The presidential debates in the U.S.A were raging while I was working on the final publication preparations of the 6th issue of the WH & UL. During the unprecedentedly negative campaigns of both the incumbent President Bush and the presidential hopeful Senator John Kerry, legitimacy/illegitimacy of the Iraq war, and the rising/declining U.S. economy received attention ad nauseam. Both sides spent multiples of millions to elate their own candidate and smear the other. The fears engendered by the September 11th events were used (and abused) to whip the insecurities of the masses and to channelize the presidential campaign on a single issue: sustaining fear and managing terror.

Despite the (almost) single-mindedness of the U.S. political machine, issues that have direct and severe implications on Americans as well as on all other peoples of the world did not stand still. For example, more than 30 million Americans remained without healthcare coverage. The hardship experienced by immigrants to the developed parts of the world, both in terms of adjustment and in terms of combating prejudice and discrimination remained paramount. Deaths due to natural disasters like hurricanes and monsoons, famines and even ugly genocides, on or off, peppered the newspaper headlines, without being able to sustain a long-term hold on or commitment from either the national or the international agendas. Some heart-wrenching explosions of violence (i.e., the violent deaths of Russian or Israeli children) received a lot more coverage than others (i.e., the violent deaths of Somalian, Afghani, Iraqi or Palestinian children). Obsessed with North American safety and security, North Americans were often too eager to turn a blind-eye to life and death struggles of peoples outside their own borders.

People of the poorest nations often become the casualties of the self-centered, first-world priorities. In the last couple of decades, about 30 million men, women and children lost their lives to the AIDS epidemic in Africa alone. African countries like Botswana, have become the involuntary “leaders” in the AIDS epidemic. What is more alarming is that the disease is now making new and threatening inroads to highly populated segments of the developing world (especially China and India). Although the number of women affected by this menace still remains smaller than their male counterparts, the rise in the infection rates of women has been growing in leaps and bounds. The rising numbers of women AIDS victims not only hollowed out the productive labour potential of the developing countries, especially those in Africa, but also is at the verge of creating a reproductive crisis. Some African
countries like Botswana find their populations dwindling due to deaths, infected women’s inability to replenish the population, and millions of young children left behind without maternal care and nurture. Despite some global efforts (UNAIDS), HIV/AIDS, especially in the already impoverished portions of the world, continue to threaten millions, especially the youth and the young. How long the developed countries can keep the AIDS epidemic “manageable” within their own borders is anyone’s guess.

In the current issue, Krishnan reports on HIV/AIDS risk behaviours amongst Botswana’s youth. The large national sample she draws from and her careful analysis bring new insights into the African STD crisis. Early on in the paper, the reader is confronted with the 40% prevalence rate of AIDS in the 15-49 age group of Botswanians. Considering the fact that this group represents the most active potential for both productive and reproductive labour, how the AIDS crisis has hollowed out the core of this small African nation becomes more obvious. For example, despite the many advances in global healthcare, the life expectancy of men and women in Botswana has decreased since the 1970’s, and now stands at 52 for men and 57 for women. What is even more alarming is that despite the lessons learned from the raging epidemic, the Botswanian youth seems to continue to hold misconceptions about the transmission of the disease. Even in those cases where the information they have is accurate, some youth still seem to resign to the “inevitability” of the disease. Even amongst those who seem to have grasped the correct knowledge about the risk factors, Krishnan shows a disjuncture between what young people know and how they act.

In Krishnan’s report, we also come face-to-face with both the real and the perceived powerlessness of girls and women. The early onset of sexual behaviour combined with the powerlessness of girls/women in the sexual-decision-making process fuel the already climbing numbers of new infections. Many young women in the study readily admit the fact that they continue to engage in unprotected sex, even after they start showing clear symptoms of HIV infection. In other words, the misconceptions and powerlessness of young women not only victimize them, but may also victimize their future partners. This is a chilling look into what might be happening in Africa in general and what is happening in Botswana in particular. Krishnan, rightfully suggests more aggressive global commitment to slow down this fatal and vicious menace. She also emphasizes the complex relations among HIV, poverty, violation of women’s reproductive and sexual rights and gender inequality. Let us hope that her plea for help does not fall on deaf ears while the world’s super-powers spend almost all their energies on gaining economic supremacy and military might.

In their research note (last entry in the issue), Larkin and Mitchell also emphasize the importance of awareness in the HIV/AIDS epidemic/pandemic. As a portion of a much larger research project, what Larkin and Mitchell address in their paper is Canadian youth’s perspective on the AIDS crisis. Like Krishnan, they too are concerned about the powerlessness of girls and women, especially in sexual matters. The authors duly acknowledge the advantages of the Canadian youth in relation to the youth in South Africa. Indeed, Canadians are buffered from many a health crisis by an extensive healthcare protection, a high standard of living and high access to education. Nevertheless, the authors also warn us that the HIV infection rates amongst worlds’ youth, especially amongst the female youth are on the rise. Canadian privileges may not be sufficient to protect the youth unless the youth also learns how to protect itself. Looking at the HIV/AIDS pandemic as a transnational challenge, the authors argue that there is much to be learned from the African experiences.

Within this context, Larkin and Mitchell probe into the knowledge and attitudes of a small group of Canadian youth about the AIDS epidemic. What they find is a strong indication of “othering” in the perceptions. If this small group’s perceptions are any indication of how the Canadian youth think in general, the young ones may be seeing themselves as less vulnerable to infection than they really are. Their false sense of security seems to drive from a skewed perception that “it happens to ‘those’ people because they are poor and ignorant.” The opposite side of the same misguided coin is “it won’t happen to us.” Although Larkin and Mitchell’s study is at its early stages, they are already on their way in situating the AIDS challenge within a global rather than local, and within gendered rather than de-genderized contexts.

The other two entries in the current issue pursue much less clamant, but nevertheless, important issues in women’s health. Koçtürk (2nd entry) attempts to assess the change in the food habits of Iranian immigrant women. Although Larkin and Mitchell’s study is in Sweden, and despite the fact that they use a convenience sample of only Iranian women, her careful analysis bring new insights into women’s health. Koçtürk (2nd entry) attempts to assess the change in the food habits of Iranian immigrant women. Although Larkin and Mitchell’s study is in Sweden, and despite the fact that they use a convenience sample of only Iranian women, her careful analysis bring new insights into women’s health. Koçtürk (2nd entry) attempts to assess the change in the food habits of Iranian immigrant women. Although Larkin and Mitchell’s study is in Sweden, and despite the fact that they use a convenience sample of only Iranian immigrant women, her careful analysis bring new insights into women’s health.

In a special report on sexual assault in the military, The Denver Post (2004a) claimed that “women who are raped while serving in the military say they were isolated and blamed for the attacks, while the system they turned to for help has treated the men who assaulted them far more humanely.” Moreover, The Denver Post (2004b) reported that women “are discouraged from reporting the crimes. Pressured to go easy on their attackers. Denied protection. Frustrated by a justice system that readily shields offenders from criminal punishment.” Also see The Age (2004) and Family Violence Prevention Fund (FVPF, 2004).
women immigrants, her results have intriguing policy implications for all host countries. Indeed, immigration is and increasingly becoming a way of life in the globalizing world. Whether by choice or by necessity, displaced populations often find themselves in countries where the food habits and food availability may be extremely different from the donor society that they have left behind. If the difference was cosmetic (i.e., hairstyle or clothing), of course, the change could be discussed within simply “cultural” terms. However, the change in food habits is not simply “cultural,” since food intake is directly linked to long-term health prospects. In that sense, policy makers and health professionals have a lot to gain from learning about the shifts in food habits.

If Koçtürk’s study on Iranian women is any indication, even after a relatively brief time after immigration (about five years), food habits seem to go through a substantial alteration. Possibly through the increase in standard of living in the host society, some of this change may indeed be beneficial to the immigrant women and their families. However, as Koçtürk’s study demonstrates, there is also a more sinister aspect to the alteration. For example, the discernable increase in fatty foods (creams, aged cheeses, etc.), coupled with a shift toward junk-food (processed snacks, sweetened drinks, complex sugars like candy and chocolates) pose a long-term health hazard for the immigrant women. The consumption of not-so-beneficial foods are at the expense of a reduction in some beneficial foods (yogurt, fruits and vegetables, fresh cheeses). Moreover, since immigrant women (like most women) are the providers of food for all family consumption, the change in their own cooking/eating habits are bound to reflect on the eating habits of their whole families.

Not only the change in preferences and tastes, but the change in the intake of calories, carbohydrates, fats and sugars have implications for all host societies to large immigrant populations. Especially in countries like Canada which hosts and provides health-care for more than a quarter of a million new immigrants each year, the healthy adjustment of the newcomers have national implications. For example, immigrants who may have arrived from areas of the world where food is scarce, are suddenly bombarded by cheap, tasty, easily accessible, but not necessarily healthy food choices. In the developed parts of the world, problems with weight, obesity, eating disorders, and other long-term health problems such as higher risk for diabetes, heart attacks or strokes are already at high levels. If the newly arrived populations also fall into the trap of making poor food intake choices, these problems will be exasperated. As Koçtürk’s study explores, the balance between how immigrants smoothly adjust to their new surroundings while retaining the healthy aspects of their pre-immigration lives is a challenge for educators and health professionals alike.

van Daalen’s study (3rd entry) brings us to the psychological prerequisites of women’s health. Inquiring into the sources of self-esteem problems in six women, the author herself as well as her participants come to the realization that the cause of these problems lies outside the self. The qualitative/longitudinal study shows that the patriarchal world, families, kin and teachers, sometimes willingly but at other times inadvertently, have bruised the developing selves of these women. Women who were repeatedly told about their weaknesses have internalized such negative evaluations to the degree that they have forgotten to see or appreciate their strengths. In “shifting the lens,” van Daalen simultaneously tries to show two things: 1) it is possible for women to break the low self-esteem chains, and emerge as women who like themselves; 2) it is necessary to break the chains of the theoretical orientations that see the roots of self-esteem within the self. Challenging Maslow’s hierarchy of needs which more or less places the onus of personal ascendancy (actualization) on individuals, van Daalen suggests that we should instead attack the components of the patriarchal world that (still) trivialize, marginalize and victimize women.

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