Concrete narratives from African women doctors,

A gender perspective

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1 Narrative ethics and reproductive rights in African countries

I am teaching a course on health and development to African doctors, women and men. The methodology I have chosen in my course aims to avoid a neo-colonialist discourse is to give voice to the women experiences with the hypothesis that the empirical data will allow us to interweave an ethics of discussion and the traditional **African Palabre**, which clearly tries as ethical discussion to build a consensus without too much compromise for the protagonists. The main genre question about such a course was to allow a gender gaze to emerge on such biopolitical questions as the victims of AIDS and reproduction rights as they should be respected in medical environment. The medical environment is specially interesting for an empirical study since it allows to articulate or confront narratives of suffering and abuse to principles which are supposed to alleviate this suffering and presuppose conflicting frame of values between traditional societies and occidental medical epistemology that necessarily radically erases the specific experience of persons. The main problem the African women doctors where confronted with, is their difficulty to help women confronted to a situation of social alienation that makes medicine

deontology or values totally powerless and the solidarity between woman difficult to exercise or not at all desirable, as we will see in the narratives below.

2 Narratives

2.1 First narrative

From Mrs. Aboukabar Fatima:

She is a medical doctor in Niamey Nigeria and I am going to summarize her story trying to respect her own wording.

" The story took place in the regional hospital of Dosso 140 km from the capital Niamey. One morning Mr. X, a Muslim, aged forty-two arrived at the consultation. He was married and father of three. He presented a urethral discharge associated to micturitional burning for a week. The results of the physical exam was normal. I advised to him to use condoms and come back the week after. When he returned I informed him that he had syphilis and that he should have protected sexual relations. Then he said that I should see his wife as well, which I did, and she presented similar symptoms. I said that it was not necessary to go though more texts since she has been contaminated. Mr. X was not happy at all and said that he required his wife to be tested for AIDS since he was suspecting her to have an extra marital relation since syphilis was a sexually transmissible disease and he was sure of his fidelity, it could only be her. His wife cried and swore she never was unfaithful. In the afternoon the wife came back crying and swearing that she was not faulty but infidelity was permitted for man but not for women and she could be rejected by her village she will kill herself if I cannot prove her innocence.

I decided to act as a professional and give only the results of the test? The AIDS test came negative for both but the syphilis test came positive for her. I explained to the husband that it was not necessarily sexually transmitted but that was not enough the man required the divorce and married a younger woman the ex-wife killed herself.

After narrating the story I thought of alternatives my respect of only medical principles not in accordance with the real situation of the woman led me benefit a man who used an uncertain diagnostic to get rid of an older wife by accusing her of propagating sex related diseased and AIDS. The complexity of the issue involved should have made me more cautious about the neutrality of my diagnostic.

2.2 Narrative number two

Mrs. Aboukabar

"I am a Guinean woman doctor working in a hospital in Gaoual 500 km from Conakry the capital of guinea. I recently had to face an ethical dilemma when the prefect came to see me with his fiancé that he wanted to marry swiftly and needed a nuptial certificate legally needed to check the occurrence of AIDS or sexually transmissible diseases.

Mr. A is forty years old married to two women already and father of six children. In our country a social promotion is often associated to a new wife. His fiancé is about eighteen and she is still in high school a guarantee of virginity and of being AIDS free. She is issued from a rather poor family. Although she was engaged to a young student, she has under the pressure of her parents to accept the marriage offer of the prefect of the locality. Her family hopes that way climb on the socio-economical scale, every body speaks about it in town.

My function as a doctor is to perform the physical examination (or is it?) Nonetheless I ask for routine supplementary examinations. The HIV test comes back positive for Mr. A. how was I to announce the results to the first authority of the locality? The best move for me was to keep silent but I would be responsible for the contamination of a young woman and condemns her physically or socially

I finally decided to take the risk and tell him the results. When I announced the reason why he could not get his certificate, he asked me to let him get married

nonetheless so people of the locality would not guess the diagnostic. I discouraged him and asked him to think about the fate of the young girl. He answered it was a great danger for his career and that he had the power to break my own career if I told his fiancé. I just wanted to break a chain of transmission of HIV without putting at risk the dignity of the one or the other. I then decided to save the girl without telling her about the diagnostic of Mr. A. I visited Mr. A in the morning, after an hour and a half of Palabre I convinced him not marry the girl by relying on our very traditional Muslim values and that I will care for him and his social image.

2.3 Narrative number three

Fatoumata Bintou

My country Mali is one of the poorest countries in the world. Unemployment is very high. In 1991 the downfall of the military regime destabilized the sanitary structures. After I had my medical diploma that same year there was unemployment for doctors due to the economical situations and most women doctors worked benevolently. One day a Malian woman residing in France who came to Mali in vacation came to the hospital with her ten-year-old girl. She wanted an excision for her daughter and I was myself a militant doctor against excision and I refused to perform she told me she would ask the midwife to do it against money anyway so. I was in a dilemma because the girl was going to have an excision anyway and I needed the money. I let myself be corrupt since I needed money and thought I could do it more professionally. I practiced the excision against my values because of my economical situation but unfortunately the girl could not stop bleeding, she received anti-haemostatic that could not stop the bleeding. The day after we contacted the gynecologist in order to intervene chirurgically but the anesthesia provoked a heart failure with a fatal issue for the girl. I felt I was accomplice of a murder, and I still think about this story ten years after. Africa being what it is, the child death was accepted as a call from god after a sacred act, while I know now that respecting my

deontological principles and my convictions a drama could have been avoided. I never practiced excision since. The dilemma for me was that I am a Muslim believer and that the excision is considered as a good tradition in Mali, which was in contradiction with what I have been taught in my medical studies the situation of scarcity oriented my judgment in this conflict of interest. Medical doctors especially women cannot guaranty alone the reproductive health of women. I understood that we have to weave a cooperation with other sectors in order to change the mentality and have minimal economical conditions that allow moral principles to be applicable. I am now a militant against excision since 2 million girls are exposed to this practice each year in my country.

2.4 Narrative number four

Bah Amadou

I performed my education at the catholic school of the catholic missionaries of Kolouma with my friend Nyankoye X I studied medicine and he became a pastor at the protestant church. We remained friends all those years.

In 1997 I received his wife in consultation she had fever and asthenian diarrhea and had lost her appetite. After the clinical exams I diagnosed dysentery and paludism she needs an urgent blood transfusion. But our hospital did not have a blood bank. So we asked the pastor and the sister of the patient for their blood We neede to perform HIV test before this transfusion the test from the pastor where HV positive and from a different blood type the sister was negative and from the same blood group as her sister. After ten days of hospitalization the patient came out from the hospital but I had to deal with the results of the pastor test. At this time HIV was still very stigmatized in guinea. the religious chiefs viewed it as a god punishment for infidelity moreover he was my friend.

I explained to him the different modes of transmission and announced to him that he was contaminated he was very emotional when he calmed down I told him he had to inform his wife for prevention and apply all prevention measures possible. But he told me that one should not in our tradition tell a secret to a

woman or to a child since they cannot keep it. He lamented that his professional life would be ruined if anybody knew. Eight month later he was a widower and according to the tradition of sorority he had to marry his ex-wife sister. I began to worry about the young girl faith if he did not inform her about his HIV status. I asked him if he used condoms and he said that his future wife would guess something was wrong if he did, but worse she could not have children which is a woman duty"

What could I do? If I inform the parents the whole town will know and I would violate medical secret the dignity of my friend would be at risk. I finally went to see the sister and informed her. She flew from her parents' house to get refuge at a friend's house in Conakry, and I lost a friend.

3 Beyond universalism and relativist respect of all traditions

My perspective here is narrative ethics. The reason for choosing such an approach as scientific responsive of the seminar was to be able not to impose values to context that I did not really know. My main problem was to be able to articulate universals raising from singular narratives or a posteriori principle that would help a horizontal collaboration between traditional set of values which I perceived as oppressive both to women doctors and their patients since I could recognize forms of neglect of autonomy that paralyzed the possibility of women doctors to exercise their medical responsibility and their solidarity towards their woman patients.

Background: the course is part of a master degree on development, welcoming about fifty doctors from Rwanda, Congo, Guinea ……. when I was asked to teach bioethical issues to a public of professionals with a quite long medical experience in their own countries of which I knew very little, it seemed to me quite absurd to teach them the "bible of bioethics by Beauchamp and Childress or Englehardt approach to bioethics since the questions they were confronted to must have been very different from those of my Belgian students and ethically it

seemed quite obvious that a bioethical discourse could well sound to them as a secularization of the religious discourse they suffered in colonialist periods. I had no concrete ideas about their beliefs or their concrete problems so that the easiest way to respect their experience and give them an occasion to share it with me in a reflective form was to find what seemed to me the closest method that could enter in dialogue with the ethics of discussion, based on analysis of cases that –is generally taught in health and development programs. Although I considered quite violent an approach that would teach them universal principles that should be imported locally the previous work I had done on the modification of the Helsinki declaration

Adopting a relativist position and relativising women oppression would have been equivalent to eschewing the very possibility of normative argument and converge with reaction, oppression and sexism. We are far from contemporary neofeminist positions that refuse to consider the vulnerability of women since in most African countries no legal and democratic structure can protect the right of integrity and my position is that relativism in this context is precisely abandoning the political dimension of feminisms which considers women as a global group. I question thus the attack on a universalism confused with essentialism that pretend that absolute truths should be shared by all and claim an open and posteriori universal based on singular narratives. and regulated by shared minimal principles that allows to have judgments on other cultures when they transgress the following abstract principles although narrative gives an hermeneutics wide range of interpretation of these principles. :As Susan Wolf said about the controversial question of mutilations in the book cited above[1]

" The upholders of tradition are eager, often to brand their internal opposition as Westernazers, colonialists…but this way of deflecting internal criticism should not intimidate outsiders. The charge of colonialism presumably means that the norms of an oppressor group are being unthinkingly assimilated, usually to carry favor with that group"

[1] Sex and social justice: page 129

what the narratives allowed these moment doctors is to acquire a vigor of internal resistance that gave them confidence that it is worth struggling to achieve change. The international organization has been very slow to recognize gender specific abuses as human rights violation. My purpose was to trigger this desire from woman African doctor from the coherence or incoherence of their own narratives. Violation of bodily integrity or injustice in health access cannot figure among the norms legitimized by relativism of value and respect of traditions :

- The respect of bodily integrity
- Respect for women capabilities
- Gender empowerment : personhood, rights, self-respect
- The capacity of asserting one's individuality in community (which is, in this case the most concrete definition of freedom)

These principles allow to avoid mainly :

- Instrumentality,
- ownership,
- Denial of subjectivity that lead to the objectification of still too many women in Africa in the name of respect of traditions.

I believe that, by telling their own stories women become able to distinguish traditional values that protect their interests and those who alienate them. Feminist studies have for long adapted the narrative methodology in order to denounce that

" The ideology of gender makes of woman's life a non story, a silent space, a gap in patriarchal culture"[2]. The ideal woman in traditional culture the ideal woman is self effacing rather than self promoting. According to Smith, patriarchy preempts any self-representation on the part of women, and does not even appreciate what it calls women virtues.

[2] Sidonie Smith in Anna Yetman, Postmodern Revisionnings of the political, New-York Routledge, 1994 p 42_53)

Autobiographical narratives are promoting on the contrary a conception of self that valorizes individual integrity and separateness and allows a distancing from communal interdependency and subjection to common values. Those stories are thus not "just personal stories but allows the person to construct a "conjectural self" which is here the condition for a responsible dialogue between woman doctor and patient, beyond the asymmetry of the two women involved. It allows moreover a consciousness of the biopolitical dimension of being a woman doctor facing problems of reproduction or victimization through AIDS.
We should remain however careful not to "globalize the local'[3]. Acquiring a sense of self through a narrative approach is a never-ending task, which has nonetheless concrete effects on the process of liberation and the struggle against sexist oppression.
This is why I will be mainly reflecting on narratives that were told to me by women doctors during a course on health and development that I am teaching in Brussels where an interuniversity program is organized for ex-colonized countries. Where the link with African countries dates from colonialism. I have been stricken as a witness by the different perspective on the same health issues according t the fact that it was written by male or female doctors.
It stroked me that women's live, especially around AIDS and reproductive rights are unequally at risk and unequally treated. The main reason is the local narrative that too often portray female life as unequal in worth to male life bare some responsibility for the situation of AIDS for women and children in Africa that should be taken into account while thinking about preventive campaigns addressing solutions that are far from being merely medical. The situation of occidental medicine is ambiguous in most African countries since the respect for tradition and the memory of alienation and colonialism put a severe gaze on the doctor figure that often played a collaborative role with the occupation or exploitive forces. The tradi-pratician is often called first especially for issues which are considered as not relevant for medicine as child bearing or AIDS

[3] Sexing the self: gendered positions in cultural studies, London routledge 1993, (82-107)Michel de Certeau.

which is rarely considered as an illness and which is considered as a shame for whom women are blamed first as we will see in the narratives below. The right of bodily integrity for women is as a foreign concept as marital rape. Women have very seldom the possibility to impose condom use to their husband since they take the risk of being rejected and become what is called a free woman, i. e a prostitute to survive which anyway multiplies the risk of contamination.
The notion of reproductive rights is alien to most Africans, since reproduction is more perceived as a natural duty to the husband, as in most traditional societies.

3.1 Why narrative ethics ?

The habermassian model of an ethics of discussion is very close to the more complex model of "Palabre" developed by most African countries. It appeared to be more relevant to African culture than the habermassian model while being quite similar though as the African philosopher JF Bidima who lectured in the seminar says himself,
"The African male intellectual or political elite have now a tendency to despise the palabre and prefer to adhere to the more juridical model imported from the west. We have an idealized vision of palabre under a tree where long discussions are held to re establish peace between members of a community who are in conflict of moral visions, the traditional approach in it's relativistic appearance seems more appropriate than pseudo-universal models but is it for all members of the community ?" This is what we will question through the reported narratives. As Martha Nussbaum has shown in her book[4], *Sex and social justice,* it is impossible to deny that tradition both western and -western, perpetrate injustice against women in many fundamental ways, touching on some of the most central elements of a human's being's quality of life-health, education, political awareness, on the other hand the reverse judgment according to which traditional thinking is necessarily retrograde perpetuate colonialist and imperialist elitist thinking.

[4] Martha Nussbaum, "Sex and social justice", Oxford University Press, 1999

4 African Women doctor narratives and how they question the politics of health and development

Among all the narratives I have chosen the narratives related to reproductive issues and the way African women doctors are dealing with AIDS on every day basis, far away from the theorization of preventive discourse and principalist issues we develop when we import knowledge.

Since I am teaching bioethical issues it seemed obvious that we cannot elaborate any reciprocal strategies if we do not listen to what exactly these women are experiencing and the societal challenges that they have to face in the way political issues raised by access to health. I want to posit myself as a modest witness of a suffering that as it is described by the main protagonists could be practically overcome through a global approach that would not put away experience but would consider it a main part of the theoretical elaboration of alternatives raising from the very narrative elaboration. I consider it as a feminist standpoint providing a corrective to the arrogance of both principalist and casuistic bioethics which are both blind to concrete existential narratives. My main criterion to evaluate the story was the criterion of justice and equality in the medical decisions essentially when they concern reproduction or unjust access to AIDS treatment to women in Africa.

Imposing views which are necessarily contextual and share minimal principles together ? Why could it still be meaningful to is that minimal principles that mediates between conflicting interest alone allow to elaborate a distanced judgment that will avoid both the pitfalls of mere relativism that would justify any oppression on women or vulnerable populations. We like to thin that we in the west have escaped the category of vulnerability but we are collaborators of this vulnerabilization if we do not elaborate a minima solidarity of gender, but a solidarity that is demanding on using the privileged countries and in women in need in the south to get minimal conditions from which the range of choice can become freedom of choice.

5 Principles versus narratives : The example of AIDS research on pregnant women in Africa

The best way we could help in this dialogue, is by negotiating the minimal principles with the one like doctor in my situation that can play a role of careful mediator between the protection of level formal adaptation of the values inherent in every knowledge applied. The best example was given recently around the negotiation of changes of the Helsinki declaration at Edinburgh in 2000 where the southern countries were very active in helping t acknowledge that AIDS is a global problem raising imperatives for the regulation of research on vulnerable populations. The background of the latest revision was very political since the Edinburgh revision of the Helsinki Declaration was motivated by the scarcity of treatment available to pregnant mothers in developing countries, who were "offered trials of zidovudine to prevent the transmission of HIV to their children a debate arose over the efficiency of research versus the intention to benefit the mothers and children participating in the study. The public citizen group denounced unethical clinical trials designed to demonstrate reductions in prenatal transmission of HIV infection in the developing world *"Apparently reacting to the fact that perinatal HIV transmission trials, in which drugs of known efficacy were withheld from HIV positive pregnant women, were in clear violation of the current Helsinki declaration. Researchers have reacted by seeking to change the ethics rules to comply with the scientific studies to be ethical. The proposed declaration was stunningly complacent. There seems to be no recognition of recent abuses in international research …opening the door to unethical research seems to be its primary agenda"*. The violation was both sexist and racist and the only way to reclaim justice was to confront two narratives that of profit-oriented research and that of the victimized women, but at this stage only groups with a political agenda sensible to women issues could defend the interests of speechless women. The fight over a minimal principalism that would assure distributive justice rather than exploitation in health care was fundamental to a possible collaboration between different narratives i.e. set of

values, rather than exploitation between north and south but it could become concrete only if it did not stay at the level of international declarations but be implemented concretely in order to assure the integrity of vulnerable women used as guinea pigs. The academic and scientific discourse that of the Lancet for instance was less critical and published a consensus statement that defended ethical relativism. New guidelines were proposed that justified double standard for research in developing countries with the collaboration of the male political power of these countries, allowing less effective therapy [5].

My purpose will become clearer after I transmit to you paradigmatical situation facing women medical doctors in Africa :

6 Alternatives to resolve ethical dilemmas between traditional values and international ethical principles ?

Globally because a gender perspective refuses to surrender social meaning to biological facts, or rather social facts based on prejudice about biological facts : The way ethical judgments were elaborated in the medical scene in Africa related to local narratives and representation of illness, women and the relation between illness and womanhood. What interested me in the storied is that a minimalist principalism or shared rational values could function as a reflexive levier that would allow these woman collaborator of an ideology. they are victimized by could take a reflexive stance and distantiation that would allow them to perceive day to day situation from another perspective and allow us to adapt our discourse to their real needs.

The confrontation of the principles of a Ethics of discussion and the rational that they suppose was confronted very fruitfully to the African version of this theory which is called **Palabre** and is a much more complex mode of interaction were woman are very seldom participants but turns around a principle of justice and consensus when

[5] see my article Mylene Botbol-Baum in "The shrinking of human rights: the controversial revision of the declaration of Helsinki". HIV Med, 2000, 1, 238-245.

What strikes me although these women were highly educated was that they did not defend a narrative of their own and submitted to the main narrative of their patriarchal society, going as far as putting their lives at risk rather then resisting it.

Before I make myself any judgment I would like to methodologically first give a voice to these silenced experiences and reflect with the writers themselves what could be the alternative if not writing another scenario that would suit best their interest without rupturing totally the possibility of reciprocal discourse with there male colleagues and patients husbands not because I do not believe in radicality but because this seem the most radical way of liberating all the actor from alienating discourses : narrative ethics clearly will try to oppose traditional principality theory as objective and impartial knowledge. We will try to show that tradition knowledge confronted to the epistemology of medical rationality caused most of the conflicts of convictions and decisions in the situations we are about to describe. And how the capacity to be the author of one's story allows women to be more autonomous in judging their experiences as alienated.

If our experiences are mediated through our body the medical settings around reproduction and health seemed to be the best narrative setting to elaborate a subjective ethics that would transform shared experience in a sharable minimal theory that would allow the women involved to analyze reflectively the gender oppression that seemed un-historical and un-situated in their own practices. Narrative ethics allow embracing the plurality of discourse and remaining demanding on a rational response over vulnerable situations and going out of the serial status of victim to the individual position of actors of their lives.

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