General Editor's Introduction

During the last year (2008), the US economy crashed, pulling down the economies of almost every other state in the world with it. Although Canadians fared slightly better in this adverse economic environment, no one can claim that it has been an easy year. According to the economic analysts, who often do not have much predictive power, but who all become post-mortem experts of the crash, the culprits were many: They blamed the banking industry that approved mortgages for people who were definitely not able to pay their mortgages, thus creating toxic assets. They blamed the insurance companies which insured shaky loans for houses/businesses based on rates that were more than the worth of the properties. They blamed the credit card companies that issued cards to people who could not afford the things they bought. Moreover, they charged such exuberant interest rates that even those who had all the good intentions to get out of debt were not able to do so. Post-mortem philosophers of the crash also blamed CEOs who brought home multi-million-dollar pay checks and bonuses, the American auto-makers who have lost their original edge over Asian competitors, and the illegal aliens who jump borders and compete with good-old American jobs. Politicians also blamed China, for holding so much of American debt, never questioning why the Americans were indebted so much in the first place. Of course, there was also anger about the Iraq and Afghanistan wars, to the degree that American voters ousted the Republican party that had initiated these wars, to near-extinction. This anger was not about the questionable morality of such wars in general, and these particular wars in particular. The morality issue was brought up many times before, without having too much of an impact on the masses. What moved the American voters was the cost, and the impact of the cost on the pocket-book of the nation.

Indeed the impact of the crash was momentous, and effected the rich and the poor — but not in similar ways. The rich lost maybe a few 'zeros' from the magnitude of their wealth, and maybe saw a trimming-down on their most extravagant consumptions. The multi-billionaire Bill Gates is rumoured to have lost many billions of dollars from his investments. Of course, for 99.99% of the population who cannot even comprehend what being a billionaire means, such comments appear surreal. However, it is quite clear that the richest Americans did not lose their homes or cars, did not lose the food on their table or the clothes on their children’s backs. They did not lose their health coverage in countries where health-care is exclusively or mostly privatized. Those few who lost their jobs, or had to change them, did take with them huge compensation packages. What the middle-classes and the working and the non-working poor lose in times of economic downturns is much
more tangible. They may lose their jobs to down-sizing or closures, without much of a cushion to soften the blow. Many lose their homes and/or their ability to send their kids to school. Many lose their health-coverage, especially if the health-coverage is not a universally available social benefit. Some may lose the ability to pay rent, pay for utilities, buy food, medicine or clothes. Economic downturns have a sinister way of re-victimizing the already not-so-well-off, and the marginalized.

Of course, this journal is neither about the US nor about the world economies, and how these economies are increasingly tied together from their umbilical cords. The journal is not about who deserves the most blame in the 2008 crash either, although there seems to be a long list of people, companies, organizations and politicians to blame. What this journal is about is health and well-being, especially of women and their families. The literature repeatedly shows that even in times of prosperity and peace, women's health and well-being are often stretched to their limit by a variety of structural and interpersonal pressures placed on them. At the structural level, women often work in low-paying jobs with little job-security or hope for upward mobility. The types of jobs women occupy rarely come with decent benefits. Moreover, their work may be devoid of decision-making power and repetitive, which come with their own level of stress. Moreover, many women are expected to carry double or even triple burden, such as work for pay, house-work and child-care. Many women also are expected to be kin-keepers, and the care-givers of their aging parents/in-laws. Even at best of economic times, the structural constraints on women's lives are ominous.

When the economy experiences a bust, the hurt is more seriously felt by women. Often, their already tenuous position in relation to the public world becomes even more tenuous. Their over-burdened position in the private domains, may even become more over-burdened. The already substantial pressures on poor women, immigrant women, women of colour, women who are lone-parents, women with disabilities and/or women with various levels of health problems may be pushed to their breaking point. At these times, even more than others, women may need additional social safety nets. Help with income security, help with social assistance and housing, help with child-care are the areas which may bring some relief to their over-burdened lives. It is also true that there is an undeniable link between socio-economic status and health. So, in times of a downturn, women and their children may indeed need additional health-services. Unfortunately, and especially in times of economic turmoil, most governments turn away from a model of social responsibility, and get locked into an economic survival model. Even the well-meaning, and socially conscientious governments like the newly elected, ambitious government of President Obama, are consumed by
saving the financial system from further implosion. With the exception of acute threats such as a flu or a plague, health and well-being of the populations, especially the marginalized populations, again lose the primacy on political agendas.

In Canada, we have been exceptionally lucky not to experience the worst of the worst of this latest economic havoc. Our banks did not close down due to unbearable levels of toxic assets. Although our unemployment and bankruptcy rates remained quite substantial, they did not reach crisis proportions. The Canadian Government did not have to pay billions of tax-payer dollars to bail out our banks and other financial institutions. So, in a way, Canadians are faring the storm with fewer scars than their sisters and brothers in the US and in most other parts of the G-20 world. However, the conservative Harper government did find the economic slump as an additional justification to dilute some social and environmental programs. So, can we ever say that there are no serious cracks in the Canadian social safety networks? Can we say that our female new immigrants, lone-parents, the sick are getting what they need under the new over-stretched socio-economic realities? If most of the articles in this issue are any indication, the answer is 'no'.

In the first article of the current issue, Toba Bryant looks at housing and income as a social determinant of women's health, through the lens of a political economy model. The model suggests that the policies of conservative or neo-liberal governments effect income distribution and housing conditions, and they, in turn, effect health status. Of course, these links reach their most negative adversity for those who are already in compromised social locations (class, gender, race, etc.). Bryant's study addresses income distribution and housing conditions in three Canadian megacities (Toronto, Montreal and Vancouver). The data are drawn from Canada Mortgage and Housing Corporation's housing indicators and Statistics Canada findings on incomes for 2005. Moreover, her work is important in looking at the detrimental effects of 'clustering' of disadvantages. For women, these clustering of disadvantages may be more important than they may be for men, because of their more precarious relationship with the job market, and the higher dependence on income transfers.

The review of the literature as well as the current observations support the vulnerability of women in general and female lone-parents in particular. Indeed, lone-parents live on much less income, and face many more shortages, including shortages in affordable housing. Amongst the three metropolitan cities in the comparison, it seems that women in Montreal are the worst off, possibly due to their lower propensity to engage in the paid labour market. What direct health consequences these adverse conditions have on women are only implied in this research: For example, lone-mothers spending more time at home
with small children, may be more prone to stress-related ailments, as well as susceptible to environmentally induced problems due to poor housing (moulds, allergies, etc.). Poor women are also more likely to experience more chronic diseases like type-2 diabetes, and even premature mortality. The resolution of some of these problems lie at the structural levels, such as job security, a livable minimum-wage, decent benefits, affordable housing, help with child-care, etc. Yet, the policies of the conservative or neo-liberal governments have been to get out of rent controls, to reduce the creation or provision of housing geared to income, and to put childcare issues to the back burner. What Bryant's research on the 2005 indicators does not (and cannot) show is how much worse the situation is likely to get for women and their children due to the deep economic crash of 2008. The resultant economic frugality of the governing political system will not smoothly merge with social responsibility towards the needs of the disadvantaged.

In the second article, Johner et al., also explore the link between social exclusion and health. In this case, the focus is on female lone-parents, more specifically, female lone-parents in a Canadian prairie province (Saskatchewan). The authors argue that social exclusion can be conceptualized in its more traditional way (through socio-economic indicators like low income, low education, lack of employment), or through its social relations dimension (lack of social support, lack of social networks, feelings of loneliness, etc.). The negative connection between socio-economic variables and health has been already shown through numerous studies. The link between health and the social relations-related indicators of social exclusion are less well-known. It is possible that social exclusion in terms of social relations may cause poor health, but it is also possible that poor health may lead to higher levels of social exclusion. The authors also draw our attention to the fact that social exclusion may be more complex than just being the opposite of inclusion. For example, there is the possibility that inclusion in one area (the access to social assistance) may simultaneously occur with levels of exclusions (lack of respect for the social assistance recipient, lack of social networks, low density of social networks, etc.)

Johner et al.’s survey study attempts to decipher some of these paths of causality and their link with perceptions of health in a sample of female lone-parents. They have gathered responses from 163 (TEA) versus 202 NON-TEA mothers (those who are receiving transient assistance versus those who are not). Given the context of the study, some of the findings are in line with previous findings. For example, there is a large proportion of Aboriginal women in the sample, and moreover, a higher proportion of these women are in the TEA group. Moreover, the TEA group is significantly younger and poorer than the NON-TEA group. However, some of the observations are less intuitive.
For example, numerous variables other than strictly economic ones seem to contribute to the variation in perceived health of the NON-TEA mothers (income, Aboriginal identity, disability, presence of young child, and social support). For TEA mothers, perceived health seems to be determined by disability status and sense of control alone. As the authors admit, there is not a simple way to interpret these findings, other than saying that social exclusion is an important and complex aspect in health.

In the third article, Guruge and her colleagues again address the link between structural variables as social determinants of women's health. Their focus is on language proficiency of immigrant women, and how lack of efficiency disadvantages health. Their methodology is qualitative, and their analysis incorporates the voices of women from different ethnic/language groups. On the one hand, the authors acknowledge that Canada prides itself to be a welcoming host to its heterogeneous groups of immigrants. Canada also prides itself in having one of the best universal healthcare systems in the world. However, in terms of access to the healthcare system, all Canadians (or landed immigrants) are not equally placed. Guruge and her colleagues argue that English (or French) proficiency of the groups will have crucial implications for seeking assistance and delivery of services. In relation to men, immigrant women may be particularly vulnerable, since there is a higher possibility that they may have arrived as 'dependents' of men. They may not speak either of the official languages of Canada, and family expectations, life circumstances may not allow them an opportunity to learn one of the official languages. They may not be employed. Inability to communicate may have a direct as well as an indirect effect in their dealings with the healthcare system. For example, women who cannot speak or understand English (or French) may find themselves not being able to access the available healthcare system, experiencing delays in the response they receive, or even face problems with inaccurate diagnoses. The authors provide numerous examples to each of these scenarios. In addition, there are also adverse indirect effects of lack of language skills. For example, women may not be able to obtain jobs, and even if they do, they are likely to be paid much less than their English-speaking counterparts. They may feel isolated, and they may experience discrimination and other forms of racism. All may combine to increase the stress levels in their lives. All these adverse conditions do not mean that women are victims. On the contrary, most show amazing resiliency to overcome the challenges. Yet, sometimes, individual patterns of resourcefulness are not enough to alter the social structural adversities. At other times, individual attempts to combat adversities have their additional shortcomings, such as increased stress.
So, in Guruge et al.’s work, as in Bryant’s research (this issue), readers are driven to a similar conclusion: the necessity of governmental policies to address systemic disadvantages and intervene in cases of blatant forms of discrimination. Increasing the availability of language classes, offering them in more convenient locations and during flexible hours are the most obvious recommendations. However, equally important are the raising the standard of living of the immigrant women through higher minimum wages, vocational training, providing better affordable housing and day-care, and combating systemic forms of racism. Although the authors do not address this point, the last economic downturn and the scrambling of the governments to deal with the financial carnage do not provide much hope for proactive policies to address social issues and problems. Again, the problems of immigrants who cannot even give voice to the consequences of their marginalization may be very low on the priority of governments trying to solve issues that receive more vociferous social expression (i.e., closure of automobile plants, solvency of banks, etc.).

The fourth article by Boisvert & Harrell is also about the link between English speaking, immigrant status and health. The authors also look at and/or control SES and age variables. The dependent variable is self-reported eating disorder, which is measured in a variety of ways. The body mass index is also used as a control variable. The self-reported eating disorder symptomatology is measured by items on drive for thinness, body dissatisfaction and what the authors call the 'bulimia' item (which is a question about over-eating). The responses are analyzed for men and women.

What the authors are really after is whether ‘acculturation’ into the norms and values of the host society (Canada, in this case), will have detrimental or positive effects on the eating habits (and health) of immigrant populations. It has been shown in various earlier studies that although immigrant groups arrive, on average, in better health than the average Canadian born populations, they lose this positive advantage through acculturation. Of course, there are additional complexities to the suggested link. For example, 1) do male and female immigrants experience similar adverse effects of acculturation (the present study shows this to be the case), 2) how long does it take for the acculturation to show its negative effects on eating patterns? (the present study looks at only one generation, so it can only speak for that generation), 3) is English speaking a robust measure of acculturation (the authors say yes, but this assertion may be a debatable one), 4) are all immigrants effected through acculturation in similar ways (although distinctions between immigrant groups have not been made in the study, the authors discuss how ties to the cultures of origin may speed-up or slow-down the acculturation process).
In sum, for countries such as Canada which has become the chosen home for extremely diverse groups, not only the entrance-level health, but also the continuation of the health of immigrants are national and social concerns. It is also possible that acculturation may indeed play a negative role in eating habits of some groups, and female immigrants might be more susceptible to this pattern than their male counterparts. However, health of immigrants are also related to the availability of services, and their ability to access them. So, the link between English proficiency might be a more robust index of structural determinants on immigrants’ lives than being just a simple measure of acculturation. In that regard, this journal issue is privileged to have both the Guruge et al., study and the Boisvert & Harrell studies appear back to back.

In article five, Sev’er, Sibbald & D’Arville explore the physical and mental consequences of a rare, but a very serious disease: Mastocytosis. The fact that this disease can take many forms, can cause many ailments, can create visible (skin) or non-visible (internal organ) damage, can hit many age levels, etc. makes this ailment one of the serious orphan diseases of our time. In general, although it disproportionately (maybe almost exclusively) effects ‘white’ people, its occurrence in men and women seems to be equal. However, the authors argue, the gender neutrality in its occurrence does not translate into a gender-neutrality in the process of diagnosis. The complexity and the unpredictability of the triggers and the symptoms make Mastocytosis a very difficult disease to diagnose, in general. Moreover, the symptoms may mimic other diseases, such as anxiety attacks, depression, flushing related to menopause, eating-disorder like symptoms, etc. This being the case, female patients may have a harder time getting an accurate (and sometimes, life-saving) diagnosis. It is quite common that female sufferers get shifted from emergency to emergency, from specialist to specialist, just to be told that there is nothing wrong with them. Some are openly suggested that their problem is in their minds. In the current article, 12 sufferers speak for themselves in showing the loopholes in the diagnostic process. The marginalization of the female patients is also a very important part of these narrations.

Sev’er, Sibbald & D’Arville’s main goal is an educative one, in bringing clarity to a serious disease which is little known so far. They also draw our attention to the gendered responses to a gender-neutral disease, which implies the continuation of gender-stereotypes amongst the health-care providers. However, the current article also sheds indirect light into the over-loadedness and over-specialization of the health-care system. Especially in cases where the symptoms (and damage) of a disease crosses over specialization fields, and the totality rather than individual parts of a patient are affected by this ailment, the
presently preferred medical model of over-specialization becomes cumbersome, possibly very expensive, and ineffective.

The last article by Plagge & Antick is about social support, and looks at the differential perceptions of and reactions to miscarriage versus stillbirth. Two basically homogenous groups of young women (university students) were given vignettes where either a miscarriage or a stillbirth was described. Their responses to the perceived grief of the mother, and the level of fault they attributed to the mother were analyzed. In the grief variable, there were statistically significant differences between the two groups. Respondents assumed more grief in case of a stillbirth. In terms of attribution of blame, there were no statistically significant differences. Both groups of respondents attributed little blame to the grieving mother in the vignette. In terms of the expected discomfort in visiting the grieving mother, there was again a statistically significant difference. Participants (hypothetically) expected more discomfort in visiting the stillbirth versus the miscarriage case.

Of course, this study is at the micro level, with most of its implications geared to interactional (rather than structural) dimensions. Moreover, with the exception of a few respondents who reported some kind of an experience of child-loss (15), the majority were young women whose lives were not previously touched by a similar experience. So, whether the perceptions from these young women are generalizable to perceptions of the larger community cannot be deciphered from the current study. Moreover, given the fact that there are differences between what people say and do in general, we must be cautious in terms of whether these respondents will act in line with their own perceptions, or will act in other ways if they were to face a real event as opposed to a vignette. Yet, these ambiguities are not exclusive to this particular work, but are often applicable to most survey research. Therefore, our knowledge about the workings (or failures) of social support systems can only be further advanced if some of the observations from this work are compared and contrasted with in-depth explorations of the real experiences of women who have actually suffered a loss. What is more clear in the existing literature is the link between social support and the ability of individuals to avoid adverse effects from personal crises. What is also implied is that 'health' is not only a medical, but also a social process.

Aysan Sev'er (General Editor)
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