General Editor’s Introduction

Since the May, 2005 issue of the Women’s Health & Urban Life was published, the world community experienced many wounds due to natural disasters. Most seriously, hurricane Katrina decimated the Louisiana State and hurricane Wilma took its toll on Mexico and parts of Cuba. On the one hand, these events showed the ominous power of nature within which manmade (sic) structures had little survival chance. However, these events also showed something even more dangerous and more sinister: While a large proportion of the affluent had the privilege to leave the risk-prone areas well in advance and thus curtail their losses to their immobile possessions, alternate choices the poor could make were either non-existent or grossly limited. Disproportionally, the latter were the ones who had to go without food, water or sanitation. Many lost their health, lost their limbs, lost loved ones and hundreds lost their own lives. It was mostly the poor, the black, the aged and/or the single-mothers who had to be rescued from the tree-tops or from the collapsed roofs. They were the ones who had to face the surging waters, rummage through the mud and breathe in the noxious elements and the spores of mould. The President of the United States took his time, first to survey the devastation from the comforts of his Air Force One, then from well-selected patches of dry ground. In contrast, the television reporters were there from day one, recording the class, race and gender interaction before the eyes of the world, and giving a human face to the desperation of the poor black women. These women had to endure the cries of their hungry, injured children, while at the same time, coming to grips with the loss of their meagre possessions and low-paying jobs. Many also had to live through the nightmare of sexual assault and rape that were inflicted on them in dark, crowded and dangerous so-called shelters.

In Louisiana, along with the basic concern for the health and well-being of the masses, the social order itself collapsed. In this conundrum, of course, it will be unfair to ignore the losses the rich and the affluent suffered. Indeed, many lost important possessions, their homes, experienced fears and had to do without the comforts of their past. However, it was the poor, the disadvantaged, the aged and the black who were truly tormented and displaced. Despite the extraordinarily generous response by the world, and delayed promises of their political leaders, they are also the ones who will face the greatest difficulty in carving out a new life.

Shortly after Katrina, hurricane Wilma hit the prized tourist locations in Mexico and Cuba. It also reversed its route to re-visit the already
battered coastline of Florida and Louisiana. Again, the devastation was massive. Again, the deep divide between the rich and the poor unfolded under bright camera lights. Vacationing tourists were shaken, frightened and certainly disappointed in their holiday expectations. Many had to share rooms, skip leisurely comforts and even miss meals and their flights. However, almost all had a safe home to go back to, away from the carnage of the hurricane. More than any other, locals who serve rather than stay at luxury hotels and cook or wash dishes at the fancy restaurants had to face and will continue to endure the long-term effects of what hit them. The tourism industry will find ways to regenerate itself much sooner than the health and well-being of those who are already living at the margins.

The pain and suffering the two hurricanes brought to where North America meets South America was matched and many-fold surpassed by the nameless earthquake that struck an area which overlaps Pakistan, India and Afghanistan. Pakistan took the brunt, but all three countries suffered unbearable losses, mostly in human life. Estimates range between 70-80,000 dead and 2-3 million homeless. Another cruel trick of the nature was to immediately subject the survivors to a cold, harsh winter on the unforgiving heights of the Himalayas. The already poor, the already disadvantaged men, women and children were forced to forget the terror they had just lived through in order to face equally bleak challenges that still awaited them. Most will get nothing more than a plastic sheet to shroud them from the rain, snow and sleet of the mountains. Mothers will give life under those circumstances, while many women and children will lose theirs.

What do the locals and the tourists of Louisiana, Florida and Mexico have in common with the tribal nomads of the Pakistani, Indian and Afghani mountains? Under normal conditions, probably nothing! However, when the disaster struck, either as a wall of water or as the crumbling of shanty homes, it hurt the poor and the weak the most. Those who are lucky to live in the US will eventually have reason to count their blessings. Regardless of how late or how grudgingly, the enormous economic machine of the US will indeed make a difference. For those in Mexico and Cuba, the prospects might not be as good, but still exist. After all, their governments cannot help but oblige to the needs of wealthy tourists and will help with the recovery efforts. Unfortunately, the story will be very different for those who are hit by the earthquake and who are stuck in the ruthless winter of the Himalayas. Despite the initial good will of the world, and sooner than later, other interests will emerge; other needs will take precedence. Even the most dedicated news people will find fresh stories and the cameras will zoom on new places and new faces.
Like the Tsunami survivors of the yesteryear, the quake victims are mostly on their own. Their health and many of their lives will fall through the cracks of their abject poverty and deprivation.

In the current issue, the work which most closely echoes the health and well-being woes of poor women is by Chris Lockhart. In his case, the situation is not about a natural disaster that capriciously hits, but about women who chronically live in one of the most forsaken parts of Africa. His paper is not about a ‘natural’ disaster, but about the disaster of STDs. STDs in the form of HIV/AIDS are ravaging millions of sexually active Africans and their children. The place of Lockhart’s study is Tanzania, the women are older, some with, others without children, some discards of irresponsible marriages or survivors of husbands who have died. In their own ways, all are discards of their own social and cultural system. They are exceptionally poor women, living in a society which does not or cannot extend a meaningful safety net to them. In most other studies, Lockhart observes, we see such women not as persons but as high-risk groups, particularly as a high-risk group for sex-work and HIV/AIDS. Not disputing the general relevancy of such a link, Lockhart nevertheless re-directs our gaze on these previously married Tanzanian women as women. He analyzes their daily lives, identifies their work-related struggles, discusses their agentic efforts to survive and to keep themselves safe. Indeed, some engage in sex, and some may even do this for tangible returns, but their survival is more linked to the community of women they become a part of than by their occasional sexual encounters. The betterment of these poverty-stricken, isolated lives is more dependent on the social legitimacy they carve out for themselves than on transient, risky encounters with men. Thus, Lockhart criticizes the biases in the literature and cautions us against making over-generalizations about African women’s role in the HIV/AIDS pandemic.

Maureen Baker’s article explores childbirth practices and policies, on mostly New Zealand based data with some comparative information from OECD countries. All are more or less affluent societies with relatively developed health policies and practices. Thus, Baker highlights a general convergence in maternity related gains they have made, especially in areas of using health facilities, skilled attendants in the birthing process, etc. Indeed, in the OECD countries, there have been important improvements in mothers’ and newborns’ survival rates within the last few decades. After mentioning these positive developments, Baker reserves her analysis for more irregular and less positive trends. Among issues of concern are the declining emphasis on natural births and the increased reliance on caesarean births and the marginal role and position of midwives in relation to the dominant role of the medical
professionals. Other policy and differential practice examples Baker reviews relate to breast feeding and medically assisted conceptions. The common denominator in these varied and complex dimensions can be summarized under three simple headings:

- Despite the cost-cutting efforts of all OECD countries, birthing related costs and expanses are on the rise. Some of this rise is due to higher standards and expectations the affluent societies have come to expect. However, even a larger part results from the vested interests of medical establishments, drug companies and the greed of professionals that have made the most natural processes in women’s lives into cash-cows.

- Another axis that ties the relatively differentiated areas in Baker’s analysis is the decline in women’s agency over their own health. Under the auspices of freedom of choice and expanded alternatives, many women still find themselves to be the pawns in sometimes pronatalist, sometimes antinatalist policies that govern their lives.

- The third and perhaps, the most thought-provoking aspect of Baker’s work is to show the interplay of class and gender. Even in the affluent countries of OECD and most certainly in Canada and in New Zealand, the birthing system feeds on private profits to be had from the rich, despite the proclaimed checks and balances in the heath system. Sometimes, wealthy women seem to benefit from the privileges their money buys (i.e., better information about and opportunities for breastfeeding). At other times, they may be the silent targets of unnecessary, non-essential and possibly dangerous interventions (high rate of caesareans). In sum, all women loose, one way or another.

Tammy George and Geneviève Rail’s paper turns our attention away from class as the major determinant in health issues. Instead, they are interested in the social constructions of health by a small, visible minority group in Canada (from South-Asian origins). These women do not define health as an absence of disease, like many of their counterparts in India and the rest of the developing world would do. Neither do they define health in terms of safe-sex, keeping fit, freedom from drugs or alcohol or smoking, like many of their Canadian counterparts may. Instead, their perception of health is intricately and complexly intertwined with how they see themselves within the ‘judgmental gaze’ of the dominant culture. More clearly put, their constructed perceptions of health revolve around looking good (cleanliness, grooming, body size, body shape) and whiteness.

One may think that the looks-centered construction of health is a bit frivolous in a world where millions of people live with imminent or full-blown diseases and struggle through the aftermaths of disasters. Nevertheless, constructing health in terms of ‘looking good’ has its own
pitfalls and dangers. For example, linking ‘health’ with ‘whiteness’ has the potential to set young women against ideals that they can never reach, regardless of how much they try. Linking ‘health’ with ‘individual and/or moral responsibility’ will have a similar negative effect on those who are born with physical characteristics incompatible with the beauty notions in the dominant discourse. Especially in formative years when young women (and for that matter, young men) are developing a sense of self, even a subtle pressure to alter their skin, looks, hair etc., in order to fit within the dominant discourse is a heavy burden to bear. It is a relief when George and Rail inform the readers that the young women in their study are not totally subservient to the dominant discourse, but are negotiating with it. Yet, these participants seem to be mostly from relatively affluent circles. How much harder would it be for visible minorities who not only have to navigate the class structure of their host country, but also struggle with the discourse which links health with looks.

The current issue comes to a close with a step towards a new paradigm in research in urban women’s health. Toba Bryant argues that not only the traditional factors such as physical spaces and presence of toxic substances, but also the social determinants must be an integral part of the health research paradigm. More specifically, she reviews the traditional urban approaches with their medical focus and the public health approaches with their focus on health, social and community infrastructures. She then discusses the healthy cities approach with its policy-oriented emphasis on cleanliness, safety and quality of housing. She urges for the expansion of the traditional approaches to include dimensions that are particularly relevant to women’s health, namely, weight issues, reproductive issues, violence, mental health and access to social welfare. The extensive review of the literature, with few exceptions, shows the need for a paradigm expansion in the dimensions Bryant suggests. Social factors, as much as the environmental ones, determine women’s health outcomes. In order to more accurately reflect the experiences of urban women, researchers should start incorporating social (and gendered) factors into their research designs to guide their academic or public policy pursuits.

Aysan Sev’er,
November 19, 2005