General Editor’s Introduction
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Papers in this Special Issue were originally presented during the International Sociology Association (ISA) RC06 (Research Committee on Family) meetings that took place in Toronto (May 8-11, 2007). The first Special Issue from the same conference was published as Vol. VI, Issue 2 of the Women’s Health & Urban Life Journal. Professors Aysan Sev’er and Lorne Tepperman from University of Toronto organized the ISA-RC06/Toronto conference and served as Special Issue editors for both Special Issues. Many other intellectual collaborative efforts have also emerged from this important Toronto conference. The first paper in the current Special Issue was originally delivered as a keynote address during the conference by Pat and Hugh Armstrong. The Special Issue, like the ISA conference, welcomes their insightful comments and analysis.

In Canada, the term ‘bringing it home’ often leads to the word association: ‘bringing home the bacon.’ Like in most other societies, bringing home the bacon conjures up a ‘male provider image’ and a traditional division of labour: Where men toil, and earn a living, and women stay at home, cook, clean and bring up the children. Whether the Armstongs meant the title in the subtle irony I see in it or not, I particularly liked their reversed play on a traditional message/image. In this paper, men do not bring in the bacon. The topic is gendered division of labour, but in this case, the real burden is carried by women’s health work. It is women’s toil that assures the well-being of their families’ mental and physical health. Armstrong & Armstrong focus their discussion on Canadian health care and the gendered implications of that care. They present their analysis chronologically, by reviewing theories and practices of 1960s and 1970s, 1980s and 1990s, and finally in 2000s. The first stage of the paper summarizes the debates in the division of labour, women’s changing roles in the paid labour market and their segregated work. In the 1970s, the authors also emphasize that there was an unprecedented interest in violence in the household and the first acknowledgement that this violence was gendered. In the second section of the paper, the authors emphasize that there was an unexpected interest in violence in the household and the first acknowledgement that this violence was gendered. In the second section of the paper, the authors emphasize that there was an unexpected interest in violence in the household and the first acknowledgement that this violence was gendered. The feminist debates have...
matured to incorporate how women as receivers and providers of care are placed not in a unidimensional hierarchy, but in a multidimensional matrix.

Armstrongs argue that the beginning of the 2000s has seen the emergence of new issues. Examples are increased privatization of health care as well as increased precariousness/instability of paid work. Moreover, older issues such as gendered inequities in non-paid work, violence and increasing disparities amongst women themselves have complicated the health related debates. Nevertheless, what seems to be resistant to change is the gendered nature of the work. Using Bonnie Fox’s (1988) ‘hidden in the household’ term, what is hidden across all the decades of analysis is the disproportionate toil of women, as workers in a labour market which marginalizes their work, and as care givers in the institution of marriage which often takes for granted their burden as wives, mothers, child-raisers, and the guardians of the elderly and sick. Looking for the future, the authors underscore the importance of ‘context,’ at the international, national and local levels. They also point out to the need for an ‘active state.’ An active state is not one which intrudes in private affections, exchanges and intimacies, but one which is democratic and enabling. An active state is one which is responsive to the differential needs of its citizens rather than treating them as an undifferentiated mass, is equity seeking and delivering, as well as one that insures meaningful employment. Unless the state actively provides the needed services in the education, work or health-care areas, some families, some of the time, and many families, most of the time, will be one step away from social or economic disintegration. Unless the state actively assures the much needed services, especially in health care, women’s leisure, intimate relations, work opportunities and even personal health will be compromised.

Tessa LeRoux’s work continues the conceptual framework set out by Armstrong and Armstrong, as she brings focus into the continuing gendered inequalities in provision of care. Socialization differences that instil in women/girls an ‘ethic of care’ is probably true today, as they were true when Gilligan addressed these issues in her seminal 1982 book. In contrast to women’s interpersonal ethic, men/boys are still socialized into more instrumental roles (and morality), and still by-pass the emotional pressures/burden/guilt that accompany caring roles. Moreover, and equally important is the societal expectations and state policies that shift the responsibility of care as part and parcel of the women’s private (read: unpaid) work. The result is, as LeRoux rightly points out, not only the work women provide is marginalized, but also that care-giving women have to work twice as hard as their (male) counterparts who by-pass such responsibilities.

When it comes to the topic of care, the ‘different voices’ Gilligan
has theorized about men and women can also be heard within the feministic literature itself. According to LeRoux, part of the tension in the feminist literature is due to the recognition of the assumed superiority of personalized ‘family’ care versus depersonalized/institutionalized/profit-driven forms. However, personalized, privatized care also means double or triple work for women, through expecting them to make sacrifices from their leisure, their career goals and aspirations, and from their intimate lives/relations. It may also mean heightened health risks for women care givers, such as chronic anxiety or depression. The feminist literature, like the woman care-givers, seems to be caught between a rock and a hard-place, as the ‘family’ continues to be a locus of struggle (Hartmann, 1984). As the population ages and demographic make-up of societies change, and as wars and accidents leave behind severely traumatized individuals, there needs to be more concentrated efforts to apportion the responsibility: at the micro level, inequities between men and women must be addressed, and at the macro level, the hijacking of the private lives of women by the public demands for free care provision must be better balanced. Although LeRoux does not use the same terminology, her work is also showing the need for a ‘responsible state’ that the Armstrongs have called for.

The general debates about health care and gender take on a more narrowly specified focus in Donna Rochon’s paper. She starts with the assertion that many medical advances have been made in the area of the HIV/AIDS pandemic. Nevertheless, social attitudes towards the carriers of the virus, or those who live with its full-blown manifestations have not changed much. Like the unjust treatment, prejudice and discrimination other victims of disfiguring/emaciating diseases have suffered (TB, VD, leprosy, etc.), social rejection and stigmatization also victimizes those who are HIV+ or have AIDS. According to Rochon, this is not just a medical but a social malaise and the latter can be especially rampant if HIV+ people happen to be women who are or who become pregnant. Social marginalization may quickly transform into moral condemnation for infected women as if to say: how dare you have sex, how dare you get pregnant and how dare you bring children who may also be infected into this world.

The medical establishment itself, consciously or unconsciously, also engages in the chastisement of HIV+ women. Stigmatization may be so blatant and so rabid that expecting HIV+ women may forgo seeking treatment for themselves or for their to-be-born/new-born children. Rochon states that the probability of perinatal transmission is now less than 1% if the mother is on antiretroviral drugs, but social condemnation rarely heeds homage to low probabilities. After all, societal values subsume hierarchical evaluations based on race/class/gender and sexuality and there is little tolerance for those who are deemed to deviate
from the norms. Poor women, women of colour, or those who have mental or physical ailments are often seen as the primary authors of their own problems. They are also seen as potential dangers to the societies they live in. History is peppered with state-level attempts to control the reproductive powers of the ‘undesirables’ through cajoled or forced sterilizations. Rather than being the protector of the health of the disadvantaged, the often reified medical institutions also serve as the extended arm of the social and prejudicial judgments concerning HIV/AIDS. However, general public’s and the medical institutions’ obsession about HIV status does not reflect the concerns of the HIV+ women. Ironically, the most primary concern of women may not be their HIV status, but may be a host of other factors such as their general aspirations, personal standards, emotions, SES, housing conditions, employment status, presence of (partner) violence and availability of social support systems. Reducing the complex lives of women to their HIV status, and paternalistically, attempting to determine/control their reproductive choices are seen as injustices to the women. Moreover, the tunnel vision about HIV status and accompanying prejudice and discriminatory practices may alienate the women so much so that they may be reluctant to seek help. Their avoidance may kick-start a self-fulfilling prophecy, where marginalized women increasingly fail in their own health, and may increasingly fail the health of the children in their own care, thus becoming the ‘health problem’ the society attributed to them in the first place. Rochon suggests that only attempts to decrease stigma and increase knowledge can reduce the drama and hardship of already a very difficult disease, help reduce its transmission to the young and break the described vicious cycle.

Alvi, Clow & DeKeseredy give us an insider’s view about minority women’s resilience, mental health and access to support systems in dealing with or preventing abuse. The study they report involves 117 people, mostly representing two groups: Hmong (originally from Vietnam) and black women from a low income area in a US Midwestern city. Of course, the concept of resilience is complex and in the Alvi et al. paper, it is defined as the ability to change and adapt to harsh life circumstances, the capacity to ‘bounce back’ and the capacity for a determined engagement rather than avoidance of problems. In turn, the authors claim, resilience is linked to physical/mental health and social support. The authors highlight that the Hmong culture is particularly patriarchal and controlling. The androcentric clan structure may also pose additional dangers for women who challenge their social location, so how social support and efficacy will work for Hmong women is not easy to predict. Authors use psychological, physical and sexual abuse as their dependent variables.

Indeed, in this study, both black and Hmong women report high
levels of psychological abuse (62% vs 67%), physical abuse (36% vs 35%) and sexual assault (14% vs 32%), in the last 12 months. These findings support the earlier findings that poor, minority women may indeed be at much higher risk of experiencing abuse than their non-minority, more affluent counterparts. Moreover, the reported rates in this study are many fold greater than most other findings. The findings also show that Hmong women are much more vulnerable to sexual violations than their black counterparts. For both groups, better mental and physical health seem to act like a buffer against abuse. The silver lining in this study which attempts to predict abuse is the reverse relationship between some resilience measures and vulnerability to abuse. For example, there was a significant protective effect of one of the mental health measures (self efficacy), for both groups. However, the effects of personal and/or institutional support systems were less clear, possibly because of the operationalization of support (as perceived availability rather than actual utilization), and perhaps other confounding factors (such as language and other barriers, especially for the Hmong group). Of course the authors are well aware of the complexity of predicting abuse through mostly intrapersonal aspects of efficacy, and the dangers such a causal argument may pose for those who are already eager to blame the victims. They are also well aware of the shortcomings of suggesting clear paths of causality, since abused women may lose self efficacy rather than self efficacy predicting abuse. Last but not least, the social support effects which go against the grain of most other findings in the literature deserves a much careful analysis than the limited generalizability this study can offer. Having said that, the study generates many fruitful ways of studying the complex interactions between health, support, efficacy, culture and abuse, and the women’s role within it, whether as care providers or as victims/survivors.

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