General Editor's Introduction

At the time of the publication of the December, 2010 issue of WH & UL, the first decade of the second millennia is coming to a close, giving way to the next decade. In utter contrast to the seamless flow of time, issues that pertain to women seem to move along a more bumpy, a more unpredictable path. Moreover, some issues that are of particular concern for women seem to be resilient to positive change, by showing either stagnation or even regressive trajectories.

Most social science research has already illuminated time and time again, why women in the developmentally challenged or marginally developing parts of the world are at disproportional levels of disadvantage in relation to their male counterparts. Earlier issues of WH & UL has also contributed many articles addressing the health concerns of the 3rd world women. Although absolutely crucial, the current issue is not about the challenges for women in the developing world. The challenges that the four manuscripts in the current issue address are those that pertain to women who live in two of the most affluent countries of the world, namely Canada and the United States.

So, why are women’s issues so resistant to change? In my view, there are numerous factors for why women, even in the highly affluent parts of the world, continue to experience conditions that hinder their unabated development. Although readers may have additional suggestions, here are some of the reasons I will offer:

1. There is a general ‘satiation’ in the public, policy level and even social scientific discourses about talking about and/or insisting on a research focus on the gendered nature of social problems. Even when one talks about the triangulation of gender with other imperative social factors such as race/ethnicity and class, the eyes of some of the audience get glazed over as if to say “please, not again”. In Canada, we have seen a long list of Women’s Studies programs change their names and tweak their priorities from ‘women’s issues’ towards ‘Gender and Equity’ or ‘Gender and Social Justice’ studies or similar variations, just to survive academic cuts. Feminism, one of the most powerful driving intellectual forces of the 1970s and thereafter, and perhaps one of the most legitimate forces behind both theoretical and methodological advancements in social sciences, has almost become a dreaded label many scholars run away from, rather than wear with pride.

2. Political conservatism is also shrouding more and more developed nations, and certainly is in full swing in North America. In what appeared to be the exceptionally long eight years of the 2nd Bush administration, the world watched in amazement the unharnessed
actions of one of the most regressive, conservative, right-winged governance in the US history. Rather than addressing social equality and social justice, or world-wide equity issues, the 2nd Bush administration attempted to expand American military dominance over the world, by warring against specifically targeted ‘enemies’. At the end, the rigidly conservative politics and militaristic actions of the 2nd Bush administration brought down even the US on its economic knees, through the instigation of the worst economic crisis since the 1930s depression. Like the implosion of a huge building which takes down smaller constructions around it, the US economic crisis shook, and continues to negatively affect world markets ever since. In the 2008 presidential elections, although the ‘wisdom’ of the American electorate seemed to say “enough is enough” to the painful Bush years by giving extraordinary support to a more liberally inclined leadership—including the Democratic majority in the house, the senate and election of President Obama—the same American electorate substantially reversed its course in mid-term elections in 2010. Basically, and just after two short years, the conservative ‘red’ substantially washed over the more liberal ‘blue’ states, delivering an embarrassing numerical as well as a moral defeat to a more equity oriented governance. Within the shifting tide, Republicans re-gained majority in the house, and substantially added to their presence in the senate. In light of the shifts in representation, even the ‘relatively tame’ health-care reforms accomplished within the first two years of the Obama administration are at the peril of possible reversal.

During the same time period, Canada did not experience major swings in power and governance. Notwithstanding the reversed association of the political party colours (‘red’ for liberals, and ‘blue’ for conservatives), Canadian politics also encompass a more nuanced spectrum (‘green’ for environmental, and ‘orange’ for more socialist parties). Despite their small numbers, the more nuanced distinctions in Canada rather than the polarized splits in the US, may have provided the Canadian politicians a better opportunity to see the complexities of the lives and the needs of their constituents. Moreover, and despite its general affluence, Canada has a much more muted role amongst the world’s economic and military superpowers, so what it does and how it does it, has few repercussions for the rest of the world. The most distinguish clout Canada has is derived from its stance on human rights types of issues. Given these most visible distinctions from its southern superpower neighbour, what is similar is that in the last decade, Canada has also been locked in a conservative
political governance pattern, where economics have mostly trumped other, more socially meaningful priorities. For example, universal healthcare, a singularly crucial distinguishing characteristic Canadians take pride in, has suffered an insidious deterioration in the last decade. Under the auspices of an economic downturn, the conservative Federal Government of Canada has shifted more and more responsibilities to the provinces, especially in education and healthcare, rather than remaining the vigilant protector of high standards of care for all its citizens. This tendency to dump additional responsibilities on the provinces without the provision of sufficient Federal funding, has insidiously chipped away from the otherwise much beloved healthcare delivery system in Canada. Not only fissures between quality of care amongst richer versus poorer provinces and territories, but also fissures between urban versus rural Canada has been the undesirable outcome. Slowly but surely, the social support systems such as government supplements and benefits have also become leaner and meaner. Shrinkages and added-on qualification requirements in myriad of social benefits have hit the poor and vulnerable where it hurts the most: their mental and physical well-being. Women in general, and women as traditional custodians of children, and women as ageing and/or immigrant/refugees constitute the bulk of the vulnerable population categories. Women in general, and racialized women, mothers, and members of immigrant/refugee groups in particular, feel the impact of already limited and/or shrinking social resources. When the priorities of conservative governments disproportionally get focused on the economy, neither social nor cultural concerns occupy the front scene. Problems arising from the triangulation of sex/race/class get pushed down a few rungs in the ladder of importance, as political arguments hone in on social wealth instead of social justice.

3. I also see relentless specialization as part of the problem, although ironically, it is also part of the matrix of solutions we seek. Perhaps the clearest example of this almost ‘contradictory’ and ‘incongruous’ effect of specialization can be seen in the medical field. Through specialization, women have been reduced to brains, hearts, breasts, ovaries, etc. On the one hand, there is no doubt that medical professionals save millions of lives through their extraordinary specialization on parts/organs that may need help and intervention. On the other hand, over-specialization also means segmentation, while the whole is—and should be—much more important than the sum of ‘her’ parts. In an effort to establish ‘legitimacy’ of ‘the science’ in ‘social sciences’, I am
afraid, social scientist have also gone in the way of overspecialization. Through our specialized knowledge, specialized theories and methods, we also end up dissecting women’s problems into a million pieces. For example, we study ‘abuse’, an area which is already mindbogglingly complex in itself. We study ‘immigration’, yet another area which is frighteningly complex. We study ‘HIV’, we study ‘poverty’, we study ‘divorce’, we study ‘addictions’. We look at social phenomenon under a microscope, trying to magnify what is under the lens as much as we can. The information we gather, the data we collect, the observations we make are certainly greatly valuable... as long as we keep in mind that there is a whole other reality out there, which does not fit under the boundaries of our research lens. Although none of our research is capable of looking at every possible link, all the time, it is at least crucial to remind ourselves as well as our readers that our efforts should never been taken in isolation. Just like a healthy heart or a healthy breast cannot exist in a vacuum, but needs a relatively well-functioning body to sustain it, a healthy individual needs a healthy psychological, social, structural, economic environment to sustain that health. Conversely, a problem—be it addictions, HIV, violence—can only be partially understood through putting the individual’s choices and behaviour under a research lens. The lens must somehow be adjusted to incorporate how the social, environmental and structural determinants are impacting what appears to be individual choices.

In the current issue, four manuscripts have tried to address individual problems, by also trying to understand their social and structural contexts. More specifically, the articles have tried to deal with women’s health issues within the triangulation of sex/race/class dynamics. In the first article, Guruge et al., give voice to older immigrant women’s experiences of neglect and abuse. The focus is on a Sri Lankan Tamil sample from Toronto. As the authors contend, ageing of the population is one of the most challenging demographic realities of the 21st century. In a couple of decades, Canadian population over the age of 65 is expected to constitute about one quarter of the total population. Although life expectancy is slightly lower in the US, the expansion of the ageing populations show a similar trend. To complicate the matters, a substantial proportion of the elderly population in general and elderly women in particular are from visible minority and/or immigrant/refugee communities.

Although ageing and violence are social problems facing all groups regardless of their cultural background or place of origin, ageing combined with neglect or violence have particularly dire consequences...
for immigrant/refugee women. In the Guruge et al. article, the Sri Lankan Tamil women provide insights into the complexities of this process. Older women who do not speak at least one of the official languages, women who are economically or legally dependent on their sponsors, and women who do not know or are misinformed about their ‘rights’ in the host country are likely to feel entrapped in patterns of abuse and maltreatment. Loyalty they feel towards their families, the shame that comes from abuse, and communal norms and values which emphasize family privacy also work against reporting of abuse and receiving help. Moreover, and as the authors argue, there are just not sufficient and culturally sensitive community resources to provide help and/or information. So isolation and marginalization of the older women compound the already serious consequences of abuse by family members.

The Stewart et al. article addresses the development of and implementation of programs that help women who smoke. The 44 participants in the study were women from what Canada defines as low income groups. Almost half (20/44) were Native Canadian. These women participated in 3-hour meetings across 14, weekly sessions. The article is about smoking cessation within a supportive environment, where women engage in learning and other targeted activities to help with their addiction. However, what is of even greater social scientific significance is the window the study provides to the gendered difficulties in these women’s lives. Most of the participants are poorly educated (22/44 with high school degree or less), and many are not employed (27/44). Thirty-four of the 44 are receiving some sort of income supplement, disability payment or welfare. Thirty-six participants report an income below $15,000 per year. With the exception of two who seem to be partnered, 42 participants are on their own, either as a never married or as separated/divorced women. Yet, with the exception of seven, all have one or more children to take care of. Nineteen participants have more than three children each. So, although their dependence on cigarettes is certainly a health-related issue that the carefully designed programs have tried to ameliorate, the difficulties in these women’s lives require much more integrated social commitment, both at economic and governmental levels. The readers glean a picture of the dire needs of these women—and probably many like them—when participants express concerns about not being able to find baby-sitters during the evenings, or not having enough tokens/tickets for transportation. Participants express gratitude for little gifts and food packages the program organizers have provided, which also reflect their need for basics in life. The fact that almost 1/2 of the participants in the program were Aboriginal women also brings race/class/gender issues into focus even within the diversity consciousness of an affluent society
such as Canada. The poor and the vulnerable women still need help with the most basic human needs, in addition to needing help with their addictions.

The last two articles in this issue pertain to vulnerabilities of women in relation to their sexual health. Both articles focus on North American patterns—mostly the US. The Sharp et al. article is about HIV infection rate amongst women, especially the poor, visible minority and substance-dependent women in the US. Indeed, HIV related problems of the underprivileged groups of women have reached discerning proportions. As scholars of the medical field, the authors do touch upon women’s physiological vulnerabilities to sexually transmitted diseases. Yet, as they also agree, physiological determinants only explain a minute proportion of the overall gendered vulnerabilities of women. Much more important determinants of women’s health issues are related to the distribution of power in intimate relationships, and vulnerabilities that emerge from class/race/ethnicity within highly stratified societies. In most discussions of women’s health, the structural vulnerabilities indeed trump whatever physiological and even psychological factors that may exist. As the authors concede, some characteristics of women themselves require study in understanding and remedying their specific vulnerabilities in sexual health issues. However, as researchers, scholars, medical personnel or policy makers, one can never begin to address sexual health problems that specifically target women unless one also understands women’s socioeconomic and sociocultural disadvantages. For example, it is exceptionally telling that one of the groups that has been showing the highest new HIV infection rates in North America is heterosexual women in marriage or marriage-like relationships. It is also telling that the infection rates are much higher amongst racial and racialized groups of women.

The Elifson, Klein and Sterk article also addresses women’s sexual health issues by looking at predictors of unsafe sex. In the study, responses from 178 sexually active adult women are analyzed to find why women engage in safe or unsafe sexual behaviours. Elifson and his colleagues have chosen their sample from what they consider to be an ‘at risk’ population. In their conceptualization, at-riskness of a population is related to specific demographic and socio-economic determinants, such as low education, employment, income, living in drug and crime infested neighbourhoods, and having little or no access to adequate healthcare. In the study, the concept of ‘risk’ is also equated with the sexual behaviour and choices of women. As ‘rational’ individuals, women are expected to weigh the ‘risks’ of engaging in one type of behaviour against the ‘risks’ of not engaging in that particular type of behaviour. For example, a woman in a stable, long-term heterosexual relationship may find it more risky to insist that her partner use a
condom, than to engage in non-protected sex. Whereas, a woman with a casual sexual partner may feel that not insisting on partner’s condom use may risk her bodies exposure to potentially numerous and possibly deadly STDs. Indeed, one of the most highly predictive factors the results show is the marital status of women.

However, and as the Elifson et al. article carefully articulates, simple ‘rationality’ related arguments, by themselves, are not capable of explaining the choices of women. For example, one would assume that women who have access to correct information about protection condoms provide will be more likely to use or insist on the use of condoms by their sexual partners. In fact, the correlation between knowledge and condom use is shown to be tenuous indeed. Instead, more of the apparent choices are based on other factors (such as having had two-drug using parents, having experienced childhood abuse and neglect, etc.) rather than access to knowledge. Moreover, in a large proportion of heterosexual relationships where gendered power is not balanced, women’s choices may not be a true choice at all, but may consist of acts that reflect their relative powerlessness. Just to give an example, in abusive heterosexual relationships, do women really possess the power to demand compliance—condom use—from a sexual partner without risking a physical or sexual retaliation? Do homeless women who live on the mean streets (like the sample of women in this study which is specifically drawn from a disadvantaged population of women) really have a say over the sexual and reproductive aspects of their bodies? Although the examples I have provided may not apply to all women all the time, they still invite us to contest the otherwise uncontested conceptualizations of ‘rational choice’.

Despite the pitfalls behind assuming straightforward ‘rational’ choice arguments, Elifson et al.’s article still provides insights into the statistically varifiable determinants of women’s risk taking behaviour in sexual practices. What the findings show is that traumatic early experiences (parental addictions/childhood abuse and neglect) do explain some of the variation in propensity to engage in unprotected sex. Age (older, more against condom use) and self esteem variables (the lower the esteem, the lower the condom use) also reach statistical significance in explaining women’s behaviour.

Due to the specificity of their research questions, neither the Sharp et al. nor the Elifson et al., article has asked questions about why it is that so many women are already in vulnerable population categories in the first place. Why is it that in the most affluent nation of all—the US—black women and other women of colour are disproportionately likely to remain in at risk categories. The US is not the only culprit, since the earlier two articles that address health issues in Canada also show the interactions of gender with ethnicity/race/class. In the Guruge et al.
article, the compounding factors are immigration status and age, and in the Sharp et al. article, the compounding factors are Aboriginal status. So, regardless of what the individual questions are (addictions, abuse, sexual behaviour, etc, etc.), and regardless of what the individual answers to the research questions appear to be (be it more information, more services, more individual esteem, more sensitivity towards childhood experiences, etc. etc.), what really keeps the social matrix of problems is the existence of systemic and structural disadvantages. Poverty, differential access to resources, possible racism or racialization of groups, and gendered power differences are the nubs in this social matrix. Solutions to singularized problems related to smoking, or abuse or sexual behaviour can rarely be meaningfully addressed unless as educators, researchers, policy makers or health-care providers we also address the structural determinants that lock women in general, and older women and women of colour in particular, to disadvantageous locations in the societies we live in.

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