems? This is a dilemma faced by development agencies, particularly the NGOs. Is it a mission of the organization? Does its staff have the necessary knowledge, skills and attitude to respond to those problems? Does it have these resources to carry out the work?

The dilemma rests more heavily on the community development workers who are not in a strategic position to effect change in an organizational direction. Take, for examples our experience with the Philippine Partnership for the Development of Human Resources in Rural Areas (PhilDHRRA), a network of social development NGOs. The National Director is a woman while two of the three Regional Directors are men. Overall, the PhilDHRRA workforce is composed of 42 women and 38 men. But PhilDHRRA's structure is complex. Because of this, regional staff who take responsibility in integrating gender and reproductive health in the network and member-NGO programs need to go through the exhausting process of informing, influencing and convincing the people throughout the hierarchy about the problems. One has to first work with her/his Regional Director, who must make sure that the National Director is sold on the ideas. In turn, the National Board and the Regional Assembly must be made to understand the importance of responding to gender issues and reproductive health problems in order for the General Assembly to appreciate the need and decide favorably on the new endeavor. If one fails anywhere in the set-up, she/he fails the whole way

through.

Under these circumstances, how could the problems of gender and family violence, reproductive tract infections, bughat, rape and incest, sexual abuse of girls working as domestic help, trafficking in women and girls, unsafe abortion and early pregnancy, be responded to? If it is difficult to influence a network that has an almost balanced leadership of women and men, and that has a developed interest in gender and reproductive health, how much more difficulty would there be among passive, insensitive, male dominated organizations? In my ten years' experience influencing people and institutions to develop positive attitudes towards gender and reproductive health, I learned that the following changes have to be effected:

- 1) Formulating and enforcing institutional policies that set the direction towards responding to gender and reproductive health concerns;
- 2) creating more spaces for women in the social, economic and political arena, since women are in the best position to understand women's special needs, general circumstances and aspirations;
- 3) cultivating a positive attitude towards gender and reproductive health,
- 4) developing the capacity of the staff, and eventually the partner communities, in identifying, understanding and responding to problems resulting from gender power relations and reproductive health problems;
- 5) influencing donor organizations to provide financial and other forms of support to gender and reproductive health initiatives.



Financial Empowerment of Women to Seek Treatment for the Sick Child

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Acute respiratory infections or ARI, primarily pneumonia, is the major cause of under five childhood morbidity and mortality in developing countries. In the Philippines, 1500 children under five years old get sick with pneumonia every day; eight children die from the disease; only four are medically attended. In response to this silent emergency the World Health organization developed a standardized case management algorithm which should be used by peripheral health workers in the diagnosis and management of pneumonia based on simple, easily recognizable signs such as rapid breathing, chest indrawing, inability to drink and history of convulsions. Within standard case management of pneumonia, the mothers' responsibility is

primary. She must detect these critical signs of pneumonia and make the appropriate referral. This is imperative because a child with rapid breathing or pneumonia may die within 48 hours when not treated with antibiotics.

A large study was conducted in the island of Bohol, Philippines in order to, among other things, identify and examine factors which could facilitate or cause delays in mothers seeking appropriate health care for pneumonia episodes in children under five. Forty-seven mothers were extensively interviewed about their experience.

The data revealed that only 36% of the mothers sought immediate appropriate treatment when they perceived their children to have rapid breathing or chest indrawing. Two fifths resorted to home treatment - specifically the use of herbal concoctions and applications, while another group of mothers referred to folk healers for their children's treatment. There was a range of 1.5 to 6 days delay in bringing the sick child to the hospital (an average of 3.5 days).

In-depth interviews revealed that inadequate finances was the primary reason for delays in hospital referral. The reported monthly household incomes ranged from US\$ 31 to US\$ 385 with a median of 2400 pesos (US\$ 92), or 80 pesos (US \$ 3) a day for an average family of six. Mothers in the study reported that they spend more than half of the household's monthly earnings on food. Allocations for other basic and household necessities such as water, clothing, and housing is minimal; cash used for recreation and health is incidental and spending is opportunistic. All the women in the study claim that their intra-household resources were inadequate to meet their daily needs and the financial requirements of emergency situations. As treasurers of households, mothers were expected to make the money stretch to the next opportunity when the breadwinner could bring in cash--the next pay day, the next harvest or a good catch from the sea. None of the women in this report have savings in any form. As one mother stated, "How can I save something which I do not have? My husband may be able to catch fish tonight, but it may be just be enough for our consumption. We do not have money coming in, but we need rice and gasoline for the fishing boat everyday. If I am able to set aside some money today, I do not call it savings, because I will be using it tomorrow."

A second factor inhibiting health-seeking activity is household decision-making dynamics. Mothers reported that they cannot bring the child to the hospital even if they feel that they should. They stated that fathers have marked and significant roles in the decision to disburse household resources, particularly in such emergency cases as hospital confinement. A mother often has to wait for the father's opinion and decision because fathers need to determine how much cash can be borrowed or identify supplementary sources of

income. More importantly, only fathers can assess or credit their capacity to pay for the child's hospitalization.

So how did the women respond to the crisis situation? In all these cases, mothers were faced not only with the anxiety of saving their child's life, but also the dread of not having cash to buy medicines or other supplies needed at hospital. The majority of mothers had no money or had very little cash with them when they went to the hospital. All of the caretakers gathered whatever monies they had allotted for the day's needs: the women storekeepers scooped all of the day's earnings, a few mothers had to pass by the market to sell livestock before going to the hospital and four had to borrow money from their relatives before seeking hospital treatment.

Should women and mothers then be encouraged to take on economic activities to enhance their child care and health-related tasks? This is a difficult question to answer. In Philippine society, gender stereotypes dictate that men are the breadwinners and household heads. Women are identified with domestic activities and household maintenance. However, because of socialization into gender roles, women tend to undervalue or even discount their economic contributions to the household. It is not uncommon for women to allege that they are plain housewives, only to discover afterwards that they are food vendors, laundrywomen or women engaged in micro-enterprise. As mothers and grandmothers, women shoulder almost all the responsibilities for child care. The perception of the Filipino woman's domestic role is that of a solicitous mother, securing the interest of her children.

The economic development approach in empowering women places women's economic vulnerability at the center of her powerlessness and posits that economic empowerment will have positive impact on other aspects of women's existence. A woman is empowered, according to this approach, by strengthening her position as a worker and income earner by mobilizing, organizing or unionizing, and providing access to support services, such as credit organizations and child care services.

Though this approach undoubtedly improves women's economic position, it is not clear that this change necessarily empowers them in other dimensions of their lives. Where pressures for economic survival force women to take up employment, they face gender-based inequities in the labor market including lower wages, less regular employment, and higher rates of underemployment. Men workers earn almost twice as much as women; in the agriculture sector, women receive only a fifth of every peso earned by the men. More importantly, women have limited access to training and credit. In such situations like this, women's employment may do little to strengthen their

participation in decision making. Evidence shows that strengthening women's economic status does not always reduce their other burdens or eradicate other forms of oppression; in fact it often intensifies pressures. Since the woman is now earning, she is expected to contribute to household maintenance and child care expenses. Moreover, to ensure the smooth running of the household and adequate child care, working women need dependable support (often provided by other women such as the mother-in-law, other relatives or a domestic helper) which may not be available to everyone.

If indeed women should be economically empowered to have a more active voice in seeking health care for sick children, then strategies are needed that lead to increased autonomy and decision making power. Three crucial issues must be addressed in assessing the empowering potential of maternal employment or earning:

- 1) the conditions of work must include a satisfactory and healthy work environment, protection against unemployment in cases of pregnancy or marriage, and access to appropriate services such as child care;
- 2) women must not only have access to income, but control over it;
- 3) maternal earning will be more empowering to the extent that it provides women access to non-kin support, including women's groups, independent sources of information and contacts with outsiders.

As Bruce and Dwyer, *A Home Divided: Women and Income in the Third World*, Stanford University Press, 1988, have noted, "The invisible women of economic theorists become the all powerful mothers of the health and welfare advocates." And truly they should be.



Grassroots Knowledge as Wellspring of Feminist Theory Building

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The ascendancy of experts' leadership in feminist conceptual and theoretical explorations can easily make us forget the richness of grassroots women's wisdom about struggle and resiliency. While it is true that these women are often victims of cultures which moralize patriarchy and perpetuate gender discrimination, these cultures contain nuggets of ideas and insights which can provide building blocks toward a theory of women's emancipation and empowerment. The emerging perspectives and theories will then be grounded in

grassroots wisdom which can resonate for impoverished and illiterate women.

Elite intellectualism has originated principally in western, technologic cultures which were globalized during colonialism. This intellectualism follows a paradigm which stresses scientific approaches and methods. The western model of social science insisting on verifiable, measurable findings was universalized. This approach to truth requires practitioners trained in specific techniques. So trained experts emerged whose function it is to discover social truths and explain social phenomena. Later, many of these experts were hired by state agencies to provide expertise in designing and implementing projects to change the social landscape. The faith in experts to initiate and manage social change has another face too: belief in the ignorance and incompetence of grassroots communities to know and decide what is *good* for them. This is a foundation of the top-down approach to social development.

The emergence of the participatory approach to development, while an improvement on the top-down approach, does not turn the ladder upside down. It democratizes the arena by broadening the base of decision making to enable grassroots communities to participate in the decision making process, but it does not provide a paradigm for the empowerment of communities. Why should communities participate only when their own future is being charted? Worse, in many of these participatory projects, community participation is limited to the periphery of the projects (Castillo, 1983). I suggest that this is due to the persistence of the mental construct among development experts that the grassroots, though important for the success of a project, cannot be relied upon to think objectively because they are immersed in superstition and fatalism.

In fact, grassroots traditions were held up as enemies of progress and bulldozed. Many of these traditions were unsupportive of the capitalist market. Stuart Hall (1981, 228) observes that in order to create cultural support for the market economy, the cultural changes engineered from above were actually "euphemisms for the process by which some cultural forms and practices are driven out of the center of popular life, actively marginalized . . . so that something else can take their place."

While we must not romanticize grassroots cultures by imagining them to be pristine and perfect, we also must not perpetuate the delusion that they are full of superstition and inertia. While there are disempowering traditions, there are also empowering praxis.

Western knowledge is not the only knowledge although it is dominant in the world. Experts' science is not the only science although it defines for the rest of humanity what is scientific. There is a science of the folk which has been largely ignored.

We must not only recast our paradigm, but also change our mental constructs to recognize the need to

build on these cultures and histories in grassroots theory development. We need to build an appreciation of the sciences into the competencies of grassroots communities. According to Mohamed Seedat (1997; 8) communities have “organic structures and an intricately woven social fabric that contains the power to generate, uphold and enforce a specific vision of community order.” There are “enabling niches” in their cultures which help them to struggle and survive. This is what Bordieu calls “symbolic capital” with potential as weapon for women’s liberation. We can find these, for example, in their oral literature, their collective memories of struggle and resilience. I suggest that culture be viewed not as a way of life, but as a way of struggle among disempowered women.

The Ngano folktales of North Africa, for example, are stories of women’s lives told by women in a male-dominated society (Hoffman, 1997). These are women creating avenues and forms of expression, articulating their understanding of their oppression. Folktales are native forms, which can be seen as idioms of protest. They possess the *power* of bringing people together, replete with symbols and values which resonate with the women whenever they are told (Realubit, 1983). Aida Santos (1992) captures the significance of folk literature in women’s struggle: “In oral literature, we might find the missing history of women.”

The majority of women are poor; they live in impoverished, disempowered communities. The primary locus of struggle should be these women. Their everyday struggle has not captured the excitement of researchers, but here we can find some useful insights. We need to inquire into grassroots alternatives. Then, perhaps, we can develop insights which can inspire theories which are not alien and alienating to the women in poor communities.

If my suggestions are to be seriously considered, we need to reconsider our styles and methods of research and learning. Not only do we need to develop methods which will allow us to capture experiential data including lessons, cultural insights, and histories of these women, but also to evolve shared languages of communication and discourse. Evocative, dialogic, reflexive methods can be a start. There is *so* much that we can learn from liberating pedagogy (Freire, 1984), from women activists immersed with the grassroots, community workers, participatory researchers, and from the women in these communities themselves. They have a lot to teach those who are sincerely willing to learn.

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The Ethics of “HIV Clearance” for Returning Overseas Filipino Workers

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The exodus of overseas Filipino workers (OFWs) has continued to be a great factor in redeeming the country from economic bankruptcy both in terms of revenues and the impact of poverty on their respective families. Denial of travel documents and the opportunity to seek foreign employment, particularly in the Middle East Countries, is a big drawback when prospective OFWs are found positive for HIV infection. However, there is no provision for HIV clearance for overseas Filipino workers upon their return to the Philippines.

The Research Institute for Tropical Medicine, which is a National Reference Center for HIV/AIDS laboratory and management, documented eleven cases of returning OFWs infecting their wives with the human immunodeficiency virus (HIV). Of these, six men knew of their seropositive status long before they came home, but refrained from informing their wives. Four were surprised to find out the consequences of their colorful sexual history as they reapplied for job placement in countries where HIV testing is mandatory. Only one man hesitantly gave his wife some vague reasons why they could not have their sexual renewal on the night that he came home.

When disclosure of diagnosis became inevitable, all of the wives of these eleven men admitted that they could not have prevented the sexual transmission of the virus. To further probe this observation, a simulated dilemma situation was utilized in an AIDS Awareness

Campaign conducted in six municipalities in Metro Manila with a total of 64 Volunteer Barangay (community) Health Workers as target participants. The majority (88%) confirmed that they too would have readily acquired the infection as a "given" factor. Towards the end of these animated discussions, where HIV related socio-cultural issues were discussed, a member of the Speakers' Bureau for Persons Living with HIV/AIDS (PLWHAs) came forward to provide a human face to clarify myths and misconceptions that surfaced during the discussions. She introduced herself as the wife of an ex-OFW; her incentive in sharing the story of her life was for women to use their better judgement when confronted with a similar situation. Her emergence and testimony had a dramatic effect, for her identity was never suspected when participants aired their perceptions and prejudices against PLWHAs.

The issues raised required clarification of misconceptions that could not be readily corrected by an inexperienced or non-infected resource person. She responded candidly, saying that on the night her husband told her that they could no longer have their sexual relationship after his three years of absence, she felt lost and unwanted. She explained that more than anything else, the burning desire and yearning for his warmth and touch mattered most, and she could not hear any word of explanation that could cause any further delay. The matrimonial pledge states, "shall stick to one another for better or for worse 'till death do us part'"; she added; "second thoughts came in later when AIDS made us one." She further explained that the risk of STD or HIV was far from her mind as she did not know any better, or if she did, the pressure was insurmountable. She emphasized that women need to be empowered to negotiate with their husbands on matters that endanger reproductive health. However, both parties have to invest time in order to be sensitized to their values and be given an intervention that will clarify these values long before the moment of need strikes.

Some women in the study and the community concurred that circumstances can make it difficult to negotiate with their mates. The sleeping quarter for the family is usually limited, where a slight movement or sound of hesitation would awaken some sleeping souls. There is also the fear that denying their husbands sexual demands might drive them away to look for an alternative release of their energy and to re-channel their hard-earned money away from their wives. Finally, traditional submission of wives to their husbands' sexual demands is still very strong among Asian women. Barrier contraceptives are associated with illicit relations and prostitutes; they conflict with religious beliefs. These culturally sensitive issues are generally not discussed and are taboo even among adults or between married couples.

During the discussion some asked whether women are entitled to pursue justice through the courts like any

other victim of crime when infected husbands knowingly have unprotected sex with their wives, as six men in the study did. Their wives perceived this behavior as part of the macho culture and they thought it best to keep silent to maintain peace. They reasoned that men generally will not admit their crime. They considered the infection as one of the "fringe benefits" of being married to an OFW.

The need to address the issue of migrant workers in terms of HIV infection and transmission is a fast growing concern. Labor exporting and host countries have already initiated activities towards this end. Dr. Borromeo of the Philippines' National STD/AIDS Prevention and Control Program said that although HIV/AIDS prevention is included in the Pre-departure Orientation Seminar for OFWs, the seminar should also focus on the following: human sexuality, gender sensitivity, psychosocial needs, skills and options in sustaining safe behavior change, and the socio-economic impact of acquiring and sharing the HIV infection.

The study has shown that regulating the chain of infection among OFWs and their sexual partners depends on finding the key embedded in the sanctuary of one's value system. In other words, before we can even talk about empowering women to control their bodies, we should understand why infected wives and community representatives have opted to acquire the virus as a "special bonus." Hence we must broaden the range of concern beyond the technical aspects of HIV testing to rethink the meaning of informed consent and recognize the lethal consequences of uncontrolled passion.

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Sexuality and Reproductive Health in Developing Countries

Pilar Ramos-Jimenez

De La Salle University, Manila

Several ethical issues emerged when I conducted a multi-method social and clinical study on reproductive tract infections (RTIs) among married and unmarried Filipino urban poor women and men with a team of health and social scientists from 1995 to 1997. These ethical issues were most salient when we asked our respondents about sexuality, family planning, domestic violence, fetal wastage, and their experiences about RTIs. We were also faced with an ethical dilemma during the conduct of Pap smears and physical examinations of women volunteers because some of them asked our medical doctor to provide incorrect diagnoses or falsify health findings to protect them from domestic violence, especially from their spouses or partners. Some wanted the doctor to perform a Pap smear assuming erroneously that it could induce abortion from unwanted pregnancy. Confidentiality of information was another issue that confronted our team when women's groups that served as our conduit to the urban poor communities began to

divulge the outcomes of the clinical assessment without our research team's approval. We also learned about high-risk sexual behavior of some groups that we studied in the communities and we had a dilemma about keeping the information confidential to protect vulnerable groups (e.g. young boys as the favorite sector for sexual initiation by gay men).

The RTI community study made me and my project team realize that, in future similar researches, we need to have ethical guidelines that would serve as our framework in fieldwork. We also need to have an interdisciplinary ethics committee in our college that would review the research design and the ethical requirements of bio-social and cultural studies. For many years, we have been doing social science research, but the ethical issues raised by such research were not given much attention by the university. In the past seven years, we have been doing research on health and social science. We are aware of ethical principles that we should apply in conducting our work, but there are no efforts on the part of our institution to monitor our activities to comply with these principles. There is a need to be part of local and global bioethics networks such as FAB so that we are attuned to various bioethical issues facing researchers and health activists from developed and developing countries.

Should We Keep You on Our Mailing List?

In our last issue (vol. 6 no. 2 - October 1998) we enclosed a renewal card so that readers could indicate whether they are still interested in FAB membership and in receiving the Newsletter. And we wished to put up-to-date information into our new database so that this "Network" could begin to network.

We guess that most of you failed to see this card because only 25% of our long-time members (who joined before 1998) returned them—and from outside the U.S., a much smaller percent.

Because of this poor response, for this present mailing we dropped only those people who requested it or whose country representative recommended that they be removed.

Please look at your mailing label. If you see 'OK' after your name, that means we know you are really interested in FAB because you joined in 98 or 99, or because you did indeed return that renewal card.

If there's no 'OK' then please take the card from your last issue and send it right away - to the Membership Secretary, address on p. 23. If you can't find that card, then you may print out a renewal form from Becky Holmes's web site at: www-unix.oit.umass.edu/~fholmes/renew.html. Or you may ask Becky to mail or fax a form to you.

Our Newsletter costs a bit to produce and mail, so we want to be certain that those who receive this free publication really do want it. That's why renewal forms should be sent by post with a signature on them.

There's been turnover at the Kennedy Institute address, so we know that some cards have been lost. If this might have happened to you, please give Becky an explanation via e-mail or fax.

To request Newsletter renewal forms, reaffirm your interest, or send us address, phone, or e-mail changes, contact FAB Membership Secretary at: joinfab@fnr.umass.edu
24 Berkshire Terrace, Amherst, MA 01002.

Eubios Ethics Institute invites you to Bioethics in and from Asia: The Fifth International Tsukuba Bioethics Roundtable, and Intensive Cross-Cultural Bioethics Course, **November 20-23, 1999**

The intended total size is 60 persons in roundtable, workshop style. The style will focus on extensive discussion with precirculated papers placed on the Internet prior to the meeting. The days planned so far will be on: Methodology in Cross-Cultural Global Bioethics; Bioethics Education; Clinical Dilemmas across Cultures;

A Healthy Global Environment; Ethical Dilemmas of Biotechnology and Genetics. There may be chances for associated sight-seeing at Nikko, and sites in Ibaraki and a fieldtrip to Mt. Tsukuba Shrine.

Updated details on-line <http://www.biol.tsukuba.ac.jp/~macer/TRT5.html>

Reflections on FAB 2

Nicola Biller, *School of Medicine*
University of Göttingen, Germany

Thinking back to Tsukuba and Tokyo, where the FAB and IAB meetings took place last November, what thoughts and pictures come to mind? Once the sunrises over rice paddies, the shrines, and the buzzing Tokyo streets have passed my inner eye, I see those people who made a difference to my idea of the world and what matters in it. They did not seem to be in the field for promotion or tenure, for well-paid jobs and first-class flights. What I remember is the particular concern in their eyes, the urgency in their voice and the commitment in their gestures.

These people told about abortions on the street, organ traffic, and ambulances that would drive away when the patient's skin had the "wrong" colour. Talking with them, I could feel the echo of their sadness, rage, hope, and the will to speak out and be heard. Those were the instances when I was allowed to glimpse some of their worlds - worlds, which are only some hours' flight away from my country and are yet utterly unknown to me. Moments of

excitement, mutual exploration, and empathy, which I will treasure a long time.

Global bioethics? Through universal love, "aggressive talks," principles, virtues? I'm no more certain than before the conference if there can be one fit-for-all bioethics and what it would look like. Certainly, there are minimal standards we can probably all settle on, at least in theory. But are we ready to set up an agenda, on the substantial, methodological, or institutional level, to address the critical issues beyond this minimal consensus?

We probably cannot afford to wait for universal love as a panacea for our struggles, and an aggressive communicative style usually reveals nothing but uncertainty or recklessness. Maybe in our quest for global bioethics we should go along with the philosopher Habermas and focus on the preconditions for a genuine discourse, which ideally includes all voices and arguments without any form of repression. I think this conference has helped us to hear many more voices than we usually do. And I am very keen to continue hearing them, through journals, e-mail, phone, and eventually at our next meeting in London in the year 2000.

Noako T. Miyaji, *School of Medicine*
Kinki University, Japan

I would like to express my gratitude to the participants of FAB2 last November for coming all the way to Japan. I was not directly involved in the organization of the conference. As a country representative, I was sorry for the inconveniences at Tsukuba. However, now we have a shared identity as "survivors of Tsukuba" with a vivid memory of our mutual support.

The content of the FAB conference was incredibly rich. The participants were very diverse, with men and women, from east and west, south and north. Despite the differences in their interests, concerns, and the burning issues in their home countries,

participants were deeply engaged in the topics presented. Discussion was always heated in a constructive way. We learned a lot about diverse situations and diverse problems. For myself, the NGO work of Filipino women and South African human rights activities in medical fields were especially intriguing. I also found that at the following IAB4 conference, many interesting papers were by FAB members. I hope you enjoyed our panel, which introduced ideas in feminism and men's studies on reproductive issues in Japan.

This conference was really a good opportunity for feminists to widen their scope both in practice and in the development of theory for the future. Let's keep the warm atmosphere in the heart of each of us, nurture it, exchange it and bring it to FAB3.

Pilar Ramos-Jimenez
De La Salle University, Manila, Philippines

Participating in the Second FAB conference in Tsukuba, Japan last November was a lovely experience because it exposed me to other female and male researchers and health activists who faced similar ethical issues and dilemmas in their respective social settings. It was also heartening to learn that there is a support group of women and men from the North and South who are concerned with bioethics and the different issues emanating from various efforts in the area of sexuality and reproductive health. I noted from that meeting that the principlist's perspectives on ethics are useful but there is still a need to review these carefully in various contexts with the lenses of gender, power, ethnicity and class.

The Second FAB conference was well organized but more time should have been provided for the participants to discuss their

concerns and enable us to draw out commonalities from our experiences. Research and advocacy in sexuality and reproductive health are fairly recent and we need to learn how other groups and individuals are applying ethical principles effectively in their social contexts.

The Bioethics roundtable discussion, unfortunately, afforded little opportunity for dialogue and synthesis of the numerous papers that were presented. The people who attended came from various disciplines and this would be a good opportunity to bring them together. There is also a need to bring in gender perspectives in such a gathering. I hope that the FAB can influence the Bioethics Association in coming up with a more organized, gender-sensitive format in the future because of the potential force that it could bring to perspectives from the North and South regarding the numerous ethical issues confronting the world today and into the next century.

Book Review Section

A review of **Feminism and Science**, edited by Evelyn Fox Keller and Helen E. Longino. New York: Oxford University Press, 1996. 289 pages, \$18.95, paper.

Feminism and Science is a collection of essays from some of the most prominent and provocative contributors to scholarship in the field. The readings here, by authors grounded in such disciplines as philosophy, history, anthropology, sociology, biology, and women's studies, all advance thinking on the ways in which the social context of scientific research can profoundly affect its course. In particular, the readings examine how modern science has evolved out of a specific conceptual structuring of mind and nature, an ordering that has incorporated particular ideologies of gender. Moreover, they propose strategies for reforming scientific endeavors so they are less likely to perpetuate the subordination of women and other social groups, or to harm the environment.

In Part I, Early Statements, classic essays by Dorothy Smith, Evelyn Fox Keller, and Genevieve Lloyd are reprinted. Smith considers how sociology might look if it started with the historically silent standpoints of women, offering an analysis of the role that subject position plays in the development of knowledge. Keller, similarly, critiques certain patriarchal biases that have undermined women's participation in the biological and social sciences, and that ultimately constrain scientific potential. Lloyd offers a philosophical account of the way that "reason" has been interpreted, namely by discounting the capacities and experiences of women.

Part II, Representations of Sex and Gender, includes papers that explore the effects of gender bias in the structure of inquiries on sex differences. Here, Donna Haraway situates primate research in its social and political context and considers the gendered subtext of accounts of evolution. Helen Longino and Ruth Doell, looking at behavioral neuroendocrinological research, examine the ways in which culturally based background assumptions and the organization and interpretation of data support the expression of gender ideology in research. Elisabeth Lloyd and Emily Martin take up the influence of gender ideology on representations of sexuality and reproduction.

Language, Gender, and Science, part III of the anthology, focuses on the role of images, metaphors, and analogies of gender in shaping research agendas and scientific representations. Nancy Stepan casts light on the ways that metaphors guide categories of analysis, while Linda Schiebinger considers gender politics in the development of animal taxonomies. In the remaining two essays of the section, Keller, aiming at evolutionary biology, and Carol Cohn, at defense policy, concentrate on the costs of gendered metaphors to scientists and society, including the constraints they place on our ideas of what is possible.

Finally, Part IV, Gender and Knowledge, takes up the themes laid down in Part I, yet reaches beyond the aims of early critiques in aspiring to articulate liberating alternatives to conceptions of subjectivity and objectivity which privilege the "view from nowhere"—the epistemic ideal of knowers and knowledge as disembodied and detached from social, historical, and cultural context. Keller and Christine Grontkowski draw our attention to the history and implications of using vision as a metaphor for knowledge, while Naomi Scheman critiques Descartes's rejection of the body for knowledge-seeking projects and discusses its consequences for those who are associated with it, namely women, cultural minorities, and the poor. Scheman contends that reintegrating mind and body calls for new conceptions of subjectivity and suggests new epistemological values and relationships. Mary Tiles considers the "logic of domination," or the interest in prediction and control that has characterized science, and invites us to imagine how other values might shape scientific projects. Sandra Harding and Donna Haraway focus on reformulating conceptions of objectivity. Finally, also reconceptualizing objectivity, Longino contends that rather than consisting in an interaction between an individual and objects, knowledge-seeking is a fundamentally social endeavor best understood as the fruit of engagements among members of a community and between them and the so-called objects of knowledge. Such a reconceptualization, she argues, calls for a change in our views of the relationship between knowers and the world, and in the structures in which knowledge is sought and generated.

Feminism and Science has a number of virtues to recommend it. To begin, it demonstrates the contributions that diverse disciplines can make to inquiries concerning how science reflects social values. Philosophers, historians, anthropologists, sociologists, biologists, and scholars in women's studies should all welcome it as a valuable addition to their collections. While those who follow the literature in feminism and science closely will have already come across some of the essays before, the contributions are diverse enough that most will find something new and provocative here among the classics. For newcomers, this anthology is a must, for it offers samples of the work feminists have been engaged in for the past twenty-five years, spanning from critiques to constructive strategies for reform. Moreover, the volume contains a useful bibliography of feminist critiques of the sciences. It could be incorporated into graduate courses; some of the essays might even be used for advanced undergraduates.

Having said all this, it warrants mention that the book will most likely not be well received by popular audiences. Some will not consider this troubling, yet I believe that more collections on these topics that can

reach a wide readership are needed. Troubling too is the fact that all of the authors here are “white and Western.” The editors themselves observe this and call for contributions on the relationship between “race,” gender, and colonialism as it emerges in the sciences.

Despite these flaws, *Feminism and Science* is an essential addition to the collection of anyone interested in challenges to the received view of the sciences, namely, that their cognitive authority rests on value-neutral and context-independent knowers and methods of inquiry, and that science can offer us a single, unified, and liberating account of the world for all its inhabitants.

Lisa Eckenwiler, *Old Dominion University*



A review of **The Mother of All Myths: How Society Moulds and Constrains Mothers**, by Aminatta Forna. London: HarperCollins, 1998. 288 pages, £16.99 cloth; £9.99 paper.

Thorough research, activism, and conscience should inform feminist work, and so they do in this perceptive analysis of the development and maintenance of society’s prescription for the perfect mother. FAB member Aminatta Forna views such a mother as “devoted not just to her children, but to her role. . . . She must be capable of enormous sacrifice. She must be fertile. . . . She alone is the best caretaker for her children and they require her continual and exclusive presence.”

Although Forna comments on motherhood practices in non-Western societies and continental Europe, her main focus is on Britain and the United States. She includes concise descriptions, with citations, of legal cases against mothers. As a journalist, Forna is a strong critic of the media for alarmist headlines and guilt-inducing first lines in what she claims is a fixation on maternal behavior.

In a chapter on history, Forna traces modern Western attitudes toward motherhood to the influence of Rousseau. Until publication of his *Emile*, European mothers were unsentimental about their children and casual about who cared for them. After that came the Victorian era of romanticized motherhood; still later feminists obtained the vote and a sense of liberation. But Forna warns that this freedom is now illusory, due to “the massive revitalization of the motherhood myth.”

In many places the book exposes paradoxes of motherhood: it is “revered and reviled, natural yet policed.” Poor mothers must work; middle-class

mothers must abandon work to stay at home. Mothers must breast-feed their children but can be arrested for doing so in public. Advice books on pregnancy and child-rearing in the nineteenth and twentieth centuries reflect the changes in how-to-do-it fads throughout this period. Furthermore, modern advice books, web pages, and women’s magazines may offer conflicting advice within a single source. For example, historical and modern inconsistencies include whether to encourage or discourage weight gain in pregnancy and what method of delivery is best. For other perceptive and fascinating analyses of the content of pregnancy advice books, I also recommend another recent book: *Confinements: Fertility and Infertility in Contemporary Culture*, by Helene Michie and Naomi R. Cahn (Rutgers Univ. Press, 1997).

Interwoven with these paradoxes are recurring, somewhat redundant, themes of guilt and blame. Society simultaneously glorifies motherhood and lays a guilt trip on mothers. We punish deviant mothers; we vilify single mothers; we try to protect the unborn child from its own mother; we blame mothers for social problems and disintegration of society. For example, while a playground may be built next to a toxic waste dump, anyone feels free to chastise a pregnant woman who smokes or drinks in public.

Forna has an excellent chapter with few technical errors on my specialty, reproductive technology. Although these technologies seem new and radical, they bolster contemporary cultural assumptions about parenthood. One paradox here is the definition of “mother”: surrogacy brokers insist that the “real” mother has the genetic link; centers soliciting egg donors claim that the mother is the one who carries the baby. “Motherhood is being redefined by the . . . sales pitch.”

According to Forna, feminists have failed to “tackle motherhood.” Her main concern seems to be “exclusive” motherhood. She urges us to replace “having it all” (the need to fulfill desires) with “sharing it all” (collective responsibility for children). However, the reader is left with no clear prescription for action.

An excellent supplemental reading for undergraduates, this book is lucid and accessible. Unlike edited collections, the single voice gives coherence to the arguments developed as the chapters progress. FAB members will also find it useful for sources and to liven up our lectures.

Helen Bequaert (Becky) Holmes, *Amherst, MA*



A review of **Killing the Black Body: Race, Reproduction, and the Meaning of Liberty**, by Dorothy Roberts. New York: Pantheon Books, 1997. 384 pages, \$26.00 cloth; \$14.00 paper.

Roberts successfully shows the striking intersection of racism, politics, and reproductive rights in *Killing the Black Body*. She chronicles the lives of African American women from the time of slavery, when they were tortured through sexual terrorism that upheld the breeding and selling of their children, through the 1970s, when the government supported sterilizing great numbers of Black women on welfare without their knowledge. In fact, the strength of the book is that it provides a cultural backdrop to the bioethical issue of reproductive freedom. It is my impression throughout the book that Roberts is telling us that feminism (and hence feminist bioethics) is still failing Black women.

While infertile white couples (who can afford it) turn to in-vitro fertilization to have children, many Black women's reproductive lives are still a subject of public debate, especially in regard to their "right" to have children if they are receiving welfare benefits. Roberts does a good job of exposing the conscious decision of certain policymakers to use the Norplant contraceptive as a tool to control the reproductive behavior of poor Black women. She discusses the role of Margaret Sanger and the eugenics movement of the 1920s, which aimed primarily to reduce the numbers of Blacks (because they were deemed biologically inferior) and to move toward the "betterment" of the human race.

One of Roberts's main points is that conservative politicians continue to try to solve social problems through control and racism rather than through seeking reforms of social justice. As feminist bioethicists, we must be concerned about what Roberts tells us. We are, in great numbers, white, middle-class academics. We are reminded in this book that policy in bioethics has largely been directed at issues concerning the mainstream, heterosexual, white population. She gives us clear examples of policies that assume that questionable ends are desirable, and that unethical means may be used to achieve them.

One chapter discusses in detail how needing to accept welfare has turned into a complete surrendering of one's privacy rights, including the most private decisions about reproduction. From there she leads us to a disconcerting discussion of the growing climate of criminally punitive hostility toward pregnant, drug-addicted women. She sets this against a backdrop of the politics of race, not just fetal rights, and provides persuasive arguments regarding the state's ever-growing control over women's bodies in general and Black women's bodies in particular.

Another theme that Roberts weaves into her book is the responsibility of the media in perpetuating the image

of the Black, crack-addicted, pregnant woman on welfare. With this picture, the media created a politician's dream and incited a public frenzy of indignation for "those babies." Roberts explains that the media seldom ask how many women have sought treatment for their addiction and were turned away because very few (in some states, none) drug treatment centers will accept pregnant women. She considers such centers criminally responsible, especially in the light of research indicating that if women are treated early enough in their pregnancy, "the harmful effects of prenatal crack exposure may be temporary and treatable" (p. 158). As a political issue then, we have one more example of women being blamed, as opposed to a solution being sought for pregnant women who are drug-addicted.

In short, Roberts's book produces compelling and chilling arguments about the racism and sexism rampant in our reproductive policies and laws. One should not read this book to "feel good" about "our progress." It functions, rather, as a wake-up call, challenging the morality behind the policy.

Kathleen S. Kurtz, Syracuse University



My name is Linda Hopkins. My company, Intelliware International, is developing a conference under the direction of the National Institutes of Health (Institute of Human Genome Research) on Genetics, Law, and Society to be held October 1999 in Minnesota. I would appreciate any information on experts on the topic of Women and Genetics (genetic research, artificial reproduction, discrimination based on genetic issues, etc.). The conference participants are from a variety of disciplines. We hope to include proponents of genetic research, cloning, as well as legal scholars, federal judges, and federal and state government officials. Please contact me at lkhopkins+AEA-intelliwareint.com.

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Argentina
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susana@clacso.edu.ar

FAB COUNTRY REPRESENTATIVES

Contact these memers who have volunteered to be country representatives if you want to initiate a group project, receive back copies or membership application forms, etc. If your country is not included and you would like to volunteer, send us your names.

Argentina
Maria Victoria Costa
vcosta@huma.fahce.unlp.edu.ar

Florencia Luna
florluna@pccp.com.ar

Australia
Susan Dodds
susan_dodds@uow.edu.au

Austria
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Studer@univie.ac.at

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United Kingdom
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United States
Hilde Nelson
hlnelson@utk.edu

**Coordinator of country
representatives**
Wendy Rogers
wendy.rogers@flinders.edu.au

News From the FAB Organization

FAB in Cyberspace

FAB's WEB PAGE

FAB's web page has moved to Rosie Tong's home institution, UNC at Charlotte. You can access it at www.uncc.edu/fab. Over the summer Rosie and her talented assistant (and son!), Paul Tong, will be working to improve the site; ideas for improvement are welcome and can be sent to Rosie at her email address: rotong@email.uncc.edu.

Also of interest are the following Web Sites:

www2.umdj.edu/ethicweb/bioethic.htm

Contains hyperlink to list of international bioethics conferences and events. Compiled by Robert Wood Johnson School of Medicine, New Jersey.

www.utc.edu/~kswitala/Feminism/Ethic.html

The Feminist Theory Website provides research materials and information for students, activists, and scholars interested in women's conditions and struggles around the world.

www-unix.oit.umass.edu/~fholmes

Women and Genetics in Contemporary Society. Contact information for some 60 women knowledgeable about the social and ethical impact of genetics on women; bibliography; conference report; cartoons.

www.4woman.gov

The National Women's Health Information Center. Sponsored by U.S. Public Health Service's Office on Women's Health.

FAB's LISTSERV

The FAB listserv, which was started by Corinne Bekker at Utrecht University in 1995 and has been maintained by her ever since, has now moved to the University of Tennessee, where Hilde Nelson will be its moderator. Corinne's four-year stint required much energy, time, and patience, and all FAB members owe her a strong vote of thanks for her important contribution to our welfare.

If you haven't yet subscribed to the list but would like to do so, send a message to:
listserv@listserv.utk.edu

In the body of the message, write: subscribe 1FAB Your Name. To unsubscribe, send the message: unsubscribe 1FAB Your Name

To post a message to the list, send your text to the FAB list. The new address is 1fab@listserv.utk.edu. Calls for papers, discussions of FAB-related issues, and announcements of conferences, job opportunities, and courses are most welcome!

You might also want to check out the FAB listserv's archives, at: <http://listserv.utk.edu/archives/fab.html>.

FAB 1998 Election

The results of our FAB election in September and October 1998 were first announced in Japan at the international FAB2 conference on November 2, then on the FAB listserv on December 2, and subsequently posted on the web site www.uncc.edu/fab.

The Nominating Committee was appointed by Anne Donchin and consisted of Becky Holmes (chair), Laura Purdy, and Susan Sherwin. Active FAB members who are interested in serving on the Nominating Committee for the next (2000) election are urged to contact one of the Coordinators.

In total, 64 ballots or e-mail responses were returned from 270 ballots sent, a 24% response. Officers elected by this ballot:

Coordinator team:

Rosie Tong (USA) Laura Shanner (Canada)

Treasurer and assistant:

Anne Donchin (USA) Becky Holmes (USA)

Board members:

Gwen Anderson (USA)

Susan Dodds (Australia)

Anne Donchin (USA)

Maggie Little (USA)

Laura Purdy (Canada/USA)

Wendy Rogers (Australia)

Mary Rorty (USA)

Viola Schubert-Lehnhardt (Germany)

Susan Sherwin (Canada)

In Japan the Nominating Committee appointed the following three other members to the Board, taking into account suggestions written onto ballots:

Jeanelle de Gruchy (South Africa)

Aida Santos (Philippines)

Susana Sommer (Argentina)

After the election, the Board and the new Coordinators decided that it was necessary to have a Membership Secretary to oversee the directory of members, and they appointed Becky Holmes to this position.



The People Behind The Scenes

The best way for a Network to function is for many individuals to shoulder specific tasks and share the load. We are delighted to report that, in recent months, FAB has shuffled a few duties to share the burdens more efficiently. In a spirit of feminist cooperation and mutual support, here are the volunteers who make the network tick:

Maggie Little remains Editor of the Newsletter, with support from the Kennedy Institute of Ethics at Georgetown University. Elysa Darling, who helped with the past two newsletters, has left the KI to pursue other opportunities. The new assistant editor is **Moheba Hanif**, who has been with the KIE over ten years. Welcome aboard, Moheba! **Hilde Lindeman Nelson** remains the Editor for Book Reviews in the Newsletter.

The Listserv, which has been maintained by **Corinne Bekker** with support from **Karst Koymans**, has been moved to **Hilde Nelson's** locale. (Congratulations and best wishes to Corrine, who is expecting a baby this spring!)

Becky Holmes has become Membership Secretary,

generously shouldering some of the burden formerly borne by Maggie and her staff at Georgetown. Becky, along with her assistant **Cathie Fiorilla**, will be updating the membership list and making it easier for members to access FAB. Other new developments are afoot in the Membership arena, which Becky describes elsewhere in this newsletter. **Wendy Rogers** keeps the list of Country Representatives up-to-date amid frequent (wonderful!) additions.

Finally, FAB country representatives (see Contacts page) work hard to keep us all connected. The role of a FAB country representative is to promote feminist bioethics in your region of the world. This includes acting as a contact person for FAB members, and at times recruiting new members. FAB reps have an important role in informing us all of relevant bioethics activities in your country. This can easily be achieved through submissions to the newsletter in the form of calendar items, advising of forthcoming conferences or meetings, or short articles about current events. Finally, we encourage reps to organize meetings, discussions or sessions at local conferences, if this is possible. Please let us know if you are successful in this area.

Financial Support of FAB

FAB's work is supported by voluntary contributions to our Audre Lorde Memorial Fund for Bioethics Research; this arrangement frees us to devote our efforts to advancing FAB's work without being hampered by the cumbersome dues collection process that bogs down so many other nonprofit groups. Instead we suggest that every two years members contribute a minimum of \$10 and, where personal means permit, up to \$100 or more.

Presently we are in a reasonably secure financial position because the Kennedy Institute is subsidizing the printing and mailing of our Newsletter, and the Ford Foundation contributed toward the publication of this larger issue. We currently use our funds for stipends to the students who maintain our web site and database, for out-of-pocket expenses of officers with no institutional support, and especially for travel subsidies to FAB members who would not otherwise be able to participate in our international conferences.

Yet—YOU OUR MEMBERS really keep us afloat, and we are grateful for and dependent on your many small and several generous contributions. FAB officers

give their time unselfishly without recompense. In the first four years most of our budget went to the Newsletter; this may be necessary again when the Kennedy Institute no longer covers it.

So, if you haven't contributed recently, please write a check to the Audre Lorde Memorial Fund and mail it to Treasurer Anne Donchin or to Membership Secretary Becky Holmes.

Canadian dollar checks can be handled by our bank, but overseas members cannot always get US\$ checks easily. In some instances our country representatives can arrange to pool contributions and send them collectively, or participants in one of our conferences can contribute in local currency there. We want to assure members in countries where such arrangements are not feasible that we will not drop anyone who is unable to contribute financially. Our members across the globe bring new and valuable perspectives to us and are fundamental to FAB's mission.

If you sent a check that has never been cashed, it may have been lost in the reorganizational upheaval between October and March. Would you let us know if we have not cashed your recent check?

Calendar of Events

Call for Papers

The 1999 Canadian Bioethics Society, Edmonton, Alberta, Oct. 28-31. The conference theme is "Expanding the Boundaries of Ethics." It is hoped that feminist insights will be well represented in the conference. FAB member Vangie Bergum is coordinator for the Conference. Contact Vangie or Laura Shanner. Both of them can be reached by phone at (1) (780) 492-6676; fax at (1) (780) 492-0673; and mail: John Dossetor Health Ethics Centre, 8220 114th St., Room 222, Edmonton AB T6G 2J3 Canada. www.ualberta.ca/~cbs1999

Deadline for abstracts, June 15.

FEMSPEC, an interdisciplinary feminist journal. If you are interested in speculating, theorizing, creating and questioning gender across the boundaries of what is real and what is not real, consider submitting your work to FEMSPEC. **Deadline: September 20, 1999** for the next issue. Contact: Department of English Cleveland State University, Cleveland, OH 44115. Tel: 216-687-6870. Fax: 216-687-6943.

3rd International Conference of the Feminist Approaches to Bioethics Network, "Feminist Bioethics at the Turn of the Century," London, Sept. 19-20, 2000, solicits papers on any topic in feminist bioethics, but those that have a What Next? quality are particularly welcome. **Deadline for submission Nov. 30, 1999.** Contact: Rosemarie Tong, Center for Professional and Applied Ethics, University of North Carolina at Charlotte, Charlotte, NC 28223-0001. Tel: 704-547-2850. E-mail: rotong@email.uncc.edu

19th-Century Feminism, to be published twice yearly, beginning in the Fall of 1999. This journal will be devoted to issues of gender, culture, and writing by and about women from anywhere in the Empire, Britain, Canada, and the United States in the long 19th century (1785-1918). Please submit paper to Joanna Devereau and Lorraine Dicicco, Editors, Nineteenth-Century Feminism, Dept. of Modern Language, King's College, University of Western Ontario, 266 Epworth Ave., London, Ontario, Canada N6A 2M3. E-mail: jdeverau@julian.uwo.ca or visit their website: www.odyssey.on.ca/~ncf

Courses, Seminars, and Conferences

June

Comparative Health Policy and Law, June 2-25. A 6-credit traveling course studying issues in health policy and law in London, Amsterdam, and Geneva. Sponsored by Syracuse University. Contact: Karen M. Horn or Diane O. Leneker, Syracuse University, 315-443-9420.

The Seventh Annual Congress on Women's Health, Hilton Head, SC. June 12-15. New Diagnostics and Therapeutics. Details from: BioConferences International Inc. Tel: 800-5-BIOCON

Contemporary Challenges in Health Care Ethics, Washington, DC, June 12-17. Intensive Bioethics Course offered by the Kennedy Institute of Ethics,

Georgetown University. Details from: Course Coordinator. Tel: 202-687-5477. Fax: 202-687-8089. E-mail: kicourse@gunet.georgetown.edu or visit the website: www.guweb.georgetown.edu/kennedy.

Colonialism and Public Health in the Tropics, York University, North York, Ontario, June 18-19. This conference is an opportunity to discuss the role of colonised populations in constructing health care systems that reflected their own world views. Details from: E-mail: stilwell-stilwell@yorku.ca www.h-net.msu.edu/events/showevent.cgi?path=32682907708692

Global Health, Poverty & Development, Arlington, VA, June 20-23, Details from: Global Health Council/NCIH, 1701 K St., NW #600, Washington, DC 20006-1503. Tel: 202-833-5900. E-mail: conference@globalhealthcouncil.org

Talking Ourselves to Death: Narratives and Caregiving at the End of Life: The 7th Annual Summer Seminar at Hiram College, Hiram, OH, June 22-27. A collaborative project of Hiram College and Northeastern Ohio Universities College of Medicine. The seminar seeks to collaboratively convert theory, text, story and experience into teaching materials for use in the classroom and clinical setting. Details from: The Center for Literature, Medicine and the

Health Care Professions, Hiram College, Hiram, OH. Tel: 330-569-5380. Fax: 330-569-5449. E-mail: donleycc@hiram.edu

Medical Ethics for the 21st Century: An Intensive Skill-Building Workshop, Michigan State University, East Lansing, MI, June 24-26. Sponsored by the Center for Ethics and Humanities in the Life Sciences. Contact: Office of Continuing Medical Education, College of Human Medicine, A117 East Fee Hall, Michigan State University, East Lansing, MI 48824-1316. Tel: 517-353-4876. Fax: 517-432-0148.

Courses, Seminars, and Conferences

July

The National Organization for Women Annual Conference, Los Angeles, CA, July 2-4. Advance Registration Deadline: June 1, 1999. After June 1st, participants will be required to register at the conference. Details from: www.now.org/organiza/conferen/1999/index.html

Conflict and Community: Culture and Ethical Decision Making in Health Care. A Basic Course in Bioethics, Northwestern University Medical School, Chicago, IL, July 15-17. Sponsored by the Center for the Study of Bioethics, Medical College of Wisconsin. Contact: Kristen Tym. Tel: 414-456-4299. Fax: 414-456-6511. E-mail: ktym@mcw.edu

Genetics and Ethics in the 21st Century: The Ethical and Political Challenges of Behavioral Genetics, The Given Institute of the University of Colorado, Aspen, CO. July 23-25. Sponsored by Program in Health Care Ethics, Humanities and Law at the University of Colorado Health Sciences Center. Details from: Jackie Brinkman. Tel: 800-882-9153. Fax: 303-372-9065. E-mail: jackie.Brinkman@uchsc.edu

Women and Technology: Historical, Societal and Professional Perspectives, International Symposium on Technology and Society (ISTAS '99), New Brunswick, NJ, July 29-31. Details from: David Morton, IEEE History Center, Rutgers University, 39 Union St., New Brunswick, NJ 08901-8538. Also, contact: Juanita De Barros, at:

jdbarros@yorku.ca; Sean Stilwell, at: stilwell@yorku.ca; or Dawn Harris at: dharris@yorku.ca. Website: <http://www4.ncsu.edu/unity/users/j/jhkerkert/ist99cfp.html>.

August

Healthcare Issues in Pluralistic Societies, Nijmegen, Netherlands, Aug. 2-6, 1999. Sponsored by International Programme in Bioethics Education and Research. Details from: Bert Gordinjin. Tel: 31-24-361-53-20. Fax: 31-24-34-02-54. E-Mail: b.gordijn@efg.kun.nl

Summer Seminar in Healthcare Ethics, University of Washington, Seattle, WA, Aug. 2-6. Sponsored by Dept. of Medical History & Ethics, Univ. of Washington. Details from: Marilyn J. Barnard at: 206-616-1864, fax: 206-685-7515, e-mail: mbarnard@u.washington.edu.

Quotidian Ethics: Moral Deliberations about Everyday Life, Cape Town, South Africa, Aug. 11-12. FAB member Maggie Little will be presenting. Website: www.ethics.acusd.edu/pubs/ConferenceList.asp.

13th Annual Conference of the European Society for Philosophy of Medicine and Health Care: Epistemology and Medicine, Linköping, Sweden, Aug. 18-21. Sponsored by European Society for Philosophy of Medicine and Health Care. Details from: Professor Dr. Henk ten Have, secretariat ESPMH, Catholic University of Nijmegen, Dept. of Ethics, Philosophy and the

History of Medicine, Faculty of Medical Sciences, PO Box 9101, 6500 HB Nijmegen, The Netherlands. Fax: 31-24-354-02-54.

Celebrating Women Retreat, Ubud, Bali Indonesia, August 28-Sept. 4. A nurturing, nourishing and healing week of exploration into the female Spirit with Robbi Zeck, ND. Details from: Aroma Tours. Tel: +61-3-9481-1933.

September

Quandaries in Health Care: Illness and Culture in the Postmodern Age, The Given Institute of the University of Colorado, Aspen, CO, Sept. 16-18. Details from: Jackie Brinkman. Tel: 800-882-9153. Fax: 303-372-9065. E-mail: jackie.Brinkman@uchsc.edu

International Conference on Applied Ethics, Chinese University of Hong Kong, Dec. 28-30. Details from: Hon-Lam Li honlamli@cuhk.edu.hk or Kai-Kee Wong wongg31k@cuhk.edu.hk. Tel: 852-2609-7144; 852-2609-7145. Fax: 852-2603-5323. Website: <http://www.arts.cuhk.edu.hk/~phidept/>

October

Feminist Ethics Revisited, Clearwater Beach, Florida, Oct. 1-3. Details from: Peggy DesAutels, The Ethics Center., Univ. of S. Florida, St. Petersburg, FL 33701.

Second Annual Meeting of the American Society for Bioethics and Humanities, Philadelphia, PA, Oct. 28-31. Many FAB members will be presenting. Look especially for the Invited Speakers Panel on New Feminist Angles on Abortion. Details from: Jennifer Reinard, ASBH Second Annual Meeting, 4700 W. Lake Ave., Glenview, IL 60025-1485. Website: www.asbh.org

Canadian Bioethics Society conference, Edmonton, Alberta, October 28-31. The conference theme is "Expanding the Boundaries of Ethics" which is intended to guide discussions of bioethics into international realms. FAB member Vangie Bergum is coordinator for the conference. Details from: Vangie Bergum at: vangie.bergum@ualberta.ca, or Laura Shanner at: laura.shanner@ualberta.ca. Both of them can be reached by phone at: 780-492-6676. Fax: 780-492-0673.

November

Women's Health Update, San Francisco, CA, Nov. 11-13. Details from: Education Programs Associates at: 408-374-3720.

Forging Alliances on Global Health Issues: American Medical Women's Association (AMWA) 84th Annual Meeting, San Francisco, CA, Nov. 10-14. Details from: The Meetings Dept. Tel: 703-838-0500. E-mail: lleonard@amwa-doc.org.

Get Involved in FAB

To Join FAB

Members receive the bi-annual newsletter, which contains helpful announcements of upcoming events and opportunities, book reviews, and articles of interest to those working in feminism and bioethics. To join, send a request for a membership form with your name and address, either by mail or electronically to Becky Holmes (see page 23).

To Contribute to the Newsletter

We welcome contributions of all sorts: articles, announcements of upcoming events, information about articles or books you have published or find useful, reviews of books. Book reviews are organized by Hilde Nelson. Any other contribution should be forwarded to Maggie Little (both addresses on p. 23). *It's particularly helpful if you can send them in electronically.* **Deadline for submissions to the next newsletter is September 15, 1999.**

RECRUIT A FRIEND TO FAB

If any of your colleagues (far or near) are doing feminist work in bioethics, how about asking them to join FAB? To join, someone must complete the paper membership form. You can print a form for a friend from the FAB web page at www.uncc.edu/fab/joinfab.htm. OR - request a form with an e-mail or fax message to the Membership Secretary. See her address in the "Mailing List" box on page 23 .

FIRST CLASS

FAB Membership Secretary
24 Berkshire Terrace
Amherst, MA 01002



Feminist Approaches to Bioethics