

ESL Speaking Immigrant Women's Responses to Creating and Using a Photonovel in
Order to Raise Their Critical Consciousness and Understand a Specific Health Topic

By

Laura Nimmon

B.A., Malaspina University-College, 2000

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B.A., Malaspina University College, 2000

Supervisory Committee

Dr. Deborah Begoray (Department of Curriculum and Instruction)

Supervisor

Dr. Robert J. Anthony (Department of Curriculum and Instruction)

Departmental Member

Dr. Darlene Clover (Department of Educational Psychology and Leadership Studies)

Departmental Member

Dr. Irving Rootman (Faculty of Human and Social Development)

Outside Member

Supervisory Committee

Supervisor

Departmental Member

Departmental Member

Outside Member

Abstract

The process of creating and using participatory photonovels can empower immigrant ESL speaking women and also act as a tool to educate these women about a specific health topic. This was a qualitative case study that was conducted at an immigrant society in an urban center in British Columbia. The ESL speaking immigrant women in this study created a photonovel called *From Junk Food to Healthy Eating: Tanya's Journey to a Better Life*. The findings of this research reveal some of the health experiences of ESL speaking immigrant women in Canada. The results also contribute to the growing body of knowledge that discusses effective or ineffective means to educate ESL speakers about health by improving their health literacy. Most notably, however, the photonovel project engaged the women in an educational process that raised their critical consciousness.

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*I have, as an educator, the right to think and dream about a world that
is less oppressive and more humane toward the oppressed, just as the
poet has the right to write and dream about a utopian world.*

Paulo Freire (1995)

DEDICATION

This thesis is dedicated to immigrant and refugee women who come to Canada. My sincere hope is that you are happy, healthy, and free in your hearts here in your new country and that this small contribution facilitates this in some way.

Your presence is an honour.

In Memory of Maki Yamamoto
1948-2007

*I have only one desire: that our thinking may coincide historically with
the unrest of all those who are struggling to have a voice of their own.*

Paulo Freire (1970)

CHAPTER 1
INTRODUCTION

Once we differed
But the backdrop of life
Told me that your membership
Is my ticket
To the advantage of life

Laura Nimmon (2005)

In 2000, I lived in South America and, in 2003, in Italy and was deeply moved by being able to work with others who come from a different cultural background and understanding about the world. It wasn't the role of being a teacher that I was fond of, but the incredible privilege I was offered by being able to work closely with people from different cultural backgrounds. I found that through teaching others from a different culture, I was involved in a constant exchange, where I was learning as much from the students as they were from me. This opportunity certainly changed my life and inspired me to spend my professional career working in multicultural settings. Hence, upon returning to Canada, I worked as a volunteer teacher at the Intercultural Association (ICA) of Greater Victoria, which is a place where immigrants and refugees go to learn English. I also found this to be an incredible teaching experience because of the students' eagerness to learn and the fascinating life stories that they brought to the classroom. I felt honoured to work daily in my own country with people who come from such rich cultural

backgrounds. Thus, since I first applied to graduate school I was certain that I wanted to focus my research on improving the lives of Canadian immigrants because I had enjoyed working with this population so much when I was teaching.

When I really think about it, however, I believe that the main reason I am choosing to focus on research that may lead to improving the lives of immigrants is because of how I was treated when I was living abroad, which was with open arms and warm hearts. Furthermore, I believe that when immigrants relocate to Canada it provides our country a unique opportunity to diversify and gain all the cultural richness that these people carry with them. My experience of connecting with others from different cultures and the impact this has had on me has led me to want to give back by helping people migrating to our country with their transition.

One topic of specific importance to immigrants is health literacy. Of the many approaches aimed at educating ESL speakers about health information; that is, in assisting them to become more health literate, user-created participatory photonovels are an effective way to have them think and learn about health (Rudd & Comings, 1996; Wang & Burris 1994; James, et al., 2005). A photonovel is participatory because it gives learners the opportunity to choose a specific topic and create the photonovel themselves. Based on Freire's educational philosophy that promotes critical consciousness and empowerment; having participants create the words and images to form a health-specific photonovel challenges a more traditional educational approach where the learner is a receiver and not a creator of information (Wang, Yi Kun, Tao Wen, & Carovano, 1998; Wang & Burris, 1994).

THE HEALTH OF IMMIGRANT WOMEN IN CANADA

According to the Canadian Public Health Association (2006) despite Canada's having one of the healthiest populations in the world, major health disparities continue to persist, especially in female population groups. In particular, immigrant women have been reported to have poorer health status than Canadian-born women. Immigrant women experience greater stress, are less likely to know preventative behaviours, and have lower health care use rates (Hyman, 2001). Immigrant women tend to be at a lower socioeconomic status than Canadian-born women; and they also face a lack of host language skills, have a lack of access to dignified jobs and uncertain legal status. Despite high education levels, immigrant women tend to earn less, are more likely to be unemployed or underemployed, and are more likely to live in low-income situations than their Canadian-born peers (Meyer, Torres, Cermeno, MacLean, & Monzon, 2003). These immigrant-specific conditions are also superimposed on other systems of oppression, such as class, race and ethnicity, to further increase women's feelings of vulnerability (Menjivar & Salsido, 2002). Most troublingly, "there is also growing concern in Canada that immigrant and minority women are not always included in health research" (Anderson & Hatton, 2000).

THE PRESENT IMMIGRANT EXPERIENCE IN CANADA

Currently, and somewhat serendipitously, immigrant people are the focus of much media attention in Canada, perhaps due to their increase in numbers; and because of this, there is an increasing awareness within the Canadian public of the social issues they face. For example, Statistics Canada (2005) predicted that Canada's immigrant numbers are going to increase substantially over the next decade. Depending on the growth scenario,

this would be an increase ranging from 56% to 111% starting from 2001, when immigrant numbers were estimated at about 4.0 million. Immigrant numbers may, thus, rise to 8.4 million. In contrast, the projected increase for the rest of the Canadian population was estimated at between only 1% and 7% between 2001 and 2017.

In March 2006, the *Globe and Mail* published an article (Reinhart & Rusk) shedding light on to the experience of Canadian immigrants. “Immigrants can suffer in silence within walls of suburbs: Isolated lifestyle can become a recipe for depression, resentment and even death”. The article discusses the strong sense of community that many immigrants had before they came to Canada and that “everybody looked out for everybody else” (p. A7). Upon arriving Canada, however, many immigrants describe their lives as “living within walls” and “suffering in silence behind walls made thicker by cultural alienation” (p. A7). Three days after this article was published, the *Globe and Mail* released another article entitled: “Help is in wrong places for newcomers to Calgary: Immigrant services mostly lacking in affordable outlying areas” (Walton & Armstrong, 2006). While the suburban lifestyle is the dream for many Canadians, for newcomers to Calgary it can be a nightmare. Services that immigrants need tend to be in the downtown. Access to services, for example, in the more affordable suburbs can be difficult for those with limited language skills. Another recent article about the immigrant experience by the reporter Elatrash (2006) for the Montreal newspaper *The Montreal Mirror* found that non-status immigrants in particular face major obstacles to accessing health care in Canada due to their immigration status and the fact that they have no medical coverage. An article in the *Globe and Mail* stated that the Canadian Institute for Health Information (2004) had found that when women move to Canada from another

country their health actually decreases. One factor in the media that has been considered is that “a lack of language skills make many women reluctant to leave their house at the best of times and the shame of medical issues compound this” (Reinhart & Rusk, p. A7). Thus, my research is timely because the situations and the health of immigrant people in general, and also more specifically women, is currently gaining a lot of attention in Canadian media.

STATEMENT OF PURPOSE

My research will look at how the process of creating and using participatory photonovels can empower immigrant ESL speaking women and also act as a tool to educate these women about a specific health topic. Photonovels are formulated like comic books, but they contain photographic stills with balloon-captioned text that is usually expository; that is, it is meant to inform the reader about something (e.g., Flora, 1980; James, et al., 2005; Rudd & Comings, 1996). This research is unique because it is the first study to be done that uses the photonovel as a health literacy tool with ESL speaking immigrant women in Canada.

The findings of this research reveal some of the health experiences of ESL speaking immigrant women in Canada. The results will contribute to the growing body of knowledge that discusses effective or ineffective means to educate ESL speakers about health by improving their health literacy. I also hope that this research will help create awareness for other health professionals and ESL instructors concerning ways to effectively deliver health content, in a method that embodies empowerment, to a vulnerable population of ESL speakers. Most importantly, however, my research aims to create an avenue for ESL speaking immigrant women to become full participants in our

society by providing them with access to health information that is comprehensible to them on many levels and engages them in an educational process that raises their critical consciousness. The following chapter presents the literature that forms the theoretical basis of this study.

CHAPTER 2

LITERATURE REVIEW

Language is one door to access power as an immigrant woman.

Mohab, 1999

INTRODUCTION

This literature review has several components. I will discuss a background about literacy in Canada to illuminate the dilemma our country is facing because of high functional illiteracy rates: highlighting the significance of research that focuses on ways to inform Canadian people about health information. Next, I will define the term *literacy*; health literacy and critical health literacy are then given. I will then provide some background about some of the general factors that may affect immigrant women's health upon moving to Canada. As language barriers are one of the main factors affecting immigrant women's health in Canada, I will review the literature that discusses effective ways to inform ESL speakers about health information. The methods discussed and reviewed are: (a) the simplification of patient education materials (PEMs), (b) the use of symbols and pictures in PEMs, (c) using oral instruction with text, (d) culturally relevant approaches, and (e) participatory educational methods. Participatory education is then discussed as being an empowering strategy and important way to promote the health for the women in my study. Finally, the participatory photonovel is introduced as an effective health literacy tool. The literature review then concludes with the hypothesis that having the ESL speaking immigrant women in my study create participatory

photonovels will be an effective means for them to comprehend health information and engage in an empowering educational process.

A BACKGROUND: LITERACY AND HEALTH

Literacy is a socially constructed concept, and the definition varies depending on culture and historical concepts. In other words, literacy is not a state of being but a reflection of the relative fit between the individual's various competencies and the social and historical environment (Roman, 2004). Prior to the industrial revolution, literacy in the general population was not deemed to be a social problem because reading and writing were not necessary in early industrial and agricultural occupations. Today, however, in Western society education is the norm; and many people correlate literacy levels with educational levels. However, some research suggests that levels of literacy are not directly linked to years of schooling (Baker, Parker, Williams, Clark, & Nurss, 1997). Rather, "literacy seems to be a product of both educational attainment and life experience" (Roman, 2004, p. 81). Other research shows that, although there is a contestable relationship between educational attainment and literacy, education by itself is not a proxy for ability level (Baker, et al., 1997). However, the majority of the research indicates that students in Western countries who have less than nine years of schooling have not achieved functional literacy skills (Rootman & Ronson, 2005).

Historically, the term literacy has expanded from easily quantifiable measures (the number of years of schooling and being able to create phonetically correct output of the written word) to being able to accurately comprehend text (National Center for Education Statistics, 2005). Today, literacy is defined in general as being able to "read, write, speak proficiently, to compute and solve problems, and to use technology in order

to become a life long learner and to be effective in the family, in the workplace and in the community” (Roman, 2004, p. 81). As stated by the UNESCO (2002), literacy is important because it is the key to the toolbox that contains empowerment, a better livelihood, and participation in democratic life. As well, it contributes to other skills needed for an individual’s full autonomy and capacity to function effectively in a given society. Wink (2005) also noted that literacy today helps us make sense of our world and helps us act upon it. She believes that critical literacy can help us understand the world, power structures, and our role in these power structures. According to Taylor (1993), Freire suggests that literacy is not simply the mechanical process of reading and writing but is more fundamentally the process of conscientization and a necessary means of liberating people from the culture of silence in which they have been oppressed.

In the mid-1980s, a cross-country literacy survey of over 2,300 Canadian adults was conducted. The results apparently “shocked Canadians who had not realized that almost one quarter of Canadian adults could not perform simple tasks such as reading road and building signs or locating the expiry date on a driver’s license or the place to sign a registration form” (Rootman & Ronson, 2005, p. 3). A decade later, Statistics Canada had carried out several surveys that have found that 32% of the adult population had difficulty with reading and numeracy tasks commonly encountered in everyday life (Statistics Canada, 1990). This means that 32% of the Canadian population was functionally illiterate. Functional literacy is one’s ability to process and generate information from his or her surroundings. This population did not have the literacy skills to function in Canadian society; that is, they have trouble using reading, speaking, writing, and computational skills in everyday life situations. Finally, in 2003, the

International Adult Literacy Survey (Statistics Canada, 2005) found few improvements in the overall literacy of adult Canadians since they were assessed a decade ago. In both instances, around two in five 16- to 65-year-olds scored below Level 3 in prose literacy, which is the desired threshold for coping with the increasing skill demands of a knowledge society. Notably, however, the 2003 survey found that immigrants performed significantly lower than the Canadian population with about 60% of immigrants falling below Level 3 in prose literacy, which compares to 37% of the Canadian-born population.

A specific form of contextual literacy that has recently emerged is health literacy. Health literacy is “the ability to read and comprehend prescription bottles, appointment slips, and other essential health related materials or the capacity to obtain, interpret and understand basic health information and services needed to make appropriate health decisions” (Ratzan & Parker, 2000). People with inadequate health literacy skills often have difficulty understanding diagnosis, discharge instructions, and treatment recommendations. Pamphlets and other written materials often require at least a ninth grade reading comprehension level (Wilson, 2003). More precisely, inadequate health literacy directly affects patients’ abilities to follow instructions from physicians, take medication, understand disease-related information, learn about disease prevention and self-management, and understand their rights. Health illiteracy also affects patients’ abilities to access care, in particular because of difficulties completing application forms (Roter, Rudd, & Comings, 1998). Most significantly, however, it increases the chances of dying of chronic and communicable diseases (Wilson, 2003) and the right to be a full citizen with all the rights and privileges we enjoy in Canada. Through its administration

of the Canada Health Act, Health Canada (2004) is committed to maintaining this country's renowned health insurance system, which is universally available to permanent residents and accessible to everyone; even those with financial difficulties. However, even though there are no perceived barriers to accessing Canada's public health care system, many ESL speakers still face obstacles obtaining health information because it is incomprehensible to them (Wilson, 2003) and because health care is only a privilege allocated to Canadian citizens and not non-status immigrants (Elatrash, 2006).

Nutbeam (1999) argues, however, that the traditional definition of health literacy (an individual's capacity to read and comprehend medical information and instructions) misses much of the deeper meaning and purpose of literacy. By facilitating access to information, critical health literacy enables individuals to make informed choices, to influence events, and to exert greater control over their lives. In fact, critical health literacy is defined by the World Health Organization (WHO, 1998) as more than being able to read pamphlets and successfully make appointments. Critical health literacy involves the ability to analyze information critically, increase awareness, and participate actively to use information to exert greater control over one's life, which allows for greater autonomy and personal empowerment. In short, health literacy has emerged as a critical component of functional literacy; and a lack of it arguably leads to the most detrimental consequences for both the individual and society.

A Vulnerable Population

Some of the most vulnerable populations in Canada today are new immigrants. As mentioned in Chapter 1, studies show that for many their health actually deteriorates after they arrive here. For example, the researchers at the Canadian Institute for Health

Information (2004) examined health data from the 2000-2001 Canadian Community Health Survey and found that the majority of immigrant women initially said that they were in good to excellent health for the first two years after arriving in Canada. However, after having been in Canada for two years, when they were asked again, immigrant women responded that they tended to have poorer health and had developed chronic health conditions like arthritis, diabetes, or asthma. Furthermore, Hyman, Guruge, Makarchuk, Cameron, and Micevski (2002) noted that this “healthy immigrant effect refers to the observation that immigrants are often in superior health to the native-born populations when they first arrive in a new country, but lose this health advantage over time due to changes in determinants of health such as diet, social support and stress”. In addition, according to the Canadian Institute for Health Information (CIHI), despite Canada’s open access public health care system, language barriers may prevent immigrants from accessing it. Boyd (1991) claimed that, while literacy rates for Canadian adult men and women are comparable; immigrant women have lower literacy rates on average than men. Issues such as the linguistic and informational barriers to health care must be addressed if immigrant women are to achieve optimum health status for themselves and their families (Hyman, et al., 2002) because, according to Simms (2003), the inability of large numbers of immigrant women to speak English well is a major obstacle to them accessing services like health. Language is one door to access power as an immigrant woman (Mohab, 1999). Therefore, I will, later in the literature review, present research that discusses effective materials and teaching practices that are aimed at or can be used effectively with this particular cohort of Canadians. First of all, however, I

will provide background into some other factors that can affect an immigrant woman's health living in Canada: diet, money, and social support.

OTHER FACTORS THAT AFFECT IMMIGRANT WOMEN'S HEALTH

ESL speaking immigrant women have unique health literacy needs because their lack of language skills impedes their ability to comprehend health information and, therefore, affects their overall health status. However, for this aspect of my research, I have also taken a more general perspective and looked at research that discusses the dynamic interplay of factors that can affect immigrant women's health status after immigrating to Canada. For example, social, economic, and political forces can play a crucial role in determining the subjective health experiences of immigrant women (Anderson, 1985; Simms, 2003). Also, research illustrates that immigrant women experience a decrease in health because of changes in traditional values, a lack of social support when they move here (Choudry, 2001), an inability to communicate well in English, and feelings of helplessness that create a sense of psychological isolation, leaving them with a devalued sense of self (Guo, 2004). This background review presents some of the other factors that can affect an immigrant woman's health after arriving in Canada.

Diet

One of the factors that may affect immigrant women's health upon moving to Canada is dietary patterns. According to Hyman, Guruge, Makarchuk, and Micevski (2002), before migration many immigrants, especially those from non-Western countries, consume a healthy diet but this changes upon migration. In fact, these researchers noted

that changes in diet following migration are often associated with hypertension, diabetes, coronary heart disease, and some cancers.

Researchers have found several reasons for changes in immigrant people's diets. Tong (1986) noted that unfamiliar foods and a different food marketing system are among the most pressing problems confronting Vietnamese immigrants in America. Some of the reasons Vietnamese immigrants changed their eating patterns were because (a) many women worked outside the home and had less time to shop for familiar foods, (b) women had less time than in Vietnam to prepare traditional meals and don't have any kitchen help anymore, and (c) there was pressure to adapt to an American lifestyle and eating habits. Brimacombe (2006) noted that the refugees in a resettlement classroom on Chicago's north side did not understand how to eat American food but went, instead, immediately to consuming so-called junk food. Brimacombe reported that one of the major challenges in this program was to change the way refugees think about food. For example, they purchased fizzy orange drink and crisps, believing they were a great source of vitamins because of their colour.

Welsh, et al. (1998) also discussed how factors such as (a) the availability and price of familiar foods, (b) the quality of food items, (c) being able to understand the labelling of foods and their ingredients, and (d) access to fresh foods and vegetables from the immigrants' own countries were pertinent to a healthy diet. Pan, Dixon, Himburg, and Huffman (1999) found that dietary changes were related to (a) the length of exposure to the new environment, (b) social contact with people of the new culture, (c) educational programs, and (d) the ability for the immigrants to understand a new language.

Another interesting reason that immigrants might succumb to unhealthy North American eating habits is because new immigrants want to fit in and be a part of our food culture. Sampson (2006) recently wrote an article for the *Globe and Mail* titled “Fat Nation”, which suggested that people who cannot afford to eat well “have their faces pressed against the window of a consumer society. They want to join the party and food is a symbol of belonging. That can translate into visiting KFC or drinking Coke, just like the ads tell people to do” (p. D2). Actually, the impact of Western food values on people’s eating habits is an issue that is not only prominent in Western countries but in other non-Western countries as well. McCabe (2006) recently released an article in the *Times Colonist* entitled “in the new China, obesity is blossoming like Buddha Belly” that speaks to the fact that “fueling the obesity problem is the Westernization of the country’s diet ... and the evidence is in places like McDonald’s and Kentucky Fried Chicken, both of which have become places to go in China’s capital” (p. D6). Actually, McCabe notes that Jiang, the deputy general secretary of the Chinese Cuisine Association, calls China’s eating habits “one of the toughest problems China is facing today”, which provides evidence for the impact that Western food values is having on other countries around the world (D6).

Money

Money is a second factor that affects immigrant women’s health. According to Hyman, et al. (2002), it is well established that immigrants are disproportionately poorer than the general population. Actually, despite immigrant women’s high education levels, they tend to earn less, are more likely to be unemployed or underemployed, and are more likely to live in low-income situations than their Canadian born peers (Meyer, Torres,

Cermeno, MacLean, & Monzon, 2003). Although it has been hypothesized that language barriers impede immigrant women's health upon moving to Canada (Canadian Institute for Health Information, 2004; Hyman, et. al, 2002), Hyman, et al. (2002) also found "that poverty influenced the acquisition of safe, nutritionally adequate and personally acceptable foods" (p. 126). This is confirmed by Welsh, et al. (1998), who found that what seemed to be one of the common concerns among the immigrants interviewed in their study was the price paid for accessing food items. Pan, Dixon, Himburg, and Huffman (1999), in their study that collected information on changes in dietary patterns among Asian students before and after immigration to the United States, found that some possible explanations for unhealthy diets were an increase in factors such as (a) limited time to prepare foods in America, (b) an increase in the number of men preparing food, (c) economic constraint because of limited money to spend on food, and (d) an increased availability of other American style foods. Complicating this dilemma are issues such as imported foods and specific cultural foods being more costly than Western foods more typically found in a North American grocery store (Hyman, et. al., 2002).

Social Support

Social support is the third factor that likely plays a part in immigrant women's health once in Canada. According to Lee, Arozullah, and Cho (2004), individuals are social actors residing in social environments that contain various degrees of support and resources. They noted that the concept of social support is far from new to social science researchers and that more than two decades of research have proven that both seeking and receiving assistance from other people constitute major forms of coping behaviour. The authors suggest that the positive resources and support in individuals' social networks can

improve their ability to understand and acquire medical information and to negotiate the health care system. Notably, many immigrant women who come to Canada experience feelings of being cut off from their typical social support network, which affects their ability to obtain and understand health information. For example, Reinhart and Rusk (2006) wrote an article in the *Globe and Mail* about the isolation that many immigrants experience when living in Canada. Many immigrant women stay at home while their husbands work, which is “a recipe for depression and resentment, which often can’t be expressed, since the lively village atmosphere of home is replaced by compartmentalized, isolated suburban living” (p. A7). Women can often feel shame around a medical or psychological issue, which is compounded by the fact that they may be feeling depressed and do not want to talk about health issues that cause them concern. Parikh, Parker, Nurss, Baker, and Williams (1996) also found that shame was a deeply harboured emotion that plays an important role in understanding how low-literate patients interact with health care. We need to consider that social support is an important moderator for being healthy in Canada. Social groups can support individuals as they learn about health by employing a variety of literacy strategies.

HOW TO BEST EDUCATE ESL SPEAKERS ABOUT HEALTH INFORMATION

Within the current research, some of the discussed methods to educate ESL speakers about health information are through (a) the simplification of patient education materials, (b) visual literacy approaches, (c) oral instruction with text, (d) culturally relevant approaches, (e) participatory educational methods, and (f) participatory photonovels.

The Simplification of Patient Education Materials

Many researchers have suggested that patient education materials (PEMs) need to be made easier to understand. For example, Horner, Surrat, and Juliusson (2000) looked at improving PEMs through the adaptation or creation of new materials to meet the health needs of diverse populations. Their education program was part of a community-based intervention project to improve children and parents' management of asthma. The parents read at about a grade five level. Horner, et al. noted that, although many health-related organizations created PEMs that targeted specific diseases, they failed to produce materials understandable to the most vulnerable populations (i.e., second language speakers). For example, some of the PEMs that they looked at were created for a grade nine level, and many did not include visuals to clarify print text. On the contrary, Horner, et al. found that the steps to successful revision meant simplifying the language to a grade five level. The authors did this through using fewer multi-syllable words, with more direct language, illustrations, and used examples that were culturally relevant to the topic and target population. After making their alterations in the PEMs, they used the Flesch Readability Formula and found that the revised writing was, appropriately, a grade five or six level. There was no follow up done after this study, however, to see if the PEMs the authors created were more effective in informing vulnerable populations about health.

Many other researchers also suggest that simplifying the language in patient education materials will make them more comprehensible for learners. Mayeaux, et al. (1996) discussed techniques that physicians can use to improve communication with patients with low literacy or who are second language speakers. They contend that by combining easy-to-read written patient education materials (meaning simplifying the

language) with oral instructions will greatly enhance patient understanding. Dowe, Lawrence, Carlson, and Keyserling (1997) randomly assigned patients from a general medicine clinic to read a drug leaflet written at a low or high level of reading difficulty. They found that the participants, who had less than a ninth grade education, were more likely to read the easiest leaflet than those who received more complex materials. However, the researchers did not do a follow-up test to see if the participants actually understood the material.

Common sense indicates those with low literacy levels or who speak English as a second language would have less difficulty with health literacy materials that are written at a lower reading level. However, research indicates that there is a weakness in this claim because the strategy of simplifying written materials falls short of addressing patient needs. The research shows that simplifying the language improves comprehensibility in written education materials, but it does not necessarily create sufficient comprehensibility so that crucial health information is understood and remembered. Weiss (2001) confirmed this discrepancy by stating that, although health education materials have been developed for low literacy patients and second language speakers, there is minimal evidence that these interventions have any effect on the health status of these individuals. The author noted that available research indicates that patients with limited literacy and language skills prefer simpler educational materials and they find them easier to use, but the evidence is conflicting. Weiss commented that, in fact, there is very limited data available about how to best address the needs of patients with limited literacy and language skills. This finding alerts researchers, health care workers,

and teachers that merely simplifying patient education materials for low literate and ESL learners may not be sufficient to educate these people about health information.

Alternative approaches in relaying health information to low literate and ESL learners are (a) visual literacy approaches, (b) oral instruction with text, (c) culturally relevant approaches, (d) participatory education, and (e) participatory photonovels.

Visual Literacy Approaches

The contention that simplifying patient education materials is not sufficient in raising comprehension to an adequate level forces us to look at other solutions and approaches to the health literacy dilemma. Visual literacy is the ability, through knowledge of the basic visual elements, to understand the meaning and components of images. In fact, according to Wilde (1991), the majority of information absorbed by human beings is collected through visual imagery. It seems logical to emphasize the development of visual skills as a way to deliver health information to others. The effects of concreteness and imagery on reading and text recall have also been well-established by researchers such as Paivio, Welsh, and Bons (1994) who found that concreteness and imagery effects have been found to be among the most powerful in explaining performance on a variety of language tasks because they are imaginable, comprehensible, memorable, and interesting to the reader. However, as Freire (1970) suggested, it is important that people learn to not only decode and think critically about the written word but also to learn to do this with visual messages. Using visuals with text is effective in relaying health information to ESL speakers. If we ignore the connection between the visual and the verbal, we would be ignoring years of research that emphasizes their interdependencies in the learning process (Hobson, 1998).

Levin (1996) looked at the value of symbols as a means of promoting healthy food choices in the cafeteria at an urban work site. The intervention consisted of placing heart-shaped symbols next to targeted, low-fat entrees on the list of available food choices. The author found that sales of targeted, low-fat items increased significantly from baseline over the intervention period of 28 weeks. Levin noted that one of the most positive features of this promotion was its application to populations with low literacy skills because it used no written materials other than a poster with minimal words and relied primarily on a single symbol to draw attention to recommended foods. It is likely symbols in health education materials would be easily understood by ESL speakers as well, if they were educated about their meaning prior to viewing them; however, to date, there are no studies that test this contention.

Semiotic principles are widely used in the production of commercial promotional material but virtually ignored in health promotion campaigns (Finan, 2002). She believes that visual codes are read by the viewer and are interpreted by the viewer's past experience, knowledge, and sociocultural background. Most interestingly, Finan noted that for a person to understand an image they must employ and understand culturally embedded sign systems, otherwise the viewer might establish a totally different message from that which the author intended. Thus, for second language speakers (who are new to our country) to understand many of our culturally driven, visual code systems, they likely need to be taught or guided how to decode the visual text. Unfortunately, advertising linking 'the good life' in the West often visually promotes unhealthy lifestyle choices.

Michielutte, Bahnson, Dignan, and Schroeder (1996) investigated the use of illustrations accompanied by a narrative text to improve readability of a health education

brochure. There were two versions of the brochures. One had bullet text presented with no illustrations, and a second version had more difficult text formatted in a narrative style together with drawings designed to complement the text. The authors then used a randomized study to test women for comprehension, perceived ease of understanding, and overall rating of the two brochures. Among poor readers, comprehension was significantly greater for women who read the brochure with illustrations and narrative text, with no difference in comprehension of the two brochures for better readers. The results suggest that the use of aids, such as illustrations and text style, can make health education literature more accessible to high-risk populations, while remaining interesting enough to appeal to individuals at all levels of reading ability. This finding is applicable when considering the needs of ESL learners who would benefit from reading a brochure with illustrations because of their lack of English language vocabulary.

Finally, Houts, Witmer, Howard, Loscalzo, and Zabora (2000) found that recall of spoken medical instructions was greater when pictographs accompanied spoken instructions. The participants were 21 adult clients of an inner city, job-training centre (25% spoke English as a second language); all of them had less than fifth grade reading skills as measured by the Test of Adult Basic Education. Houts, et al. chose several pictographs representing actions and showed them to the participants. Four weeks later, the participants returned and were tested for their recall of pictograph meanings. The results indicated that when pictographs are shown during learning, people with low literacy and/or language skills could recall large amounts of medical information for significant periods of time. Based on the findings of their study, Houts, et al. hypothesized that oral instruction with pictographs is more effective with these patients

than written instruction with pictographs because, in their opinion, “for people who cannot read, written materials are not useful” (p. 231). Based on the research above, it appears as though having visuals in health education materials would contribute to increased comprehension for ESL speakers.

Oral Instruction with Text

Although there is limited research in this area, another strategy that has been suggested in efforts to complement or replace written material is through the use of oral instruction. Aside from Houts, et al. (2000) discussed above, there are very few other researchers who have suggested using oral language in relaying health information. Mayeaux, et al. (1996) suggested that physicians use oral instructions following written instructions. They also advocated that health care workers reinforce oral education with easy-to-read patient education materials. The authors advised that physicians demonstrate procedures, repeat the information several times, and ask the patient to repeat the instructions to ensure that they understand the information correctly. Such advice, however, may be unrealistic when considering the time restrictions doctors often have with patients.

Another perspective to this discussion, however, comes from Eggington (1997) who hypothesized that for a traditionally oral cultural group the acquisition of higher literacy skills is more a group social issue than an individual pedagogical one. The author noted that the teaching and acquisition of survival literacy skills in a functional literacy paradigm allows individuals to participate in society only to the extent that the society’s power structures permit. Inculcating literate cultural values into a predominantly oral cultural group will help this minority culture gain control over their community’s

educational process. Eggington proposed that oral cultural values and literate culture be taught so that an oral community can function in the literate society. As a result, they will have more control over their lives and be able to access the dominant power structure. As the Freirian expert Macedo (2003) noted, the reason why masses of illiterate people could comprehend Freire's language so well had little to do with language and everything do to with ideology. He noted that this is because people often identify with representations that deepen their understanding of themselves. The community that Eggington looked at was an Aboriginal community in Australia, but he suggested that his philosophy be applied to immigrant minorities as well. He suggested that literacy skills be taught alongside oral skills. It is important to note, however, that oral skills are also deemed important. Maintaining oral cultural values will help maintain a group's culture.

According to the researchers above, oral instruction with text as a means to relay health information could be effective from a health literacy comprehension standpoint, but also can help strengthen the oral cultural values of a group while introducing them to the dominant society's literate cultural values.

Culturally Relevant Approaches

Within the discussion of appropriate strategies to meet the needs of those with low levels of health literacy, there is the recommendation that PEMs contain culturally relevant material in order to reach those from other cultural backgrounds. In the USA, many written health materials often assume that readers' worldwide views, cultural orientations, and health needs will reflect a white, middle-class perspective, which makes this information of little use to a wide range of the population (Sissel & Hohn, 1996). A group of American researchers, Horner, et al. (2000), have not only suggested

simplifying the language to improve the readability of patient education materials but also that PEMs should use examples that are culturally relevant to the topic of the target population. Singleton's (2002) opinion, which is based on years of teaching ESL speaking immigrant students about health content and various academics' research studies in the United States, was that PEMs should be culturally sensitive. She believed that ESL learners should be consulted when discussing or creating health materials.

Brach and Fraser (2000) added an interesting angle to this discussion, as they investigated whether or not cultural competency reduces racial and ethnic health disparities. The researchers conducted a review of both the cultural competency and disparity literature and identified the major cultural competency techniques that could affect the process and, therefore, outcomes of seeking health information for racial and ethnic minorities. Some of these techniques included: (a) interpreter services, (b) coordinating with traditional healers, and (c) using culturally competent health promotion materials. Brach and Fraser noted that, while there is evidence to suggest that cultural competency could be effective in reducing health disparities, we have little evidence about which cultural competency techniques are effective and how to implement them properly in the health system. Although the article does not focus on PEMs or teaching techniques specifically, it does provide a good overview of the literature that asserts cultural competency has the potential to reduce ethnic and racial health disparities.

Singleton (2002) stated that the fewer language and cultural skills one has, the less the likelihood of having health insurance, access to preventative care, and an understanding of the American health care system. She also mentioned that ESL learners may face a lack of vocabulary to comprehend health information or formulate health

related questions and that English language learners may not know what is expected of a patient in a new country (e.g., preventative behaviours and treatment compliance).

Singleton noted also that this population might not have the education in basic human physiology, which can also preclude comprehension of treatment information.

The above research provides strong arguments for including culturally relevant health care values when delivering health care information. This leads me to question, however, whose cultural health values need to be implemented when relaying health information. Perhaps it is the interplay of the cultural-based practices of the learner and the culture-based practices of the health care provider that both need to be considered when focusing on health literacy content. This is an important issue because, as Singleton (2002) pointed out, ESL speakers need to be able to understand complex health-related materials and concepts so that they can fully access the American health care system. Although it is essential that health professionals receive cultural training when working with minority people and that PEs are culturally relevant, perhaps we need to acquaint the learners or patients with our cultural health values as well. When learning a second language, there has to be some degree of learning a second culture: this process of coming to understand a new culture is called the acculturation process (Brown, 2000). According to Brown, acculturation does not necessarily mean that the learners lose their own sense of culture. Rather learners come to understand their own identity in terms significant to them and engage in a cross-cultural experience. It is important to acknowledge, however, that immigrants to a majority culture, like Canada, are vulnerable. They may lose their cultural traditions because of the power that the majority culture inevitably has over a minority culture.

Candido (2000) believed that the role of culture in language teaching has been one of conflict but stated that language and culture are one and the same and that it is impossible to disassociate the two in any real sense. Thus, she believed that it is impossible to teach language without teaching culture. Bearing this in mind, Candido investigated the diverse types of culture shock faced by American Mormon missionaries living in Brazil resulting from the differences that exist between the cultures of Brazil and the United States in hopes to gain more insight into the process of acculturation. The participants in the study were 29 young adult Mormon missionaries from the United States living in Brazil. It is interesting that her findings revealed that preoccupation with health was the second most occurring symptom of culture shock because the participants were unfamiliar with the medical system in Brazil, which perhaps would be an issue for anyone adapting to a new culture. In general, however, the author found that there were also problems of cross-cultural communication and that the topic of cultural differences should have been addressed more specifically before the Mormons left the US. It is, once again, however, important to keep in mind that this example involves missionaries from a dominant culture living in Brazil and that there would, obviously, be more barriers faced with immigrants from non-dominant cultures immigrating permanently to Canada.

Candido (2000) stated that culture cannot be taught separately from language and that if we, as educators, do not recognize this then we may prevent our learners from acquiring valuable cultural knowledge necessary for them to adjust to a new country. As Brown (2000) articulated, culture learning is a process of creating shared meaning between cultural representatives. He believes that it is experiential, a process that continues over years of language learning, and penetrates deeply into one's patterns of

thinking, feeling, and acting. According to Brown, sometimes it can involve the acquisition of a second identity, which, again, is called the acculturation process. These assertions about the acculturation process and its significance in language learning, alerts us to the importance of acquainting students with the dominant culture's values and practices.

Participatory Education

The final approach I would like to discuss that involves educating second language speakers about health information is through participatory educational methods. Singleton (2002) believed that a participatory approach to health literacy instruction is effective when working with English language learners. She suggested that students create their own materials to educate others and that this approach will increase learners' language skills, motivation and confidence. Singleton (2001) drew on her experience with using picture stories for ESL health literacy purposes to discuss the significance of a participatory approach to health education. Her opinion is that, when the students collaborate to create their own health-related stories, they will be able to draw on their own experiences with health and bring their cultural perspective into health materials. Such procedures are congruent with social constructivism. According to Brown (2000), Vygotsky described social constructivism as social interaction that is foundational in cognitive development. As Vygotsky (1978) noted, "the acquisition of language can provide a paradigm for the entire problem of the relation between learning and development because language arises initially as a means of communication between a person and the people in his/her environment" (p. 89). This social interaction takes place in cooperative group learning and interactive discourse, which is the basis of

participatory education. Thus, when peers are working together, the process of scaffolding will occur because they will draw on each other's language and cultural understanding to create new knowledge.

The participatory approach to education derives from Freire (1998) who has had a significant impact on educators around the world. Freire believes that there is no teaching without learning and that humble open teachers will constantly revise their own knowledge in light of a student's response. He critiqued the banking method of education where the teacher simply deposits information into the learner and instead suggests that the teacher and learner engage in a dialogue together to form new knowledge. Freire also suggested that learners be encouraged to take distance from their reality and think critically about it. He believes that by moving from the sensory experience (reading of the world) to a more generalized and concrete understanding (reading of the word) one comes to comprehend reading. Communicative education, the learner-centered approach, and critical thinking can be partly attributed to Freirian theory. Actually, Meyer, et al. (2003) noted that participatory research methods have been used to empower people to define their own realities and come up with solutions based on their creatively collected knowledge. The authors noted that empowerment focus is derived from Freire (1970) whose work also emphasizes the need to provide communities with the tools necessary to make social change. Thus, participatory education is also linked to empowerment.

Participatory Education and Empowerment

According to Wallerstein (1992), the term empowerment has increasingly appeared in the public health literature during the past decade. However, she noted that casual use of these terms has led to a lack of theoretical clarity and measurement

problems. In fact, the author pointed out that the health outcomes of powerlessness and empowerment are often unrecognized despite considerable research that documents the role of powerlessness in disease causation and, conversely, of empowerment in health promotion. She also pointed out that empowerment becomes the avenue for people to challenge their internalized powerlessness while also developing real opportunities to gain control in their lives and transform their various settings. The author noted that one of the ways to empower participants in health promotion is “listening to people’s life experiences and making participants into co-investigators of their shared problems in their community” (p. 203). Wallerstein noted that this kind of listening is participatory and uncovers issues of emotional and social significance for those involved.

Actually, according to Sissle and Hohn (1996), participatory theory embraces a deep belief in the capacity for humans to reflect, learn, and grow and promotes the idea that people matter more than institutions. People most affected by a problem must be involved in solving that problem in a manner that respects their needs, dignity, and intelligence. Thus, the educator acts as a facilitator in the educational process; but ultimately the learners are held accountable for their own learning. Sissle and Hohn also drew on Frieman (1970) thought when they stated that “participatory research extends these beliefs in their insistence that social problems have their roots in organizations and systems and not people” (p. 62). VanderPlaat (1998) added to this discussion by stating that those concerned with the development of empowerment-based practices also tend to see the process in terms of a collective social activity, as opposed to the more traditional Western emphasis on the individual. She believed that what defines the discourse of empowerment is its acknowledgement and deep respect for all people’s capacity to create

knowledge about their own experiences and their ability to find solutions to problems pertaining thereto.

An example of an empowerment based practice in a community and participatory health education program is a program that was led by Sissle and Hohn (1996). They found that their participants discussed “their power and their voice, articulating to the outside world what they had learned about themselves, about health and about the role of culture in health” (p. 66). Thus, the women in their project also became advocates for health education. They made presentations of their ideas and materials that they developed in various health projects across a state in the United States.

Participatory Photonovels

One participatory educational tool that can be used with immigrant women is the photonovel. There is by no means a plethora of literature that discusses the genre of photonovels. However, a background look into the history of photonovels reveals that they have been very popular in Latin America since the 1950s. According to Flora (1980), photonovels were made accessible to the public by being sold in newsstands in across Latin America. For those Latin Americans who have low literacy skills, the captioned photographs, which mimic the emotions and struggles of daily life, are more true to life than the politically tainted information that is often found in newspapers.

Taylor (2002) believed that photographs could offer rich descriptive images that can help make sense of subjective experience. He noted that photographs often reveal unconscious beliefs behind the picture taking process itself. These beliefs tell us what constitutes an event because, through shooting a photograph, photographers can reaffirm their belief about reality. Taylor also noted that “photography and language are

interdependent mediums for expression that have the potential to aid each other in creating meaning of an experience” (p. 127). The significance of a literacy tool, such as the photonovel, is that it allows participants to shape their own reality through creation of images and print. Researchers have noted the powerful effect of the photonovel on populations in the United States, China, South Africa, and Canada.

Photonovels in the United States

Rudd and Comings (1996) focused on an extension of Freire’s problem posing educational methods to include participants’ involvement in the development and production of their own learning materials. Rudd and Comings looked at four examples to illustrate the process of participatory materials in the development of ESL and health education. Based on the premise that Freire’s methods support a process that allows learners to define the content and outcome of their own learning, the authors encouraged their participants to create photonovels. These photonovels were formulated like comic books but contained photographs instead of drawings to stimulate discussion. In one case, photonovels were created by a small group of workers about occupational health and safety issues; and the materials were randomly distributed to union members in all trades across the city. The photonovels created by the participants were considered more readable by the building trades locals than pamphlets created by the National Cancer Institute. Readers scored higher on factual recall, had more positive attitudes towards future involvement in health and safety issues, and were more likely to take action in the future. Hence, the photonovels were mass produced and distributed among all the building and construction trades in the city; highlighting the effectiveness of using the participants’ perspectives in the creation of health-related materials.

Furthermore, Gallo (2001) found that participatory photography used with a diverse group of immigrant and refugee workers at a high technology manufacturing plant in the United States helped these beginning learners of English to express their stories readily through images. She found that by having the immigrant ESL speakers take photographs accompanied with writing empowered them to discuss aspects of their own lives, form community, and also enrich their language learning by being involved in a meaningful communicative activity. Gallo also found that the students' involvement with photography helped them overcome linguistic and cultural barriers often faced by second language learners by improving their literacy in meaningful ways and by encouraging them to represent themselves with images and words instead of adhering to the representations forced upon them by the dominant culture.

Verlarde (1999), in her research that involved American high school students in the development of participatory photonovels containing health information, found that the participants were able to learn how to work together, gain new skills, problem solve, communicate with each other, express their culture, and associate meaning with the completed product. The students in the study, which included some ESL students, chose the health topics they wanted to focus on and developed the storylines based on their research and direct experiences. Furthermore, actual photographs of their peers were used to illustrate youth and ethnic culture and to portray youths' reality. Verlarde also noted that that the consumers of the photonovels perceived the health messages as the students had intended the audience to understand the message.

Photonovels in China

Wang and Burris (1994) looked at the use of participatory photonovels in their study as well. Their participants were 62 rural Chinese women. They found that the photonovels ultimately contributed to changes in their consciousness by involving the participants “in a process that shifts their roles from learners to emerging teachers and social actors in their communities” (p. 185) and in, ultimately, informing policy. The goal of their participatory study was to use the participants’ photographic documentation of their everyday lives as an educational tool to record and to reflect their needs, promote dialogue, encourage action, and inform policy. They noted that photographs serve as a kind of code that reflects upon the community itself, mirroring the everyday realities that influence people’s lives. Through photonovels, the women’s images and words form the curriculum. This action challenges the traditional educational approach that fosters dependency or powerlessness. Curriculum that is dictated by others is often distant from learners’ realities. The authors also noted “learning arises from analyzing images not made by others, but by themselves, from portraits of participation” (p. 185). Thus, in this study, the photonovels remained congruent with Freire’s participatory process by occurring in the reality of the participants’ experience and encouraging them to think more as powerful subjects, rather than as passive objects, about their world. Wang, Yi Kun, Tao Wen, and Carovano (1998) reflected on the above study by noting that this approach to research provides a way to affirm participant’s ideas, creativity, and problem-solving abilities. They also noted that this approach gives explicit priority to the community’s agenda rather than to the researcher’s needs.

Riley and Manias (2004), in their literature review on the uses of photography in clinical nursing practice and research, found that the applications of photography in nursing practice and research has not been well synthesized or reported. They noted, however, that one of the major ways in which we interact with the world is through vision and that our everyday world is dominated by visual images. As a result, photographic research should become more rigorous and widely accepted in the nursing research community. They believed that some of the most accessible research incorporating photographic method is the work of the above-mentioned Wang and colleagues (1994; 1998). They contended that the participatory research of Wang and colleagues with photonovels enabled women to dialogue about effective strategies for promoting women's health and work realities, while also reflecting on their lives and communities and effectively communicating their perceptions and insights to others. In short, the authors believed that nursing could benefit from adopting more creative photographic approaches for the improvement of patient care and professional development.

Photonovels in South Africa

Another example of using a photonovel as a health literacy tool comes from James, et al. (2005), who recently studied the effects of a systematically developed photonovel on knowledge, attitudes, communication, and behavioural intentions with respect to sexually transmitted infections after a single reading by 1,168 secondary school students in South Africa. The photonovels used in the study were generated through workshops with youth in South Africa and were expected to appeal to youth in terms of its approach to contemporary sexual practices, its portrayal of characters, and the views

described both for and against sexual practices. The photonovels were one of the only AIDS education interventions that were actually developed within Africa and by African people. The authors found that there was a significant increase in health literacy knowledge about the spread of sexually transmitted infections in male and female learners after a single reading of the photonovel. In addition, James, et al. found that reading the photonovel contributed to a more positive attitude to condom use in male and female learners six weeks after the intervention. The study shows that an effect was also found on future intentions to use condoms in the next year. The authors noted that these positive attitudes are important in influencing intentions to use condoms; however, they suggested that there needs to be further educational strategies that encourage open communication about AIDS because awareness, positive attitudes, and knowledge about the problem may not be sufficient to create actual behavioural change.

Photonovels in Canada

Moffitt and Vollman (2004) recently co-published an article about Vollman's evolving doctoral study, which describes the use of the participatory photovoice (photonovel) in exploring the health beliefs and health promotion practices of pregnant Tlicho women in Canada's Northwest Territories. The article, which details a preliminary look at the method of the photonovel and its use in a remote community, is the first attempt in Canada to use the photonovel as an educational tool. In her study, Vollman noted that the photonovel enabled Tlicho women to reflect on and promote dialogue about their health beliefs and health promotion practices in the context of their own lives. She noted that the photonovel is a technique based on empowerment and is a culturally appropriate method for conducting rural and remote health research. Although both of

our studies involved vulnerable Canadian populations, Vollman's study was different to mine because it used the photonovel as a tool to understand the health beliefs and health practices of a specific homogeneous group (pregnant Tlicho women) and was used as a tool for documenting their everyday lives and health beliefs. My study, on the other hand, looked at using the photonovel as a health literacy tool for a more heterogeneous group (immigrant ESL speaking women) in an urban centre. Nevertheless, our studies complement each other because they are based on the supposition that the underpinnings of the photonovel method lie in the areas of empowerment education, critical theory, and feminist theory and that the photonovel is, essentially, a participatory action tool.

Reasons to Use a Photonovel

Aside from research that looks at the positive outcomes of using the photonovel as a health educational tool as outlined above, Leibtag and Rigby (1990) looked at, specifically, the compelling nature of the photonovel. In their guide for AIDS education material development, they commented that photonovels could provide an entertaining format for learning about AIDS and other health topics. They found that photonovels could be very appealing to readers, especially if the photonovels include interesting characters and an exciting plot. Some of the advantages of using a photonovel that they listed are (a) stories can hold readers' attention and be remembered, (b) people can identify with the characters in the stories, (c) real-life situations and problems can be portrayed, (d) they are popular among many age and literacy levels, and (e) having the characters match the target minority populations will help them identify with the characters. Photonovels are also an effective means to enhance language skills.

Peyton (1993) extended this discussion by addressing the effectiveness in getting ESL speakers to write for each other to read and found that it benefits both writers and readers. The author believed that, essentially, learners find student-written materials easier and more interesting to read than other published materials because the language used is often more accessible. As the students work with all aspects of language use, from effective genres and discourse structures to correct grammar and punctuation, they are drawn into a meaningful relationship with English. Peyton noted that commercially produced texts may contain material far removed from the realities that adult learners face, and the simple topics and language structures may hold little interest or cognitive challenge for them. The author's opinion, based on various teacher's experiences, was that when ESL speakers write for each other they will also feel more motivated to learn, which is obviously a form of intrinsic motivation (intrinsically motivated learners are motivated to engage in activities for their own sake and not because there is an extrinsic award). Brown (2000) noted that many researchers believe that intrinsic motivation is superior to extrinsic motivation. It appears as though using a photonovel with immigrant ESL speaking women in Canada would contribute to the research that has been done in various countries that discusses the photonovel's effectiveness as a literacy tool and empowerment strategy.

CONCLUSIONS

Although there are many factors that can affect ESL speaking immigrant women's health upon immigrating to Canada, such as financial burdens, nutrition and social support, one of the primary reasons, which I focused on for the purpose of this research, is that language barriers can impede an ESL speaker's ability to understand

health information. The literature reviewed shows us that traditional PEMs are not effective enough in informing ESL speakers about health information. When tested, the simplifying of language in PEMs is not sufficient in increasing comprehension to an acceptable level. Visual literacy approaches used with text are then discussed as being an effective method for enhancing health literacy comprehension. Furthermore, while using pictures or symbols in PEMs has been shown to be effective, little comprehension will occur without ESL learners having background knowledge about the meaning of these symbols or pictures within a context of Western culture. This suggests that pictures and symbols should be accompanied with instruction.

The use of oral language to inform ESL speakers about health information suggests the significance of maintaining the oral cultural values of minority populations. This is an interesting area of study because it is a mode of communication perhaps closer to the participants' own. However, there is little research on the effectiveness of oral instruction in relaying health content to patients; so perhaps it would be a significant area for future researchers to investigate.

The literature also provides a strong argument for including culturally relevant content in health materials. There is a link made between cultural competency and the reduction of racial and ethnic health disparities. A discussion about the acculturation process is made and linked to the significance of informing newcomers about Western cultural health values. Finally, the review ends with the strongest suggestion for involving ESL learners in learning about health content, which is through participatory education. Based on the groundbreaking educational philosophy of Freire (1998), through

participatory education ESL learners are empowered and encouraged to create their own PEMs and work together to find solutions to their health-related concerns and questions.

The use of participatory photonovels seems to be an effective approach for increasing the health literacy comprehension with an ESL population while also providing an empowering educational process for immigrant women who often experience barriers to accessing health care (Simms, 2003). The merging of written and visual literacy by ESL speakers themselves is effective because it combines the women's visual understanding with their growing written understanding. They can use their own language ability, which makes this health literacy tool useful for other ESL speakers. Furthermore, the literature illustrates that participatory photonovels are culturally relevant because they contain the perspective of the ESL speaker and because the images and characters are representative of them. Thus, the participatory photonovel remains truer to immigrant life than the more traditional health education materials.

Research shows that comprehension and attitude is improved upon the reading of participatory photonovels and that they are a very appealing and entertaining means to learn about health. ESL speakers can also increase their language skills and partake in a meaningful communicative activity by collaborating with their peers and engaging in the scaffolding process, which is born out of Vygotsky's (1978) theory of social constructivism.

On a final note, photonovels can provide an opportunity for immigrant and women to share their culturally based health practices from home by merging Canadian health values and their own health values. Thus, these women may find that the realities of their own lives are worth discussing, which would be very empowering for them. Also,

when these women learn about Canada's health practices, they will be able to acculturate more easily and, as a result, be more empowered members of our country. It is also important to note that, if immigrant women are to create health-related materials and distribute them to other ESL speakers to read, they will find they have a powerful voice and are playing a vital role in their new country.

In short, this literature gives a background overview of the literature that supports the actualization of my study, which is to engage the ESL speaking immigrant women in my study in the participatory process of creating photonovels. The study will look at how these women respond to creating and using photonovels as a means to comprehend specific health information in Canada and how the process of creating the photonovel can enable these women to raise their consciousness about their own lives and to collaborate on ways to live a healthier life here in Canada. The following chapter presents the methodology that was used in this study.

CHAPTER 3

METHODOLOGY

Only those who listen, speak.

Paulo Freire (1997)

INTRODUCTION

This chapter describes the methodology that was used for this thesis. This research was a qualitative case study and was situated within a critical ethnographic paradigm. As well, my ontology is that of a postmodernist. This chapter will also introduce the five core women who attended every session and provide information about their demographic background. I also describe the research setting and how I accessed the participants in the setting. I then describe each meeting I had with the participants and how I collected the data through feminist interviewing. Next, the manner in which I analyzed the qualitative data is described step by step. Finally, my own social location as the researcher is discussed and the effects this has on my own interpretations of my data. I will then refer to my use of reflexivity, which is an important element of feminist and critical research. Reflexivity involves reflecting upon, examining critically, and exploring analytically the nature of the research process. Engaging in a reflexive manner encourages us to be consistently conscious of our own shaping of the text.

METHOD

This research was a qualitative case study. According to Holloway and Wheeler (1995), qualitative analysis derives data from observation, interviews, and verbal

interactions and focuses on the meanings and interpretations of the participants. It is also reflexive (Holloway & Wheeler). As Mason (1997) noted, qualitative research is “based on methods of analysis and explanation, which involves understandings of complexity, detail and content”. Qualitative research is based on methods of data collection that are flexible and sensitive to the social context in which data is produced. Thus, to understand a qualitative case study, it needs to be understood from the perspective of those involved (Gillham, 2000). Most importantly, however, qualitative researchers can more easily write as situated, positioned authors giving up, if they choose, their authority over the people they study but not the responsibility of authorship over their texts (Richardson, 1990).

Like Rudd and Comings (1996), who used a case study methodology for their inquiry into the effectiveness of using participatory photonovels as a literacy and health education tool in the United States, I used a single case study as my research method. According to Gillham (2000), a case study has been “defined as the collection and presentation of detailed information about a particular participant or small group” (p. 1) and as something that can only be studied or understood in context. As well, case study has been defined as “an intensive, detailed description and analysis of a single project and instructional material in the context of its environment” (Yin, 1994). Thus, I looked holistically and in depth at how ESL speaking immigrant women raise their critical consciousness when involved in composing a photonovel and, also, how this tool helps them understand a specific health topic.

I collected and present detailed information and included the accounts of the participants themselves as they describe their part in the process of creating the

photonovel. I collected data through (a) two separate interviews with each participant, (b) two focus groups, (c) field notes during the meetings I had with the women once a week, and (d) photographs of the photonovel project. Yin (1993) noted how multiple data collection techniques are typical of the case study. Such an approach permits the researcher to address a broader range of historical, attitudinal, and observational issues. In fact, Muscari (1994) believed that multiple data collection approaches allow for the development of converging lines of inquiry by triangulation. Triangulation is the task of bringing together more than one source of data to focus on an issue and addresses validity concerns. According to Muscari, “findings in a case study are also more likely to be convincing and accurate if based on different sources of information”. Multiple sources of evidence essentially provide multiple measures of the same phenomenon, thus increasing validity (Yin, 1989). McDonnell, Jones, and Read (2000) added that multiple data collection methods could also be seen as a form of triangulation with each method adding a different piece to the overall puzzle.

Conceptual Framework

My research is situated within a critical ethnographic paradigm. To be critical is to stand back from the moving world and question how it operates and how it came to be there. Essentially, critical theory focuses on reflection and is designed to involve and inform people, especially marginalized or oppressed people, about actions necessary to promote their emancipation. Thus, it involves patterns of thought and action that critique institutionalized power relations (Fontana, 2004). As a critical theorist my aim is to come to know about human experience in order to promote social change. I am also aware that the production of knowledge is socially and historically determined (DePoy, Hartman, &

Haslett, 1999). Based on the work of Freire (2003), developing a critical consciousness entails developing an understanding about the society and culture within which people live and a comprehension of people's capacity to change their situation (Clover, 2002). According to Freire (1970), our orientation in the world places the question of the purposes of action at the level of critical perception of reality and involves humanizing the world in order to transform it. Thus, for example, adult literacy becomes so much more than just a purely technical action where the educator is depositing information into the informants' knowledge base. My role as a critical researcher is to encourage the participants to propose problems about their situations in order to help them arrive at a more critical view of their reality and, thus, facilitate in the creation of a more just society.

An extension of critical inquiry takes into account how our lives are mediated by systems of inequity such as classism, racism, and sexism. Thus, because my research participants are marginalized women, aspects of feminist critique perspective will be linked to the overall framework of critical theory. According to Lather (1992), feminist research assumes that ways of knowing are inherently culture bound and that researcher values permeate inquiry. Furthermore, "studying women from the perspective of their own experiences, so that we can better understand their situation in the world is research designed for women instead of simply research about women" (p. 92). Lather also noted that reliable knowledge claims are those that arise out of the struggle against oppression; not in a way that romanticizes women's experiences, but rather in a way that adheres to reflection on the conditions that make knowledge possible. In critical theory, the context of the women's lives becomes the focus of the research and it, thus, helps expose power

relationships and enables the participants to discover the possibilities for changing the conditions of their reality (Kendall & Sturt, 1996).

Ethnography, according to Pink (2001), is an approach to experiencing, interpreting, and representing culture and society that informs and is informed by sets of different disciplinary agendas and theoretical principles. Rather than being a method for gathering data, ethnography is a process of creating and representing knowledge that is based on the ethnographer's own experiences. Pink also noted that ethnography does not claim to produce an objective truth about reality, but aims to offer versions of the ethnographer's experiences of reality that are as loyal as possible to the context, negotiations, and inter-subjectivities through which the knowledge was produced. Thus, the meaning that I am studying exists inter-dependently of my interacting with it. My aim is to represent the findings as accurately as possible through a critical ethnographic perspective. Critical ethnography, thus, "offers a powerful opportunity for praxis to the extent that the research process allows people to change by encouraging self reflection and a deeper understanding of their situation" (Lather, 1986, p. 270).

In terms of my ontology, I would argue that it is postmodern because I believe that language is not truth bearing and that it shapes a particular view of reality that has multiple meanings. In a sense, postmodernism informs critical theory by its process of deconstruction and its belief in multiple and contradictory realities. A post modernist view forces the researcher to understand that there is not a single truth. The researcher relinquishes the privileged form of authoritative knowledge (Richardson, 2000). In fact, according to Fontana (2004), critical theory has been informed by postmodern thought. However, she noted that sometimes postmodernists neglect to integrate the critical

theorist's goal of reconstructing society in an emancipatory manner and she argued that, as a result, postmodernists could sometimes fail to address persistent social injustices. Thus, the critical framework in this study is necessary because it will ensure that aspects of social injustice are not overlooked.

As Denzin and Lincoln (1994) suggested, postmodern research is an interactive process shaped by personal history, biography, gender, social class, and ethnicity for both the researcher and people in the study. Postmodernism relies on concrete experience over abstract principles, knowing always that the outcome of one's own experience will necessarily be fallible and relative rather than certain and universal (Lyotard, 1979). Thus, I take into account the flux and flow of the participants' experiences and realities when I observe the participants, interviewing them, and analyzing the data because ethnography under a postmodern lens "suggests that one can no longer go merrily along presenting theory as an objective account as if it represented the reality of the participants" (Daly, 1997, p. 349). Not only do I gain understanding through the process of discovery, but I also planned for the participants to engage in experiential discovery through creating the photonovel. As a result, the participants may experience empowerment through the participatory process by actualizing themselves and becoming more human through their active participation in the research. As supported by the statement from the WHO (1978), the commitment to health promotion accepts the community as the essential voice in matters of health, living conditions, and well being. In addition, congruent with Freirian (1970) philosophy, I believe that the oppressed should confront reality while simultaneously acting on and critiquing that reality.

The Participants

The participants in this study were ESL speaking immigrant women who attend the Inter-Cultural Association's (ICA) women's group to learn about various settlement issues (I had permission to name the organization where this research took place: Appendix A). The women were of various cultural, national, and linguistic backgrounds. Alexis (*all names are pseudonyms), who was the facilitator of the ICA's women's group when I started the project (Alexis resigned from her position part way through the study and Carrie took over), helped me recruit the participants for this study by going into classrooms at the ICA with me and inviting women to participate in the project. Alexis suggested to me that I hold the meetings for my study independently of the women's group because she felt that there was not enough space, in the short amount of time that the women's group has, for me to come in and do my study (the women's group only meets once a week). Thus, this study involved the women who attended the ICA's women's group, but was held independently of it. I also notified the women that they would be able to bring their small children to the meetings because I was told that childcare responsibilities could be a barrier to their attendance. It is important to note that when I approached the ICA about this study it was welcomed very positively. Both the director of the ICA and the facilitator of the women's group relayed to me that, in the past, they have struggled when trying to deliver health information to ESL speakers because they have found that the traditional health education approaches are not appropriate for this population. This research targeted a neglected area by specifically addressing education strategies for ESL speakers. I anticipated that there would be about

ten participants in my study; however, there were five core women who came to every meeting and then about five others who came occasionally or once or twice.

As a Group

The core group was composed of five women ranging from the ages of 35-80 years old. Their time in Canada ranged from 10 months to 35 years. All of the women spoke English as a second language, and their degree of fluency in English ranged from about a low-intermediate to high-intermediate level of English. Three women were landed immigrants; the other two didn't have immigrant status yet. Two women were divorced from abusive relationships, two were married, and one was single. Three women had a university education, and the other two had gone to high school. Finally, two women were currently working in insecure jobs, one woman was at home with her child, and the other two women were at retirement age and, thus, not working.

Margherita

Margherita is originally from Chile. She is 35-years old and has lived in Canada for five years. She is married with no children; she studied to be a teacher in Chile but has found casual work in Canada because she is not a landed immigrant. Margherita confided in me that she very much wishes to have children one day, but she is concerned about her non-immigrant status and her lack of access to health care. She has also been blind her whole life and has a seeing-eye dog (called Reeces). Margherita's English level is that, in my professional opinion, of an intermediate ESL speaker; and she had the highest level of English in the group. She usually wore slacks to the meetings and a sweater, and her long light brown hair was almost always in a braid. Margherita seemed to have adopted Western dress but kept her Chilean hairstyle.

Margherita's personality is unforgettable. She is vivacious, enthusiastic, and loud. She has an outstanding sense of humour; there is most often laughter when she is in a room. Sometimes she dominated the group and was, thus, most certainly the leader of the group. Not only does she receive a lot of attention due to her outspokenness, but the other women also nurture her, perhaps because of her handicap. Margherita would often sing a song that she made up in Spanish for Maria's daughter, Angelita. Angelita loved the song and would start dancing around the room while everyone laughed.

Maria

Maria is in her thirties and is originally from Colombia. At the time of the project, she had lived in Canada for only 10 months. In Colombia, she worked as an electrical engineer; since being in Canada, she stays home with her three-year-old daughter, Angelita (whom she regularly brought to the meetings). She is married, and her English is a low-intermediate level. She is not a landed immigrant either. Her husband is also an engineer but has only found work in a printing shop since they have been here.

My first impression of Maria was that she is very intelligent and, as I got to know her, I realized that my initial thoughts were correct. Most interestingly, I noticed from the start that she seemed quite self-confident and energetic. Later, I found out she is very well educated and I wondered if this contributed to her confidence. She is quite assertive and was always direct with me if she needed to leave early or she had an opinion about something. Her lack of English language skills made her hesitant sometimes to contribute to the group sessions, but overall she was very engaged in the project. In the group dynamic Maria was quite outspoken, although she was more reserved than Margherita. When she first came into the group, she didn't know anyone and was shy. By the end, she

was quite friendly with everyone – especially Margherita. This friendship may be partially attributed to the fact that they are both South Americans and of a similar age.

Jacky

Jacky is 42-year-old woman who came to Canada from Hong Kong 20 years ago with her parents. She lives at home with her parents, has no children, and has never been married. She finished high school in Hong Kong and now does odd jobs in Canada, like babysitting, even though she is a landed immigrant. Her level of English is low.

Jacky is, in general, quite shy and passive. At the start of our meetings, she barely said anything; however, when she was nominated by the other women as the main actress in the photonovel, she came out of her shell. I speculate that the other women nominated her as the lead actress because they liked her and wanted to help her express herself by taking on a lead role. She was animated and lively in the making of the photonovel, and she laughed and smiled a lot. In our last meeting where we had a farewell potluck, Jacky didn't say anything and instead handed everyone a Christmas card and left early. I think Jacky expressed herself well in the making of the photonovel; but in normal social circumstances, she was still awkward and shy. In our individual interviews, she was frequently silent when asked about her own reactions and instead felt more comfortable talking about her parents. Like all the other women in the group, Jacky had a subtle and playful sense of humour. For example, she was laughing so hard in the scene where she is eating the hamburger that it took us 10 minutes to take the photo.

Carole

Carole is originally from Indonesia and has lived in Canada for almost 20 years; she is a landed immigrant. She is the oldest member of the group being 80 years old. She

has six children and also has grandchildren. Most of her children live in Indonesia still, but one lives nearby and the other in the United States. She confided in me that she feels safer in Canada because her ex-husband abused her. She left Indonesia with her one daughter to “get away from him”. She explained to me that she feels a lot more peaceful here and now likes singing because she has a good voice.

Carole is a woman who believes in herself and is very self-reliant. She credits her good health solely to the fact that she takes care of herself. Carole had a very self-assured personality, and she sometimes had conflicts or disagreements with the other group members. For example, I remember in one of our final meetings the group was deciding which photos they wanted to edit and Carole relentlessly argued with two of the other women because she didn't like having Margherita's seeing-eye dog in the picture. However, she was very sweet with me and often brought things like artwork or knitting she had done to show me; but perhaps she was warm with me because she saw me as an authority figure. I noticed, however, that she didn't really go out of her way to connect with the women in the group. She was very proud of her independence and repeatedly told me how good she looks for her age, which she repeatedly attributed to the fact that she takes good care of herself. Carole often wore colourful makeup and clothing to represent her dynamic and strong personality on the inside. She was lively and wise and took great pride in herself. She participated wholeheartedly in the project, attending every meeting, and being very involved as a participant with her input and ideas.

Maasa

Maasa is in her sixties and is originally from Japan. She has lived in Canada for 37 years and is a landed immigrant. She worked as a nurse for some time in Canada and

also had her own business at one point. Maasa was in an abusive relationship and has since divorced. She has one daughter who is in her twenties and lives in a city nearby. Maasa often expressed an inner desire to spend more time with her daughter, but often excused this by saying her daughter was busy and thus she needed to give her space. Although she has lived in Canada longer than any of the other women, her language level was probably the one of the lowest in the group. At the beginning, Maasa was less involved than the other women; but throughout the project, she illustrated many times how enthusiastic she was in her actions and in her individual interviews. For example, she was the only woman in the group to design and create part of her costume at home on her own time. Although retired now, she was an extremely hardworking woman most of her life; she dedicated all of her money to put her daughter through school so that she could be independent, calling her daughter “my investment”.

I think Maasa had the biggest impact on me. She is a small woman, if not frail in appearance, and she sits back a lot and watches. Maasa was extremely quiet; but when she contributed to interviews, her insight was profound. She was also generous. For example, even though she was at a low economic status, she donated her honorarium money, for participating in the project, to the ICA woman’s group. Maasa also surprised me at the end of the project by leaving a beautiful pink scarf she made for me, as a thank you, with the director of the ICA. She was very supportive of the project and me and made sure to tell me several times at the end how hard she thought I worked and how impressed she was with the photonovel we made.

When I first started the photonovel project, the women were quite shy. In fact, I wrote in my journal several times how passive they all seemed as a group with the

exception of Margherita who was outgoing from the start. Despite their shyness in a group setting, however, I noticed that in the initial individual interviews that the women were quite open with me. They confided to me about their personal history (i.e., having survived abusive relationships) and about their hopes and dreams (i.e., the wish to have a baby someday). I was excited that the women confided in me because, as this research adhered to a feminist methodology, my interviewing strived for intimacy and believing in the interviewee. In fact, “guiding this model is a proposed feminist ethic of commitment and egalitarianism in contrast with the scientific method of detachment and role differentiation between researcher and subject” (Reinharz, 1992). Thus, I felt I formed a relationship from the onset with the interviewees, which was based on sincerity and openness. According to Reinharz, “women can become like friends with the researcher because they feel valued as individuals rather than being data providers. Being listened to and respected leads to a kind of bonding” (p. 28). Thus, a believed interviewee is likely to trust the interviewer and is likely to disclose “the truth” (p. 28). Furthermore, because women participants identify more readily with women researchers, it can be easy for participants to reveal the intimate details of their lives (Fonow & Cook, 1991). This openness, however, could also be attributed to the isolation of many immigrant women who have few opportunities to talk about their needs with others (Meyer, et al., 2003).

DESIGN

Prior to the study at the ICA, I gained experience facilitating in the creation of a photonovel because I did a pilot study in Dr. Darlene Clover’s graduate course titled *Social Learning, Activism and Cultural Transformation through Arts and Crafts*. This study was limited, however, because it only involved graduate, English speaking, adult female

students. The photonovel they created was of an environmental-political nature, entitled “*Disposable Culture*”. Their photonovel was designed to inform others about the sewage problem in Victoria and, with the help of another graduate student, we used “Photoshop” to enter the pictures and captions. Facilitating in the creation of a photonovel with graduate students before my research began was useful because I gained experience before attempting this project with ESL speaking immigrant women in the community.

My research design involved having the ESL speaking immigrant women in my study create participatory photonovels about a health topic that they would like to learn about. There was a preliminary session, where I informed the women about my research and explained, in simplified English, the consent form (Appendix B). After this session, the women chose if they wanted to participate in my study or not. In the next session, I had the women collaboratively choose a health topic that they wanted to learn more about by having them work in pairs and then report back to the group about the topic that they chose (most interestingly, the women all chose nutrition and exercise as the health topics they wanted more information on). In this session, I also conducted a focus group to learn more about the women’s health experiences. In the focus group, there was a lot of talk about how the nutrition in Canada had affected the women’s health negatively. I then invited a Registered Public Health Nurse, Kris, to inform and educate the women about nutrition and exercise from a Canadian health practitioner’s perspective. The nurse had various communicative exercises for the women to do, and she used a lot of visuals to get her messages across.

In the next two sessions, the women then wrote the story line, developed characters, then acted and photographed each other to create a photonovel using their

own cultural health perspectives and the strategies given by Kris. In the next session, a graduate student who came to the meeting and helped the women compile the photonovel onto a computer program “Photoshop” by putting bubble captions on the photos. The women had decided that they wanted a technical expert to come in and help them compile the photonovel in “Photoshop” because they wanted it to look professional. Fortunately, I had the funding to hire the graduate student to come in and help with this component of the project. My role in this whole process was to act as a facilitator in the creation of the photonovel, but ultimately it was the participants who created the health related photonovels. The research took place over a period of about two and a half months, and we met for about two hours total each time with a snack break in the middle of each meeting where I provided food. Our final session was a potluck where we shared food and exchanged emails and Christmas cards. The women also had a chance in this final meeting to review the photonovel *From Junk Food to Health Eating: Tanya’s Journey to a Better Life* (see Appendix C) and make any changes that they wanted to before it was printed in multiple copies. The details of the weekly meetings will be described more in the procedure section of this chapter.

Description of Setting

This study took place at the Inter-Cultural Association (ICA). The ICA is a non-profit organization in a mid-sized city in British Columbia that assists newcomers to settle in the area and assist in their inclusion and full participation in society. The ICA’s mandate is to encourage sensitivity, appreciation, and respect for individuals of all cultures. Thus, the ICA offers a broad range of services for immigrants and refugees including citizenship and ESL classes, counselling, orientation, workshops, and a host

family program. The ICA also has a women's group where women can learn about a variety of issues such as parenting, pre-employment skills, and health. The women in the group come from a wide variety of cultural and linguistic backgrounds but share the common experience of coming to a new country. This study took place in the fall of 2005 from October to December.

Access

I approached the ICA in the spring of 2005 and explained my concept for the project. The initial meeting was with two directors (Mark and Pedro) of the ICA and the women's group facilitator (Alexis). I explained why the research was important for immigrant women and how the weekly photonovel project meetings would work. The meeting went extremely well and I was invited to do my project at the ICA. The directors and women's group facilitator told me that they had tried several ways to teach immigrant women about health, but nothing seemed to resonate with the women and there was, in general, a lack of understanding about health information. Thus, they were very open and pleased with the photonovel idea and told me that the concept "would spread like wild fire" in immigrant organizations in BC because there was an obvious gap in ways to deliver health information to immigrant ESL speaking women.

I had a few meetings before the project started in September with the directors and the women's group leader to fine tune the details of the project. On October 6, 2006, I attempted to recruit women for the project by going into five ESL classes with Alexis and explaining the photonovel project. Luckily, one ESL teacher was a friend of mine so she was extra enthusiastic at helping me promote the project. I explained to the women that they would be able to learn about health from a nurse, take pictures, and do some

acting to create a “photonovel” about health. I showed them examples of a photonovel and explained the time requirement for the project. I also explained that they would be paid 25 dollars each for participating. Alexis and I then distributed a form that the women could sign if they were interested, which included their phone numbers. Alexis then phoned the women who signed the forms a few days later and notified them that the project would start on the following Friday, October 14, 2005.

DATA COLLECTION

Procedure

Day One

The photonovel project lasted for just over two months. We met every Friday from 10:30 am to 12:30 pm. The initial meeting was to meet the women and inform them more about the project. Alexis was also at the meeting, and we began the meeting by introducing ourselves. There were nine women present, and they also introduced themselves. They were of various ages, all had different levels of English, and some of the women had recently arrived Canada. I introduced a getting-to-know-you activity and wrote it on the board. I then realized that some of the women were illiterate because they told me they did not know how to read, so I explained the activity orally. The women then asked each other questions about where they were from and about their backgrounds. Some of the women were very engaged in the activity, and some were more timid due to their lack of language skills. I noticed that a woman from Pakistan did not want to talk to her partner and instead started talking to me. She told me that she had been in Canada for 40 years and that she was illiterate.

Day Two

The second meeting occurred on Friday, October 21, 2005. I started the meeting with introductions again and gave an overview for the day. There were eight women at this meeting (including the five core women). I asked the women to work in groups and choose a health topic that they would like to learn more about or that concerned them. The women busily chatted away. I then went around the room and asked each woman which health topic she would like to learn more about. The women all said nutrition or exercise as their main health concern. I then told the women that we would be able to learn about nutrition from a public health nurse and they would create a photonovel about this topic. They seemed pleased with this. I had waited until this session to have the women sign the consent form because the week before I was simply giving the women more information about the project and inviting them to participate. I then explained the consent form slowly and using a lot of non-verbal body language. It was a lot of information for them, and I had to do a lot of concept checking to see if they understood. The women signed the forms, and there was a lot of excitement in the room and laughter. I then began the focus group interview. I noticed immediately that Margherita spoke a lot more than the other women and that she has a very outgoing and confident personality. I noticed how much the women had to say about nutrition and they feel strongly that the food here in Canada affects their health. Also, the women who are new to Canada did not speak as much as the women who had been here longer.

Day Three

The third meeting was on October 28, 2006. There were only seven women at this meeting, and I noticed that the women who had just arrived to Canada and did not speak

English very well dropped out of the group. Alexis noted that we should have hired translators, but unfortunately I didn't have the budget to provide translators. The public health nurse taught the women about eating well in Canada and did a lot of great, communicative activities with the women. The nurse asked the women questions about what affects their nutrition; some of the women said they do not like to eat alone and that they are alone here in Canada. Other women said they do not have enough time to eat well or do not have the money to eat well. The women really enjoyed learning about eating well and had many questions to ask the nurse. Maasa told the nurse what she ate that day and asked the nurse if her diet was healthy. The nurse then told the women about the four food groups, which the women were not familiar with. Maria told the group how the first word her daughter learnt in Canada was 'fries' and made everyone laugh. The nurse then talked about exercise, and Carole got up and showed everyone how flexible she is for 80 and touches her toes. We then had our snack break and ended the session.

Day Four

The fourth session was on November 4, 2005. It was raining hard this day, and so everyone showed up a little late. Everyone arrived about half an hour late except for Margherita who came in later. The group dynamic was different when she was not there. It was quieter but, as soon as she arrived, the group became more animated. We discussed the lesson from last week and started the development of the photonovel. We then chose the storyline and characters. Margherita had obviously thought a lot about the storyline because she had lots of ideas, and I had to manage the flow of conversation so the other women could have input. We talked about our audience and then a storyline (Appendix D). The story was funny and had a good plot and conclusion. The group then chose

characters, and we spent time getting deep into the backgrounds of characters such as what their families were like and what their dreams were. Finally, the women nominated each other to be specific characters. Jacky was nominated to be the main character and she complied; I was surprised because she is so shy. However, she seemed pleased to be playing the main character and was smiling a lot. Carole was nominated the director, which was great because she has a bit of an authoritative presence. It was a really exciting day, and the energy throughout the meeting was really high. Everyone had a role to play in the photonovel, and the women were planning what they would wear for next week when we took the photos. After this session, I started the individual interviews with the women.

Day Five

Day 5 was November 18, 2005. Carole, Maasa, Margherita, and Jacky were there. However, I was worried because Margherita was not there, and she was playing a vital role in the photonovel (she was the nurse). I remembered that when I lived in South America people were often tardy up to about half an hour and so I felt at ease remembering this cultural difference. Everyone was relieved when she finally arrived. I was really immersed in the project at this point, and so I forgot little details like taking attendance and putting out the food. There was a wonderful feeling amongst the women. When we started the story of Jacky arriving Canada and eating junk food, we were laughing so hard we had to stop and get refocused. Margherita was also singing in Spanish and playing the piano throughout the picture taking and Maria's daughter was dancing to the music. If anyone walked in on this session, they would wonder what I was doing because it seemed quite chaotic, loud, and unstructured. However, we got a lot

done and by the end of the day took 150 shots in various settings. Eventually, we realized we had a time change in the photonovel, but the women were still in the same outfits; so we had to re-take the pictures. This part of the project was obviously uplifting and energizing for the women, and I remember thinking that they were not just passive receivers taking in information but were creating something new themselves. It brought out a whole different part of their personalities. Maasa had made some special glasses for her role, which showed me she was thinking of the project the week we were apart. We discussed the next session, and the women requested that I hire an expert to come in to put the captions in digitally so it would look more professional. I agreed with them because the photonovel would have more power if it looked like it had been well done. The women then chose the pictures that we wanted deleted. They all requested copies of the pictures, and I promised to bring them a disk each with the pictures on them.

Day Six

Day 6 was November 25, 2006. The computer password on the laptop was blocked, and the graduate student I had hired to come in and do the digital part of the project was looking panicked. We had to run to my mother's house and borrow her laptop. Eventually, we were finally organized and the women arrived. The graduate student was putting the captions the women wanted in the photos, and Margherita was playing the piano and singing. I wondered if the graduate student thought it was hard to concentrate, but he told me he was having a lot of fun and asked me if it was stressful for me. Maria said something to me in Spanish, but I did not understand her. She then asked me why I don't remember these words in Spanish. I noticed that she challenges me sometimes. She is also very well educated and older than me, so perhaps there is

something in that dynamic that frustrates her because she and her husband have had trouble finding work here as engineers. Maria puts a lot into the dialogue and probably contributes the most in this meeting. Margherita is blind so she can't see the photos, but we explained them to her and she also gave some input.

Day Seven

On December 2, 2006, we did the editing of the photonovel. We got to the page where Jacky is on the computer and Margherita is in the background with her dog. Carole does not like the picture because Margherita is in the background and she is supposed to be the nurse (and she is not supposed to be in this scene). A power struggle develops between Margherita and Carole because Margherita wants her dog in the picture. Carole then says it is her choice because she is the director, Maria takes Margherita's side, and they start arguing. I suggest that we move on and come back to this issue later (we, later, decided to keep the dog in the picture). In another picture, Maria tells me she does not understand the word 'gross' and so we change it to 'bad'. We realized that if she couldn't understand this word then a lot of ESL speakers probably would not be able to either. The women are really surprised at how well the photonovel turned out and are happy with it. We then begin the final focus group. Margherita talks a lot during the focus group, and the women talk a lot about how they formed community during this process and about how it made them feel important. At one point the women's group facilitator takes over the focus group and starts asking questions. I felt quite offended because I had little time to get through all of the questions I had and she dominated the focus group by asking her own questions about the project and asking if the women liked it or not.

Day Eight

December 9, 2006, was our final meeting. We had a potluck, and we all exchanged Christmas cards. Everyone was chatting, but Jacky was quiet. She handed out her cards after she ate and then left early. The women told me they were surprised at how professional the photonovel looked when we were done and that they had no idea it would look so great. The ICA gave me a card signed by the staff that was full of praise for the project, so that was reassuring. The women all hugged me when they left and I felt a little sad, but the women's group leader told me not to feel that way because they all live here. The director then told me that I fit in well at the ICA because I can handle chaos well and I go easily with the flow. They also suggested I start doing workshops at other organizations. They also told me they wanted me to acknowledge the ICA in any publications I have because they were proud of the project. After our potluck, I finished the individual interviews with a couple of the women and organized to meet Maria and Margherita at a coffee shop when they had more time to talk with me.

Interviews

I interviewed the women prior to the project, then observed the women creating and using the photonovel, and then interviewed them about their responses. According to Muscari (1994), direct observation is the systematic description of events and behaviour chosen for a study. Thus, through observation, the researcher learns about behaviour and the meanings attached to behaviour. As a result, I observed and recorded how the women in the study responded to using and creating health-related photonovels and wrote down my observations immediately using field notes. According to Gillham (2000), these field notes involve evidence of discussions that I heard and actions that I observed during the

study. The field notes also involved my own personal notes that reflected on my insights, interpretations, and ideas during the study. It is important to note, however, that researchers “tend to record as data what makes sense to and intrigues them” (LeCompte, 2000). Although I intend to present the women as accurately as possible, I am aware that my own perspective will be the source from which the research results will come, thus reminding me of the importance of reflexivity throughout the research process (which will be discussed more later).

I also took pictures of the women creating the photonovel and had the women take photos of the process as well. According to Collier and Collier (1986), the camera can be used as an extension of our perception because merely learning to observe visually can be a challenge to the field worker. They believed that photographs are precise records of raw material reality and noted that photographs allow for the observations of an event as many times as needed. Pink (2001) also noted that photography is becoming increasingly incorporated into the work of those who work in other cultures: “as cultural texts; as representations of ethnographic knowledge; as sites of cultural production, social interaction and individual experience that themselves form ethnographic fieldwork locales” (p. 1). She added, however, that the photograph is contingent on how it is situated, interpreted, and used to invoke meanings and knowledge that are of ethnographic interest. Thus, in her opinion, ethnography should account not only for the observable, recordable realities that may be translated into written notes and texts, but should also account for visual images, the immaterial, and the sensory nature of human experience and knowledge around us.

I asked that the women volunteer to engage in an initial focus group and individual interviews; after the photonovel was completed, they were requested to participate in a focus group and an individual, semi-structured interview. Multiple individual interviews characterize feminist research because multiple interviews help form a bond, which some people define as characteristic of feminist research (Reinharz, 1992). Furthermore, focus groups are said to “allow the members of the target population to express their ideas in a spontaneous manner that is not structured” (Bertland, Brown, & Ward, 1992, p. 199). Participants are free to volunteer information on points that are important to them but that the researcher may not have anticipated. Flores and Alonso (1995) noted that focus groups are an important way of discovering what interviewees think about a concrete theme and what feelings, attitudes, reactions, and doubts they have concerning it, in a situation in which they can contrast their opinions. The authors added that the overall concept of a focus group is based on the therapeutic assumption that people who suffer from a problem will be more inclined to talk to others who share the same problem.

Feminist Interviewing

The interview process also adhered to that of feminist research methodology as I tried to avoid the rigid separation of interviewer and interviewee, which puts the participant in the role of the object. By listening to women speak, understanding women’s membership in social systems, and using sensitivity, feminist interview researchers have uncovered previously neglected or misunderstood worlds of experience (Reinharz, 1992). In fact, feminist researchers argue that the traditional research process reinforces the oppression of women and instead they suggest that a dialectical

relationship between the subject and object of research ties results in a truly participatory form of research. Thus, one way I overcame the traditional division between researcher and participant was to encourage the participants to talk back to me in the interview process and engage in more of a dialogue with me. Rather than speaking for the women, my goal was to empower them by giving them their own voice and by letting their voices be heard.

Although feminist research techniques aim for non-oppression and reduction of the social distance between researcher and researched, it is important to acknowledge, however, that this emphasis on collaboration between the researcher and research can hide the real power of the researcher, who undeniably has much greater control over the research process and product. Ultimately, “the researcher is free to leave the field at any time and is generally the final author of any account” (Fonow & Cook, 1991, p. 9). Furthermore, according to Johannsen (1992), any meaningful interpretation will always carry the interpreter’s perspective due to the fact that the author will ultimately be the one who makes the data understandable. However, “establishing a dialogue is the goal of a project in which the ethnographer seeks to present objectively and fruitfully a number of different “voices” each of which has the authority to contribute to a thorough portrayal of the target culture, meaningful to a variety of readerships” (Johannsen, 1992, p. 74). By recognizing that I have the power to misrepresent my participants, I hope to empower the participants by creating possibilities for them to speak for themselves by including many of their words in the results chapter.

The initial focus group consisted of nine women. Three women had just come to Canada, their English was at a very low level, thus, and they did not contribute much to

the focus group. Two women from Africa and the other four women (Margherita, Maria, Jacky and Carole) were part of the core group in my study because they came to every meeting and participated in this initial focus group (Maasa was not there). I held an initial focus group interview before the women created the photonovel because I wanted to gain a deeper understanding of the women's health experiences in Canada. The focus group questions can be found in Appendix E. The initial individual interviews were held with Maasa, Carole, Margherita, Maria, and Jacky. The initial questions were to create a demographic profile of the women. Asking the women demographic information, such as their age and marital status creates an atmosphere in which the women feel "knowledgeable and urges them to tell their life stories in their own way" (Reinharz, 1992). I then asked the women questions about their experience of health in Canada. These interview questions can also be found in Appendix E.

After the creation of the participatory photonovel, I also conducted another focus group; however, at this point it was just the above five core women who attended because they ended up constituting the photonovel group. I chose to include the option of a semi-structured interview process because I wanted to be flexible in terms of the overall interview dynamic. A semi-structured interview could also give me specific information about the women's feelings of empowerment in creating and using the photonovels and determine whether or not the women learnt anything about nutrition. The questions can also be found in Appendix E.

The individual interviews were designed to elicit the women's experiences of creating and using a photonovel to learn about health and to understand if the women had

feelings of empowerment after the project was over. These questions can be found in Appendix E.

DATA ANALYSIS

According to Miles and Huberman (1984), qualitative analysis consists of data reduction, which refers to the process of selecting, focusing, and transforming raw data and choosing which parts to code and which to discard. Analysis also organizes data in such a way that final conclusions can be drawn and verified. Furthermore, it frees the researcher from entanglement in the details of the raw data and encourages a critical level of thinking about them. According to Patton (1990), however, “because qualitative inquiry depends on the skills, training, insights and capabilities of the researcher, qualitative analysis ultimately depends on the analytical intellect and style of the analyst” (p. 372). This alerts me to the fact that as a researcher I must observe my own process and, congruent with feminist methodology, be reflexive throughout this process.

I began my data analysis by reading through all of my field notes, interviews, and looking at the photographs the women and I took of the research process. I then looked for specific theme generation in the focus groups and individual interviews, which was guided by the work of Colaizzi (1978). His analytic procedure, he said, “should only be viewed as typical, and is by no means definitive”. Accordingly, I reduced his procedure from seven steps to four steps since two of his steps referred to generating the essence of phenomenon, which was not the purpose of my study. Furthermore, I omitted a step that suggested having the participants verify the data analysis because I felt the participants’ level of English was not high enough for them to understand and interpret the analysis sufficiently. I also added one more step concerning the validation of findings that

consisted of suggestions by Guba (1978) and LeCompte (2000). The five-step procedure used in this study is summarized below:

1. Read over each participant's descriptions in order to acquire a feeling for them and to make a general sense of them.
2. Highlight "significant statements" (p. 59) that are connected to the research question. The significant statements ranged from a few words to an entire sentence. I also took note of any metaphors that the women used because "metaphors take the researcher into the heart of what matters in inquiries" (Aita, McIlvain, Susman, & Crabtree, 2003, p. 1430). Furthermore, I paid attention to any silences embedded in the interviews because "in many cases, what is not said may be as revealing as what is said ... as silences are profoundly meaningful" (Poland & Pederson, 1998, p. 294). I, thus, found that the silences in the data were quite important because "just as silence is part of voice, so voice is implicated in silence" (p. 294).
3. Read over the data again and formulate first order themes. According to Patton (1990), when data are labelled, it becomes "classified", which is a critical step because without it there is "chaos" (p. 382). As Colaizzi (1978) noted, this is the step when the researcher "must leap from what her subjects say to what they mean" (p. 59). The author also pointed out that that it is important not to sever all connection with the original data protocol but to instead illustrate the meanings hidden in the original protocols. I organized the participants' words by highlighting their significant statements and then writing my interpretation of them in the left column.

4. Repeat the above steps “vertically” and “horizontally”. Vertical readings of data involves reading each participant’s data from start to finish, and horizontal readings involves comparing each participant’s answers to each question. Then organize the discovered meanings into a cluster of themes that are similar for all of the subjects so that “items can be identified because they are numerous” (LeCompte, 2000). In the margin, beside my interpretation of the significant statements, I coded the statement with a theme by highlighting this statement in a colour to match the theme. I then looked for sub-themes, which I then highlighted in a different colour underneath the main themes. I also noted the themes and sub-themes and their matching colours on a separate piece of paper to act as a legend. This legend helps the researcher see the emerging themes at a glance, stimulates the researcher to find themes in future coding, and helps the researcher use the legend “to build a universe of all themes in the study, which the researcher recognizes, sorts, combines, discards or extends in further analysis” (Neuman, 2003, p. 423). I then referred back to the original transcripts to validate my themes by making sure that I did not miss any themes and to check if I could collapse any of the themes. Furthermore, I resisted “the temptations of ignoring data or themes which didn’t fit, or of prematurely generating a theory which would ... eliminate the discordance of the findings” (p. 61). I perceived these negative cases (Patton, 1990) or outliers as statements that inform and allow for further reflection and exploration, adding to the richness of the findings.
5. I validated the themes with another “competent judge” (Guba, 1978, p. 56)
Although the second judge cannot be expected to devise precisely the same set of

categories, this person should be able to verify that “(a) the categories make sense in view of the data which are available, and (b) the data have been appropriately arranged into the category system” (p. 57). My supervisor acted as the competent judge, providing feedback on the categories and the arrangement of the data within them. I also asked myself if I really understood and described the data in the same way that the people who live it would (LeCompte, 2000). A qualitative study is therefore considered credible if it reveals accurate descriptions of individual’s experiences and “that the people having that experience would immediately recognize it from those descriptions or interpretations as their own” (Sandelowski, 1986).

STUDY LIMITATIONS

This study was limited in a few ways. First, the meetings generally had around eight women attending but only five women who came to every session; thus, the sample size for the case study was small. Also, a few times the women who came to the meetings were at a very low level of English and, thus, found it difficult to keep up with the rest of the group. However, due to the short amount of time and resources I had, it was unrealistic for me to meet the needs of everyone. This study does not do a formal evaluation of the photonovel as a health literacy tool; however, this is a qualitative study that aims to discover, primarily, if the process of creating and using a photonovel empowers ESL speaking immigrant women by raising their critical consciousness. Another notable limitation was that Margherita spoke a lot more than the other women in her individual interviews and focus groups because her level of English was the highest in the group. Therefore, the study could be limited because what Margherita had to say

may not be representative of what some of the other group members would have said had they been able to speak English better. Finally, the study is inherently limited because my own biases affect my data collection, analysis, and findings. I tried to be aware of my biases throughout.

RESEARCHER'S PLACE IN RESEARCH

My own social location as the researcher undoubtedly played a part in the research process. I am first of all a white, Canadian-born citizen and, thus, do not share the participants' experiences of being a visible minority within Canada or the frustration of facing legal status issues and all the limitations that go hand and hand with this. I also am a native English speaker; however, I have had the experience of living in a foreign country and not being able to speak the language and can sympathize, somewhat, with feelings of isolation and disempowerment due to an inability to communicate and access information. I realize, however, that I never lived in a foreign country for more than a year and I always had the luxury of knowing I could go home at any time. I am also well educated and of a middle-class background, which may put me at a higher social positioning than most of the women in my study. I am also the daughter of a nursing professor and a doctor; I speak and read several languages. I am, however, a woman and thus share somewhat the universal experience of oppression that exists in most social worlds.

I believe that I cannot take a wholly observational distance from the participants because I am acting as a facilitator in their creation of the photonovel. I wished to empower the participants by allowing them to construct aspects of their reality through the photonovel, but I helped the participants if they had any questions during this process.

In Freirian (1978) terms, I do not philosophically view the world in a way that views myself as the subject and the other as the object. In fact, the premise of my study is participatory and it embodies the essence of empowerment because I am enabling the participant to be active in the research process and providing a space for them to broaden their abilities and share their view of the world. Thus, the participant in my study remains an active participant and not a passive one. Furthermore, as Pink (2001) advised, as an ethnographer, I need to acknowledge that the interpretations that I make of the participants' words and actions are an expression of my own consciousness and not theirs.

As a critical ethnographic researcher, I aim to be sensitive to the asymmetrical power relations between the participants and myself. Not only am I in a position of power as the researcher, but also I have the power to represent the women's experiences from my own standpoint. I have mentioned previously, however, that I see myself more as a participant observer in the research process in which I am a facilitator in an empowerment process for the participants. However, undoubtedly, my social positioning mediates how I will interpret and present the experiences of the informants. Nevertheless, I would like to articulate that my goal is not necessarily just hermeneutic and relational, but rather I hope to open up critical perspectives for the women of their own experiences. In a sense, I am also acting in part as an instrument for the women to "politicize experience, using it to instigate change in both consciousness and practice" (Lu & Horner, 1998, p. 273); and I am describing that process from my own perspective.

I have a web of perspectives about my research, but I strive to be very self reflective about my positioning when interpreting and representing the participants'

experiences. According to Lu and Horner (1998), “a theorist’s knowledge needs to be both recognized and problematized in the context of their own and others’ lived experiences” (p. 268). Reflexivity involves honesty and relates to validity as well as addresses ethical and political questions encountered in the research process (Fontana, 2004). In fact, Fontana noted that being reflexive consists much more than just reflecting on what happened. It is an attempt to identify, acknowledge, and do something about the limitations of the research, which can impair the emancipatory goal of the inquiry.

Reflexivity is an important element of feminist and critical research because it encourages us to reflect upon, examine critically, and explore analytically the nature of the research process and to be consistently conscious of our own shaping of the text. Not surprisingly, underlying much of reflexivity work found in feminist scholarship are the concepts found in the earlier works of scholars such as Freire (1970) who found that consciousness of oppression can lead to creative insights that are born out of experiencing contradictions. Often these insights are considered “breaking points” leading to emotional catharsis, intellectual insights, and political activism (Fonow & Cook, 1991). Furthermore, as a feminist researcher, working within the overall framework of critical theory, I need to examine all sources of power relations and be aware of my own biases and positioning as a writer when writing up my findings. One way to achieve this is to be clear that I am positioned as one possible voice, rather than as the neutral, authoritarian narrator, while constantly being aware of how my own class/ethnicity/gender/beliefs are implicated in my interpretations and shape my research project.

Essentially, I entered into my research with the assumption that the women I am working with are marginalized because it is the majority culture that holds most of the power and that they have difficulty accessing health information. I also anticipated that their inability to access health information puts them in a binary power relationship that involves an overall power imbalance because these women are not able to have access to information (texts with print and image) that is meaningful to them. Thus, by encouraging the women to take control and create health materials, such as texts with visuals and print that are meaningful to them (linguistically and culturally), the research can act as an empowerment process. Finally, by entering into a dialogue with the women about their health experiences in Canada, I am acting as a facilitator to raise their consciousness about their realities. I was aware from the onset, however, that I would need to be reflexive about the women's experiences, which I would most likely not be able to anticipate or conceptualize before the research took place, and my own assumptions and understandings about their experience. The following two chapters allow for the women's voices to be heard as they talk about their experiences of health in Canada, their responses to creating and using a participatory photonovel as a health literacy tool, and the process of empowerment they experienced.

CHAPTER 4

RESULTS AND DISCUSSION OF HEALTH EXPERIENCES

*Until very recently, ... the world was run by men and written
about by men, who, consequently, wrote us, our role and our place in their world.*

Isabel Allende (2003)

INTRODUCTION

As mentioned in Chapter 3, my aim as a critical theorist is to come to know about the human experience in order to promote social change. According to Freire (1970), our orientation in the world places the question of the purposes of action at the level of critical perception of reality and involves humanizing the world in order to transform it. In critical theory, the context of the women's lives becomes the focus of the research. The research, thus, helps expose power relationships and enables the participants to discover the possibilities for changing the conditions of their reality (Kendall & Sturt, 1996). Thus, the above quotation by the famous Latin American writer Isabelle Allende (2003) was included because she is representative of a woman writing in a rather machismo culture where women are often silenced. She notes that "for women in Latin America, setting down a short story is like screaming out loud; it breaks the rules, violates the code of silence into which we were born (p. xii)". Like Allende's work, this part of my thesis will aim to give voice to women in our culture who are marginalized. As Allende says, "when a woman writes, she call on us to show more love and respect for each other; why don't we just band together and set this upside-down world back on its

feet? (p. xii)”. I hope the following section will help the reader listen to the women’s voices with the respect and love that are deserved. As Freire (1970) noted, “if you do not love people, then you cannot enter into dialogue (p. 71)”.

My research questions were: how does the process of creating and using a photonovel empower ESL speaking immigrant women by raising their critical consciousness and how does this tool help them understand a specific health topic? The results appear in two separate chapters. For example, many of the initial questions I asked in the interviews and focus group were aimed to gain information and background about the women’s experiences of health here in Canada. Because the Canadian Institute for Health Information (2004) found that immigrant women’s health decreases after having lived in Canada for a few years, I wanted to have some understanding about the reasons for this phenomenon. This information is discussed in Chapter 4. However, the final interview questions and focus group were geared more towards discovering how the women responded to creating and using the photonovel as a health literacy tool and how this acted as a catalyst for empowerment. This information appears in Chapter 5.

I would also like to point out that a lot of the data in both chapters is dominated by Margherita because she was the most outspoken of the women and, also, spoke the highest level of English. Instead of occasionally omitting her voice because of its prominence, I saw her insights and opinions as valuable and interesting and, in some cases, realized that she probably spoke for the other women in the group. The sub-themes that emerged around cross-cultural differences pertaining to health were differences in life in general and health information and access.

THEME 1: CROSS-CULTURAL DIFFERENCES PERTAINING TO HEALTH

The women spoke of some cross-cultural differences relating to health. They compared their experiences with health care before and after they came to Canada. This was the theme that the women spoke of the least, but I thought it was an important theme to include because it helps the reader understand the women's previous realities and lives and also, perhaps, why the transition to accessing health information and care might be difficult for them once in Canada. The women's cross-cultural perspectives and experiences on differences in life in general, and specifically with regards to health, also help raise our own consciousness by bringing an outsider's perspective to life and health care in Canada. Participants revealed their background experiences with accessing health information and care in their previous countries.

Differences in Life in General

Even though I did not specifically ask the women about cross-cultural differences that may affect their health, the women revealed insights about this topic in their individual interviews but not in either of the focus groups. Two participants, Jacky and Margherita, spoke about some differences in lifestyles that could affect one's health status. In her initial interview (I1), Jacky spoke about how she thought that the climate in Canada affects immigrant women's health. She said, "maybe the weather is too cold in Canada. The weather. Because in Hong Kong ... in winter only 10 degrees, but here it's minus ... less than zero ... the people will get sick easily". Jacky wondered if the weather had something to do with her mother's health deteriorating here and said "before my mother came to Canada she was very healthy, but now she is always sick and going to see

the doctor. I don't know why. Maybe it's the weather. 'Cause Hong Kong is very warm and here it is very cold".

Margherita (I1) also brought up some cross-cultural differences in her experiences in Chile and then in Canada. For example, she confided in me and told me a story about when she went to see an immigration doctor about some problems she was having with her genitals; the doctor examined her and asked her what kind of sexual contact she had had. Margherita responded by telling the doctor that she had never had sexual contact, and the doctor wouldn't believe her. She reflected on her experience and said "they would believe me in Chile ... because they are more conservative there. So, if you say there you have never had sex before and you are an adult they would believe you. But, here they will think you are crazy". Margherita also later spoke to the difference in culture between Canada and Chile when she mentioned, "there is a culture here when you come. There is a culture established here, and it's different, and it's mainly sort of the Anglo-Saxon culture". Margherita also reflected on her life in Chile stating:

I grew up in real poverty ... I never had heat or I had to breath smog all my life ... It was cold all the time because we didn't have heat and stuff like that ... I didn't have the chance to go for a walk as much ... as here ... because I grew up in a big city that was crowded and there was violence ... so you could say that there is more stress down there than there is stress here.

Later in her interview, however, Margherita noted how she has been "amazed" to see how many young people in Canada have back problems and how she never saw that in Chile. She expressed her surprise and confusion about the health of Canadians (I1)

how can this be ... how can this be ... how can there be so much stress [here in Canada]. And the lifestyle down there [Chile] I mean people had to take two busses to work and not many people had cars ... and worked for more hours than the people work here ... but some how people are not as healthy here and I just don't know why ... Because here how much better can you have it? I mean ... you go on the bus, my husband has a car with heat and the streets don't flood and it doesn't matter if it rains.

Margherita also alluded to isolation being a factor that could affect health in Canada when she said in her initial interview that “in Chile ... couples stay together longer and kids are not supposed to leave home at 18 like here ... it could be my perspective, but I think that has a lot to do with health, more than lifestyle or anything”. She spoke to the topic of isolation again in her final interview when she said in Chile a grandmother usually lives with one of her kids and grandkids and has an important role to play in family dynamics. She then said that in Canada, however, “the grandmother comes here and she comes to live with another son or daughter, but probably they don't live in the same house because here that is not the norm ... and it is so depressing ... you would feel like garbage really ... you feel like you are nothing”. The women also spoke about how they used to access health information before they moved to Canada.

Health Information and Access

Most interestingly, the women in this study revealed that in their previous countries they very rarely saw a doctor for health information or care. For example, when I asked the women how they obtained health information in their previous countries, four of them mentioned that they were informed, not by a doctor, but from a teacher or a

friend. For example, Jacky found health information from her teacher in Hong Kong and noted that “in the school ... some teacher taught us how to eat healthy food and to do some exercising ... our teacher would tell us what kind of exercise is good for children and what kind of food is good for children”. Furthermore, Carole added that in her country health education was “mostly spoken. Especially schools. The information through speaking”. Most interestingly, Margherita (FG1) gives a critical cross-cultural perspective about health education in Canada and states that health education in Canada should start in schools. She believes that schools should educate kids about healthy eating habits. But Margherita also notes that if you teach kids to eat healthy vegetables and fruits and then they go to the cafeteria and buy pizza it is not a consistent message that schools are sending. Carole (FG1) also noted that there needs to be more nutritional health education directed at children.

Discussion of Theme 1: Cross-Cultural Differences Pertaining to Health

The above information suggests that the women accessed health information in their previous countries mostly through their social networks. Keeping in mind that the women’s social networks may have changed and may be less available once migrating to Canada, it may be a contributing factor to their ability to access health information in their new country.

It is notable that the women mentioned how social support could be a contributing factor affecting their health due to feelings of isolation and an inability to access health resources through social contacts. Lee, Arozullah, and Cho (2004) mentioned that a person’s social support (i.e., family, relatives or friends) can help individuals face stressful situations that may otherwise seem overwhelming and can also provide

emotional support and, thereby, promote self-esteem and self-confidence, which affects an individual's health positively. The women's revelations tie into Lee, et al's (2004) findings because the women did speak about how they never accessed a doctor in their home countries but would instead draw on their social resources for health information.

Lee, et al. (2004) also mentioned that we need to account for the social support and resources that people utilize when they encounter problems, particularly when they arise from their health literacy deficiencies. The researchers suggested "the positive resources and support in an individual's social networks can improve their ability to acquire and understand medical information and to negotiate the health care system" (p. 1314). Although the research of Lee, et al. is within an American context, it helps us understand how many people do turn to social support for health information, which, judging from the women's comments, occurs cross culturally. The above information in this section suggests that the women accessed health information in their previous countries mostly through their social networks.

Of interest also are Margherita and Carole's cross-cultural perspectives that health education should start in schools. Their perspectives likely derive from the fact that they received more health education at school. Furthermore, some Canadian researchers would agree with Margherita and Carole's comments about implementing health education in curriculum and have noted also that there needs to be education starting in elementary school with respect to good choices and poor health choices (The Canadian Teacher.com, 2005). Also noteworthy was Jacky's comment that in Hong Kong students should learn about eating well at school. However, it is interesting learn that recently there was an article released in the *Times Colonist* stating that dietary habits are changing and obesity

is on the rise in China thanks to Western food influences (McCabe, 2006). Also, Canadian statistics prove that the obesity rate of children aged 12 to 17 has jumped from 14% to 29% since 1979 (Statistics Canada, 2005). One of the key factors identified as perpetuating this problem as been the lack of access to healthy foods and the availability of high-fat food and sweets in schools and because of an estimated one-half of a student's dietary intake occurs during school hours (Dieticians of Canada, 2005).

THEME 2: COMMENTS ABOUT HEALTH LITERACY

The women had a lot to say about their experiences with health literacy in Canada. Not surprisingly, they mentioned that one's level of English could affect their health literacy comprehension. The women also spoke about positive and negative experiences they have had accessing health information and care. Furthermore, the women also voiced their opinions and comments around health education, specifically talking about barriers understanding nutritional information and about how they access health literacy information.

Level of English Affecting Health

*If I don't know English where can I go
and then I don't know anything about health where can I go?
Sometimes they'll say "go to the doctor, and I say
"I don't speak ... I don't know anything and I can't go there".*

Maria

The underlying opinion of the women is that it is very important to have English language skills to be able to understand health information in Canada. Maria (I1) told me a story about how here in Canada she once had a medical condition but didn't know the

word in English. At the doctor's office she just said the word in Spanish and found out it was actually the same in English, which she thought "was wonderful". Maria's perception of English medical terms is that they are quite similar in Spanish; however, when she tried to tell the doctor her story about her condition, she said, "I had to use my hands a lot and use a lot of expression". Carole (FG1) also shared some limitations she had in being able to understand health vocabulary in Canada. She explained that "the medicine is all from Germany in Indonesia. So, here I can't understand the medicine". The women discussed that it was easier to interact with a doctor if the doctor was able to speak their language. For example, Jacky (I1) noted that she could understand her doctor because he could speak Cantonese. Margherita (I1) also noted that a person's level of English can really affect their understanding of health information and noted that "it is a big, big concern; having translators available ... that would be a good idea". Maria also stated "sometimes it's good because you have a lot of information in English, but not in your own language ... you can find some in Spanish, like in Colombia and Chile, but something in your own language in Canada is very hard" (I2).

Margherita (I1) said she thinks it was easier in Chile to find health information, but that here in Canada she was impressed by a service she used on the phone to obtain information about the birth control pill stating that "it was confidential ... I didn't have to tell anybody ... not even my husband ... so it was good in that way". She then reflected upon her thoughts and added:

It was easy to use, but you had to speak English. I think what has helped me was that I could speak English and understand what the people said to me. I had a few instances where I couldn't understand, but that was the minimum, I could always

ask them for clarification. But I imagine for people that don't speak English that it must be very scary.

Thus, Margherita seems to confirm the Canadian Institute for Health Information (2004) hypothesis that immigrant women's health may be affected by a lack of language skills, thereby inhibiting their access to health information. In fact, in her final interview, Maria noted that she believed ESL speakers' overall experience of being in Canada would be made easier if health information was easier to understand (I2). Actually, along with Jacky and Carole, Margherita perceived her level of English as "helping" her or affecting her health positively. Indeed, Margherita did have a high level of English and spoke quite fluently compared to the rest of the women in the group. However, she did speak of a time when she had difficulties communicating with a doctor in Canada and emphasized with other women who may experience this also:

... for other people it has been something hard. Because you have to go to a doctor and you don't understand. Actually, I remember the first immigration examination that I had to do I couldn't understand what the doctor was saying very clearly. And I didn't think that the doctor was very understanding about that. Because I could speak English, but I had never been in an English speaking country never before ... and then this doctor was talking to me and asking me questions and I couldn't understand what he was saying and that can be very frustrating and frightening ... especially when the other person is not very patient about you not understanding. (I1)

Margherita's comments give an insider's perspective into what it might feel like to be unable to communicate with a doctor and powerful feelings of frustration and fear. Carole

(I1) also perceived her English as being good and stated that she never has trouble accessing health information because she “speaks English”. She added that she had a good relationship with her doctor and, thus, felt she did not have difficulties understanding health information.

Maasa (I1) who probably had the lowest level of English in the group, despite having lived in Canada for more than 37 years, said that she thinks that English is a very difficult language for her and that she will be learning the language every single day until she dies. She said

I want to say ... new immigrant people ... like the newcomer ... they have to study English before they come. If you coming here without English ... you have to study English much harder than you think. Otherwise you are not going to get any education without English. ... but so far I have found that in Canada English is very important ... you have to have English to survive. ... You don't need much money, but you have to have English to survive. (I1)

Obviously, Maasa's perception is that English language skills are more pertinent to survival in Canada than even having money. The fact that she added this comment at the end of the interview as a final thought signifies the importance she gives to being able to speak English well, which is likely based on her experience of being a low-level English speaker and the difficulties she has faced around this.

Accessing Health Information and Services

Another sub-theme that surfaced under the theme health literacy was the women's comments around accessing health information or care. Different issues were brought to the surface by each woman. For example, there was talk of difficulties finding a good

doctor and the short amount of time doctors spend with the women. There was also talk of having more trust in family members back in the women's home countries than in the medical system here. However, the women also spoke of positive aspects of health access in Canada and spoke about the availability of recreational centers in Victoria, the prompt service in emergency rooms and having a positive relationship with their doctors. One especially strong opinion on this topic was expressed by Margherita. She was frustrated by her non-immigrant status and the lack of access to medical care she experienced because of this, which she spoke of extensively throughout all her interviews, especially in the initial focus group and interview.

Margherita (I1) noted her frustrations when she stated that she wanted to have a child but was worried about being pregnant in a country where she had no access to health services. She said:

If you are not a landed immigrant, you cannot access medical and that has been really frustrating, 'cause sometimes I have needed to go to the doctor or just the fact if I get pregnant I can't just go to the doctor. And then the dental care ... that is another thing. So minimum things I can't access and I think that is not a good thing. It certainly has affected me and so thank god I haven't been sick.

Thus, for Margherita, even though she speaks English well and isn't inhibited from comprehending health information from a linguistic vantage point, she is, in fact, very limited in the way that she cannot access medical help. She spoke a lot about her frustrations around this issue. For example, when I asked her what advice she would give to immigrant women, she said (I1):

If I was giving advice to the authorities I would say that health care should be extended to immigrant and refugee women and people who come here who cannot access. And I think that medical care and health care is a right and it doesn't matter where you come from because it should be given to a person just because you are a human being. Many people would not agree with what I say, they would say you are not Canadian and you are not supposed to get it. But, I think if you are a human being. If you are here you are here. And what happens if you get sick ... I mean are you going to be sent back to your country? Or what are you going to do?

Margherita also noted that she was not able access medical care because she did not have immigration status. She said "I went many years without being able to access a family doctor. So, actually I haven't been to the doctor ... at the beginning I went to the doctor that they have for people that can't access the public health care system. They have a doctor you can go to for free, but it's a general thing ... they can't send you for examination anywhere else of for tests". Margherita also adds, however, that she is not as worried about being sick as she is about not being able to have children in lieu of her immigration status and lack of access to medical care.

Maria (I2) also commented that she gets most of her health advice from her mother who lives in Chile. She said:

Whenever I have problems I call my mother ... and the sister of my husband she is a nurse ... I speak a lot with her ... especially if I am concerned about my daughter ... or I feel bad ... or ... I prefer to talk with her and its better for me. I

understand ... and I have a lot of confidence ... or trust ... because I met her a long time ago and here it is difficult.

Some of the women who went to see a doctor complained about the medical attention they did receive in Canada. For example, Maasa stated that if there is a good doctor then they will not take new patients “so you have to cope with what you have” (I1).

Furthermore, Maria noted that she never had the chance to talk as much as she wished she could with the doctor she saw in Canada and used these words to describe her experience: “it’s always in a hurry ... what happened to you? Okay see you later” (I1).

The women also commented, however, on some more positive experiences with accessing health care here. For example, Maria (I1) noted that she was able at one time to go to the emergency room at 6 am and receive quick medical help. Carole (a landed immigrant) noted that she had access to health information from being a part of the ICA women’s group and that she had a very good relationship with her doctor, whom she sees frequently. Margherita also pointed out how easy and economical it can be to use a recreation centre in the city for exercise, but it’s just a matter of women having information about these services (I2). Furthermore, Maasa (who used to be a nurse in Canada and is a landed immigrant) stated that she has access to all levels of people in the medical system and that she can go to these kinds of people and they will help her. However, later in the interview, Maasa noted that she feels that many Canadian people have the same health problems as her and she is shocked when Canadian people ask her if she can help them and responds back by saying she thinks these people are “crazy” because they are born and educated here and that they should be helping her and not the other way around.

Opinions and Comments around Health Education

The women revealed their opinions and comments around adult health education, which helps the reader understand some of the struggles the women have had around comprehending nutritional information and about how the women have accessed their health literacy information here in Canada.

Nutritional Information

The women stated that nutrition was their main health concern upon living in Canada. Of all the women, Maria (FG2), by far, had the most to say on the subject of not being able to understand nutritional information in Canada. She often spoke of her experience of having no information about the foods or ingredients here and her struggles to become educated about this aspect of health in Canada. She notes that “my husband’s father came here and he took ... a lot of people say cook this ... and I say I have no idea what that is ... cause I don’t have a recipe”. Furthermore, she noted that she used to always buy bars for her daughter, but her doctor told her that they were filled with sugar. She was alarmed and confused because on the package they said “healthy foods”, but she then discovered from her doctor that they were actually unhealthy. Furthermore, many of the immigrants complained about a lack of clear, comparable, and easily interpretable information. Maria also said (FG1):

You can go to the supermarket, because I suppose there are a lot of the same foods as in Colombia, but if I don’t use ... But, I am not sure it it’s the same ... like vegetables. I don’t know what it is. A lot of fruits, they are delicious, but I don’t know what they all are. It’s good to go with somebody else, they describe it to you.

Maria also continued describing her struggle understanding the food here in Canada in her initial interview and told me the following story:

I miss a lot of the fruits and everything. And the other thing is that we just don't know the food. I know the name in Spanish is "cumice" and I never saw here and it's with milk and my friend told me that we have that here ... it's called buttermilk. Buttermilk is that it ... and it was the same ... the same in Colombia, but I didn't know the name in English ... the Spanish name is "cumice" and there is nothing similar. If I saw buttermilk, I would never buy it because I don't know what is buttermilk ... so I am healthy ... but I don't buy the buttermilk before, for example, because I don't know the name. But, I improve ... a little English to know the normal things to buy.

Margherita also suggested that it would be a good idea if there were a lot more workshops about health in general at the ICA or at the local refugee center that are aimed at immigrant people in particular as she believes "there is a real lack of it". Margherita believes this would be valuable because immigrants "need to worry about the dangers [gaining weight] you know ... the changes".

Health Literacy Information

It was interesting to discover what kinds of health materials the women accessed to learn about health in their initial interviews. Carole noted that she never checked the Internet or read magazines to learn about health but instead watched television and talked with her doctor. She also said that sometimes she reads health pamphlets. Jacky (I1) told me that she doesn't have a computer, so she doesn't use the Internet to learn about health, but that sometimes she watched TV to learn about healthy eating or talked to her doctor.

Margherita (I1) also stated that although she never watches TV or reads to learn about health, because she is blind; she asks a nurse or a doctor or talks to other people. She pointed out, however, that there are many good ways to teach people about health because “everyone learns in a different way”. She suggested that people read books, magazines, or pamphlets, use the Internet to learn about health or speak to a doctor or nurse. Maria (I1) seemed to obtain her health information from relatives in Colombia, from pamphlets, and from community centers. She said that at her local community center the nurse “was beautiful; it’s a woman. She sent me a lot of links about health food for my girl”. She noted that when she looks for health information on the Internet she looks for information in Spanish. Furthermore, in lieu of Maria’s struggles understanding the food here in Canada and the variety of choices she was not familiar with, she suggested that there should be classes held in the supermarket.

Maasa (I1) told me that she obtained health information through reading or asking friends that work in the hospitals. She points out, however, that there are so many different cultures of people here and you have to know how to talk to them. Otherwise without a cultural knowledge you cannot teach them because, for example, in some cultures it is not appropriate to touch someone’s bare skin. She also draws on her expertise as a retired nurse by stating that in some countries people never talk about their body, so when delivering health information she believes that “you have to study people’s culture first, but it’s difficult”.

Discussion of Theme 2: Comments about Health Literacy

As previously noted, the Canadian Institute for Health Information (2004) found through a national survey that the majority of immigrant women who moved here said

they were in good health upon arriving Canada, but after two years there is a considerable decrease in their health. Furthermore, Hyman, Guruge, Makarchuk, Cameron, and Micevski (2002) noted that research has found that the health status of recent Canadian immigrants is better than that of long-term immigrants and native-born Canadians in terms of their overall health status and the lack of certain chronic diseases, such as cancer and heart disease. Thus, the healthy immigrant effect refers to the observation that immigrants are frequently in superior health to the native-born population but lose this health advantage over time. A hypothesis for the women's health decreasing is because language barriers prevent immigrant women from accessing health care (CIHI, 2004; Hyman, et al., 2002).

Actually, the women in the interviews and focus groups help to inform us of the reasons why immigrant women's health might decrease upon moving to Canada, which is important information for health researchers. Meyer, Torres, Cermeno, MacLean, and Monzon (2003) noted that on an international level the importance of focusing on women's health has been acknowledged, but that there is growing concern that minority women are not always included in the research. Recently, however, Meyer, et al. noted that there is growing literature in the area of immigrant women and health but this is a recent progression. According to Hyman, et al. (2002), initially the focus of health promotion programs in North America was on the reduction of health risk through interventions directed at broad population segments and not toward specific groups. Therefore, majority-culture, middle-aged, and middle-class individuals were the primary beneficiaries. As there is a lack of research in this area (Hyman, et al.; Meyer, et al.; Rootman & Ronson, 2005), the women's voices help inform us about (a) how their lower

level of English affects them from understanding health information, (b) their comments around accessing health information and services, and (c) their opinions and comments around health literacy education. When women's voices are heard, it increases their participation in sharing knowledge and informs us of ways to empower ESL speaking immigrant women to understand and access health materials. Having the women's voices in my study heard around their health experiences is important because, as Meyer, et al. (2003) noted, few studies on women's health include immigrant women as participants and fewer are conducted by women themselves. Furthermore, adhering to feminist interviewing techniques – by listening to women, understanding their membership in social systems, and using sensitivity – I may be able to uncover previously neglected or misunderstood worlds of experience (Reinharz, 1992).

Lower Level of English Affecting Health

One of the sub-themes under the health literacy theme was “level of English affecting comprehension of health information”. I found the women's responses around this fascinating because they alluded to the Canadian Institute for Health Information (2004) hypothesis that one of the reasons immigrant women's health decreases when they come to Canada is because a lack of language skills inhibits them from accessing health information. This hypothesis was the basis for my study and was, essentially, what encouraged me to do a background literature review concerning most effective ways to educate ESL speaking immigrant women about health. This review of literature led me to discover the photonovel as a potentially effective health literacy tool that embodies empowerment. Thus, it is fascinating to gain insight into what the women had to say about levels of English affecting their general health status. It is noteworthy that the

women mostly commented on how lower levels of English could, in general, affect immigrant women's health status, but because many of the women in this study perceived their levels of English to be quite functional (despite some mentioned challenges understanding health information) and they attributed this to affecting their health positively. The women also voiced their opinions about the importance of having translator services available or a doctor who speaks their language, but the overriding opinion was that one must have adequate language skills to understand health information here in Canada.

On another note, Maria mentioned that she incorporated non-verbal dialogue when communicating with her doctor about her medical condition as a way to compensate for her lack of English language skills. The effectiveness of non-verbal communication coupled with verbal communication to communicate about health is discussed by Mayeaux, et al. (1996) who noted that it is important to communicate with patients by demonstrating things, giving tangible examples, and repeating information several times. Furthermore, Carole mentioned that she struggled to understand the medical vocabulary here in Canada because in Indonesia it was all in German. Actually, Mayeaux, et al. commented that researchers have found that patients with low literacy skills often struggle to understand things like oral instructions and labels on both prescription and over-the-counter medications. Most interestingly, the women's experiences of having difficulties communicating their health experiences or understanding health information in English is discussed by Simms (2003) who noted that the inability of immigrant women to speak English well is a major obstacle to them accessing services like health. Furthermore, as Singleton (2002) noted, ESL learners may

lack the vocabulary to comprehend health information or to create health-related questions, which is clearly illustrated in the above scenarios depicted in the results section.

A few of the women also voiced their opinion that one can understand a doctor better if the doctor spoke their own language. It was also mentioned that having translators available to aid ESL speakers understand health information would be effective. Stephenson (1995) who studied health care for Vietnamese immigrant and refugees in Victoria, BC, found that the most common barrier for the immigrants accessing health care was language. Stephenson noted that inadequate translation services were widely expressed by the participants as compromising health care in many ways. Most interestingly, Stephenson noted that in the United States studies have also shown that lack of interpretation services lead to underutilization and/or delayed use of health care.

A lot of the women mentioned the importance of having adequate English language skills when living in Canada. For example, Maasa mentioned that English language skills are more crucial to survival than even having money. In fact, Mojab (1999) noted that trends in Canada have indicated that education is not a determining factor in access to the job market. The play of immigrant women's skills, high or low, are constrained by factors such as gender, national origin, race and, notably, knowledge of the official languages. Furthermore, researchers like Singleton (2002) note that the fewer language and cultural skills one has, the less likelihood of having insurance, access to preventative care and an understanding of the US health care system. As well, Hyman, et al. (2006) noted that, for example, a non-English speaking immigrant woman is less

likely to be informed of healthy diets and experiences more informational barriers to being healthy than a woman with English language skills. It is also interesting to discuss the women's comments around accessing health information and services in Canada.

Accessing Health Information and Services

There was a lot of discussion amongst the women about difficulties accessing health information and services. For example, Margherita mentioned many times throughout her interviews that her non-immigrant status created barriers to her accessing health care. Actually, although through its administration of the Canada Health Act Health Canada (2004) is committed to maintaining this country's renowned health insurance system, which is universally available to permanent residents and accessible to those with income barriers, obtaining immigration status can take years for many people who move to Canada. Thus, there are many non-status immigrants in Canada who do not have access to health services (Elatrash, 2006).

Maria also mentioned that she feels more comfortable accessing health information from her trusted family members in Colombia rather than going to a doctor here in Canada. In fact, Wilson (2003) noted that low-literacy patients often avoid situations that require understanding English well and, for example, ask friends and family for help instead of going to a doctor. Once again, research by Lee, Arozullah, and Cho (2004) alerted us to the social support and resources that people utilize when they encounter problems stemming from their health literacy deficiencies. In fact, the authors suggested that positive resources and support in an individual's social networks could improve their ability to acquire and understand medical information and to negotiate the health care system.

Maasa made a comment about “Canadian people” asking her for medical advice. From a feminist critique perspective, what is fascinating to me about this comment from Maasa is that even though she is a landed immigrant and lived in Canada for over 37 years she still refers to non-immigrant people as “Canadian” people. She also illustrates feelings of disempowerment around accessing health by stating: “Canadian people cannot help me” (11). Maasa’s comment may tie into feelings of vulnerability common to immigrant women. Immigrant-specific conditions, such as economic status and low language skills, are affected by many systems of oppression, such as class, race, and ethnicity to further increase women’s feelings of vulnerability in Canada (Menjivar & Salsido, 2002).

Opinions and Comments around Health Education

As stated in the literature review, there are many ways to educate ESL speaking women about health. Methods such as simplifying patient education materials, using visuals and pictures and symbols, using oral instruction with text, culturally relevant approaches and participatory educational materials were reviewed for their effectiveness with an ESL speaking population. Based on the literature review, I found that participatory educational materials, namely the photonovel, would be a very effective means to educate ESL speaking immigrant women about health (i.e., Rudd & Comings, 1996; Moffit & Vollman, 2004; James, et. al., 2005). However, it is important to consider not only what research says about best ways to inform ESL speakers about health but also to ask what the women’s opinions are around best health education practices. By asking the women their opinions, it enables them to contribute to the body of knowledge around the health literacy needs of this population and acknowledges them as the expert, which

helps increase the participation of immigrant women in health research studies and calls for their sharing of knowledge (Meyer, et al., 2003). Barriers to understanding nutritional information were mentioned a lot by the women.

Nutritional Information

Aspects surrounding the women's experiences with nutrition were talked about at length, which is perhaps not surprising in light of the fact that several studies have reported changes in dietary patterns among different immigrant groups upon immigration (i.e., Pan, Dixon, Himburg, & Huffman, 1999). The importance of nutrition and the immigrant experience is discussed by Welsh, et al. (1998), who noted that some researchers have found that access to food is an important immigrant health issue because nutrition has been linked to several chronic diseases including cardiovascular disease, some cancers, and osteoporosis (i.e., McGinnis & Foege, 1993). The authors also noted that access to food has long been a problem for the most vulnerable segments of the population.

In the results section, Maria expressed her own difficulties about not being able to understand information about food ingredients here in Canada. Maria is not alone in her experience because food labelling was found to be an important issue for immigrant populations in Welsh, et al.'s study (1998) as they found that the immigrants in their study noted that it is difficult "to become familiar with the diverse foods in Canada, their ingredients and nutrition composition, and their health consequences" (p. 4). Maria's challenges understanding information about the food here in Canada is confirmed by Hyman, et al. (2002) who noted that access to nutritional information, strongly associated with fluency in the host country language, is an important determinant for food choice. In

fact, they noted that ingredient and nutrient labelling that respect the diversity of language and literacy skills are lacking and that there are few nutritional campaigns identified that exist in languages other than French or English. Furthermore, Welsh, et al. (1998) noted that finding familiar, culturally acceptable, and fresh foods was one of the most important concerns reported by the immigrant participants in their study. Maria also mentioned that she could not seem to find similar foods from Colombia in Canada, which affects her eating habits. Actually, Hyman, et al. (2002) noted that many immigrant women are unfamiliar with Western foods and preferred to stick to foods they are comfortable with. Tong (1986) studied the food habits of Vietnamese immigrants and found that unfamiliar foods and a different food marketing system are among the most immediate problems confronting Vietnamese immigrants. For example, she noted that fish and seafood were eaten much less by Vietnamese immigrants in the West because of the lack of fresh and familiar kinds in the supermarket. It may be difficult for women to find the foods they are familiar with in Canada.

Margherita also had a good point when she said that there should be a lot more workshops about health at the ICA or other immigrant centres because there are not many available. Actually, Margherita is correct because, according to Hyman, et al. (2002), many health interventions in Canada do not necessarily apply to immigrant women. Margherita also mentioned that these workshops would be valuable because immigrants need to be alerted to “the dangers ... the changes” of diet. Margherita refers to the changes she experienced in her diet upon moving here, which again is a common experience for immigrant women who come to Canada (i.e., Welsh, et. al, 1998; Hyman,

et. al, 2002). It is also interesting to focus on what the women said about accessing health literacy information here in Canada.

Health Literacy Information

The women in the study, obviously, had various ways to access health information here in Canada, which varied with each person. For example, there was discussion about watching TV to learn about health, reading health pamphlets, asking a doctor about health information, and talking to a relative at home. This ties into common learning theory that people learn in various ways such as through (a) visual learning, (b) auditory learning, and (c) kinetic (tactile) learning (Learning styles explained, 2005). Thus, the photonovel attends to all of these learning preferences because it is highly visual, it requires the participants to act out and say the message orally, and the end product is a concrete, tactile learning tool. Furthermore, there was talk of some of the struggles the women had understanding health information here in Canada and health education in school especially around issues related to nutrition. The women also mentioned there needs to be health education directed specifically for immigrant women and that these interventions should be culturally relevant. It is interesting to explore the women's reactions to the photonovel to see if, in fact, they felt that their health literacy needs were met with this tool.

Of interest was that Maria mentioned that she looks for information on the Internet in Spanish. In fact, there is some research suggesting that one way to improve the health literacy of patients is to provide translated health literacy materials so that ESL speakers can access the information (Singleton, 2002). Maria also mentioned that she thinks that classes should be held in the supermarket for immigrants who do not

understand the foods in Canada. Actually, Maria's comment ties into Welsh et al.'s (1998) findings who noted that food education should provide immigrant women with skills in Canadian food and nutrition and also empower them through activities related to empowerment (such as reducing isolation and improving language skills). Maasa noted that one should be familiar with another's culture when teaching health information. Maasa's wisdom is notable because along with arguments for health care workers to receive cultural training when working with minority people. Brach and Fraser (2000) pointed out that there is evidence to suggest that cultural competency techniques in health care could actually be effective in reducing health disparities in minority populations.

THEME 3: MONEY AFFECTS ACCESS TO HEALTH

Another theme that emerged from the data was how money affects the women's ability to eat well and affects their overall health. There were certainly some comments made by the women about not being able to eat well because of financial problems. In the initial focus group, for example, Carole noted that here it is more expensive to buy meat and fresh food. In my study, all of the women in the first focus group unanimously agreed with Carole's comment and there was a lot of chatter when Carole made this comment. Once the chatter settled down, a participant said, "the organic food is expensive, but I have noticed it seems no better". Margherita then added that:

people that come here ... some come with a whole bunch of money ... the business class immigrants, but most people don't. So the organic food ... you can get at the lifestyle markets ... you can get fresh meat or free range meats ... and you can buy things that taste better, but they are more expensive and if you are living in a low income it's hard to get that kind of food. And some people that

come as refugees, they have to go to food banks and food banks are left over from the grocery store.

In her individual interview, Maasa noted that you need some kind of private dental or private health insurance and that without that:

when you hit my age ... nothing. Nothing can help you and Medicare not going to cover anything ... so you should see if their own people have enough money to spend on the insurance ... I told everybody spend the money on insurance and invest in your health. I told them that ... the government is not going to cover it Even for teeth its about 400 dollars ... if you don't have 400 dollars you have to be in pain for many days until that teeth comes out by itself and that is not easy.

Later in her interview Maasa said that if you are asking for a treatment or medication that it could cost you around \$60 a week, so on her budget that is a problem for her. She told me that when she had good money and was working she had a hearing aid. Now that she is retired she needs another one but cannot afford it. She asked if she could get coverage from Medicare but was notified that they won't cover a hearing aid. Maasa pointed out that if you don't save for private health insurance "you will be in very big trouble". She told me that once she had pneumonia and had to pay for medication. She said "I had medication under the coverage of Medicare, but it was going to be very slow. If you pay more money ... they can get very quick things. So, I choose to pay the medicine. I don't want to sit for days and days. The medicine cost me a lot ... no grocery money now, only for a couple of days". Carole also added to what Maasa spoke to when she said, "yeah, I only need the money to buy the medicine for my bones".

Maria, in her initial interview, also spoke to the fact that it is difficult to eat well in Canada because it is expensive. She stated that she doesn't think healthy food is cheap and that "organic is more expensive. Because I saw organic tomatoes ... but it's a little more expensive than normal. I always choose cheaper, I don't care organics or not or who made it".

Margherita (I1) told me that she feels that a lack of money has been a factor that has affected her health negatively in Canada. She said that "money is affected because by not having money to buy the right food to eat and on the other hand not having enough money to go and work out somewhere that you like". She also told me that she could not go and see a normal doctor about getting birth control pills because they would charge her and she could not afford to pay (I1), which affects her access to health care. She later commented that organizations should set up clinics with volunteer nurses and doctors. To help people for free to give them some free relief care because so many people cannot afford it and they cannot access it. She expressed how this particularly affects refugees:

so, for example if you come as a refugee, you probably don't know this, in the process when you do your claim and then you do your hearing for them to find out if you are really a refugee, you go through a process for months and months where the maximum coverage is only 300 dollars a year and it is only for real emergencies, so you can't go to the doctor if you are pregnant ... I mean even for tourists that come here it is very expensive to get health and its something that people just can't afford ... most people can't (I1).

Margherita stated that a minority of immigrants come here with a lot of money and that there should be private health care here in Canada to accommodate those that do not have any economic resources (I1):

it would be a better thing for the public health care because their resources would be destined to the people who really need it, rather than the people who do have the money to pay private and that would be a solution for the immigrants too you know.

Finally, after the photonovel was done, Carole (I2) noted that she thinks:

if you buy your own food and cook it yourself it's cheaper than buying the junk food. You see when you eat out it's at least \$5 and you buy meat and vegetables you can eat for two to three days. If we are eating and getting old they have some sickness and so they have to buy medicine and that is why they spend more money ... just like me because I have broken hip.

Also notable was a comment by Maasa who stated that one of the reasons she thought the photonovel was a good way to give people a message was because it does not cost anything, which illustrates the accessibility of this type of health information. The following will discuss what the women had to say about money affecting their access to health.

Discussion of Theme 3: Money Affects Access to Health

According to Hyman, et al. (2002), it is well established now that immigrants are disproportionately poorer than the general population. Furthermore, the authors found “that poverty influenced the acquisition of safe, nutritionally adequate and personally acceptable foods”. The authors also noted that imported foods and specific cultural foods

are often more costly than foods typically found in a North American grocery store. Actually, the women did mention that their diet was negatively impacted by a lack of finances. This is confirmed in the research by Welsh, et al. (1998) who found that one of the common concerns (along with factors such as affordable housing) was the price paid for accessing food items. For example, many of the women seemed to agree with Carole when she stated that it was more expensive here than in Indonesia to buy fresh foods. This is also discussed in research by Hyman, et al. who noted that, compared to many immigrants' home countries, traditionally healthy foods such as fish and shellfish were more expensive in North America.

In fact, Pan, et al. (1999) speculated that one of the possible explanations for dietary changes in food was due to economic constraints because of a limited amount of money to spend on food and the increased availability of other American-style foods. Maria also alerted us to the fact that it can be difficult to eat well because healthy food can be too expensive. This was confirmed by Hyman, et al. who noted that cheaper foods are reportedly consumed more frequently by immigrant women. Margherita also brought up a good point when she noted that some people, like refugees, have no other choice than to access food banks as a means to nourish themselves. Actually, Welsh, et al. found that food banks were never viewed by immigrants as being an ideal means of accessing food and in some cases were viewed as “stigmatizing, intrusive and inappropriate in terms of the foods provided” (p. 4).

I would also like to address some of the comments that Margherita made around not being able to access health care because of her immigration status and her concerns that she would have to pay for health care if she needed to access a doctor. Her comments

were also recently paralleled in an article written by Elatrash in the Montreal newspaper the *Montreal Mirror* (2006). The author noted that non-status immigrants face almost insurmountable obstacles to getting health care in Canada. In an interview Elatrash had with Paul Caulford, a doctor at Scarborough Hospital who coordinates a Toronto volunteer clinic for non-status and uninsured immigrants, Caulford said, “most of them aren’t rolling in dough. They can’t often afford the bills, and when they do get billed it just pushes them further underground (p. 1)”. Elatrash noted that the challenges faced by non-status immigrants in Canada disturb Caulford, who says the Canadian health system could afford to treat them. Caulford stated, “if you’re prepared to say health care is a defining Canadian value, it should be extended to all our residents ... these people work, they pay taxes, they do the jobs that no one wants. And their taxes go to support the health care we don’t give them access to (p. 1)”. In light of this information, it is clear that Margherita’s insecurities over not being able to access health care because of the out-of-pocket cost is a common sentiment that many non-status immigrants face.

On the other hand, however, Maasa’s comments are also noteworthy because even though she has immigration status she still experiences barriers to accessing health care due to financial constraints. For example, some provinces in Canada have additional benefits under their respective health insurance plans, which are at their discretion and on their own terms and conditions. While these services vary from province to province, some examples include prescription drug benefits, dental care, optometric services, chiropractic services, hearing aids, transportation services, and home care programs (Health Canada, 2005). In British Columbia, for example, hearing aids and prescription drugs and dental services are not covered by MSP (Medical Services Plan, 2005), which

explains why Maasa suggests that immigrant women buy into their own private health care plan in order to undercut some of the extra expenses for health services not covered by MSP.

The next chapter conveys how the women responded to creating and using the photonovel as a health literacy tool and how this acted as a catalyst for empowerment.

CHAPTER 5

RESULTS AND DISCUSSION OF PHOTONOVEL

*We must learn to be vulnerable enough to allow our world to turn
upside down in order to allow the realities of others to edge
themselves into our consciousness.*

Lisa Delpit (1988)

INTRODUCTION

Chapter 4 represented results and discussion concerning the health experiences of immigrant women in Canada. This chapter represents the women's responses to creating and using a participatory photonoval as a health literacy tool. The experience of creating a photonoval raised the women's critical consciousness about their situation in the world and encouraged them to become aware of actions that they can take to change their reality. In particular, Delpit's (1988) words stated above – noting that we must become vulnerable in order to allow our perceptions to shift through hearing the realities of other people – relate to this chapter. The women's perceptions of their reality shifted through the photonoval project. The women's voices that are often marginalized and silenced resonate. Friere (1970) said, "dialogue is the encounter between people, mediated by the world, in order to name the world (p. 69)".

In short, the women had a lot of very positive things to say about the photonoval project once the final product was printed and they were able to see the result of their efforts. The women also commented about the effectiveness of the photonoval as a health

literacy tool. Many of their reactions also revealed their empowerment, which will be looked at as the final theme. The women had overwhelmingly positive comments about the photonovel experience.

THEME 4: POSITIVE COMMENTS ABOUT THE PHOTONOVEL PROJECT

There were a lot comments made by the women that pertained to the positive feelings that they had towards the project and the final product that they created. It was difficult to narrow their comments into sub-themes because there were many positive words spoken that became consistently woven in throughout their interviews. The five sub-themes under the positive comments made about the photonovel that I deemed most notable were the women's comments about how they felt proud of the photonovel they created especially that it was readable. They also spoke about how memorable the process was and that the photonovel is an enjoyable and innovative educational tool.

The Photonovel as Something to be Proud of

In the final focus group, Maasa commented that she liked the timeframe for producing the photonovel and the length of the actual photonovel and said, "I think it's a short program and it's in a good spot. I like that. To me it's *fantastic*. ... also [looking at the photonovel] it's not short, not too long. If it's too long it's kind of boring. But, this is just ... look at the story and it's gone at a good time". Maasa also said that she enjoyed the process of taking pictures and also said that the project "is very nice and I am happy with everything. It is very good" (FG2). Also notable was something she said later said in the interview:

this story is very simple and it's a very good idea people never think about these kinds of stories ... because some people like me I don't want to pick on

somebody, but those kinds of things come up. It's a very good idea and it doesn't hurt anybody. And months and months later I can come and pick up the book and give it other people ... I will do that (FG2)

On a side note, the above comment by Maasa is notable because it illustrates how proud she is of the final product and that she wanted to reach out and share the photonovel with other women.

Readability of the Photonovel

Margherita (FG2) noted that she would read the photonovel in a doctor's office because it is better than reading a magazine and it calls your attention. She said "I am pretty sure people would read it just to see what it is. You know those little bubbles and balloons. I am sure, yeah". Margherita (FG2) also noted, in good humour, that they should hand out this photonovel at immigration because it would help immigrants eat well. She noted that, had she read something like the photonovel *From Junk Food to Healthy Eating: Tanya's Journey to a Better Life*, she would have been better prepared for our culture of food stating: "if you read this when you arrive ... it would set off a red light ... and would help others understand the culture here".

The Photonovel Project as being Memorable

When I asked the women in the focus group how the first half of the project (which was deciding on a health topic and having the nurse come in and involved having the women receive information) compared to the second part of the project (which involved the women being active in creating a story, developing characters, and taking a photos), Maria (FG2), who is perhaps a tactile learner, answered that "you remember more when you make the thing really. It's like in school you have to touch, to feel ... if

you only sit it's not enough. It's good to feel it". Margherita (FG2) then continued this thought by saying "yes, to experience it", and Maasa then responded by saying that it is a more exciting way to learn. Margherita (I2) also noted in her interview that she would remember the photonovel well because she found the process so engaging and because they were able to choose a topic that was important for them.

The Photonovel as an Enjoyable and Innovative Educational Tool

In their final interviews, the women expressed some more positive reactions to the photonovel. For example, Maasa (FG 2) illustrated her enthusiasm for the project when she said, "I think you can have more of different types of ideas. For the next project ... you can go on and on and on. ... you can keep going and never stop". Margherita also responded to this comment in the final focus group and added "yeah, different types of topics, sure why not? ... it's a lot of fun".

Also, Maasa later in the focus group noted that what I was doing was very nice and that she learnt new forms of communication. She expressed that she thought it was a new kind of idea and that I brought so many things to the group. She stated:

I was thinking it was not serious at that time and it was just fun to play with it. It's when it comes up on paper. It's totally different. It looks very serious and very fun. I think it's a good thing you did. A really, really good thing.

Maasa illustrated at the end of our interview how appreciative she was of my efforts when she said, "I want you to know that everybody likes you. And you did a good job and I liked it so much. It's just the beginning; you just started it ... this kind of program. It's very nice". She also noted that she liked making the photonovel "very, very much" and that she was glad to have been there. Carole also commented that she liked

the photonovel very much. When I asked her what in particular she liked about it, she said, “It’s perfect. Just perfect”. She also told me she thinks other women will enjoy reading it and added, “I enjoyed both of them touching their tummies. Both of them big, big tummies because of junk food. It’s quite a good story”. Furthermore, all of the women stated that they would tell their friends to participate in a photonovel project if they had the opportunity. Jacky (I1) expressed that she felt she learnt about being healthy from the photonovel and that it was a positive experience for her. She also felt it was nice to know she made something that she could keep, which illustrates her sense of ownership and empowerment. Margherita also had positive things to say about the final product of the photonovel and stated that she thinks it was great and that she was really excited about the final product. She noted that the process was also fun and that she enjoyed it a lot. She told me she loved creating it and then told me: “it’s a part of my life that I really have to put more into” (meaning her creative side). She also found some comfort in the photonovel project because it related to her own culture, in the sense that photonovels originated in Latin America and were very popular there when she was little. Maria’s comments were perhaps less positive as she noted that the photonovel helped her understand health better and that she enjoyed making it, but that she needed more information. However, she did note later that it was a nice way to learn and that it was a very different way to learn. Maria suggested later in her interview, however, that the photonovel should go deeper and, if there were more time, a series of photonovels on the same topic would be helpful. Finally, the women unanimously noted the part they liked best in creating the photonovel was taking the pictures. The following will add perspective to some of the comments the women made about the photonovel project.

Discussion of Theme 4: Positive Comments about the Photonovel Project

The women made a lot of positive comments about the photonovel process and the photonovel product. I found it interesting when Maasa showed her pride about the photonovel product and commented that she would like to give it to other people to read in the future. In my opinion, this shows that Maasa feels empowered to share her voice that has meaning with others. By having the women as full participants in the research process they are, thus, empowered to define their realities and share their knowledge with others, which helps create social change (Meyer, et. al, 2003).

Margherita also spoke about how the photonovel is readable because it is engaging and different. This adds to the research by Rudd and Comings (1996) who noted that in one instance the photonovel the immigrant workers created in their study was considered more readable by the building trades locals than pamphlets created by the National Cancer Institute. James, et al (2005) also spoke to the readability of the photonovel when they found that there was a significant increase in knowledge about the spread of sexually transmitted infections in male and female learners after secondary school students in South Africa underwent a single reading of the photonovel.

It was also fascinating that Maria commented that she would remember more of the learning in the project because she was actively involved in the educational process. This reminds us of Freire's (1970) critique of the banking method of education, where the teacher simply deposits information into the learner, and Freire's philosophy that the teacher and learner engage in a dialogue together to form new knowledge. Freire also suggested that learners be encouraged to take distance from their reality and think critically about it. I believe that the participants were encouraged to think critically about

their reality through many of the interview questions I asked them. For example, I aimed to facilitate in critical thought about the women's realities when I asked them questions about how living away from their family, friends, or community may affect their health or if they thought they were in better health in Canada or in their previous country. Actually, Freire believed that by moving from the sensory experience (reading of the world) to a more generalized and concrete understanding (reading of the word, i.e., reading of the photonovel) one comes to comprehend reading and the world around them in a critical way, which is empowering for the learner. Actually, as VanderPlaat (1998) noted "researchers who are focused on creating empowerment based practices tend to see also the research process in terms of a collective social activity, as opposed to the more traditional emphasis on the individual" (p. 73), evident in the empowering community building process, which occurred in the photonovel project. Finally, there were also some comments made about how the photonovel was a new and different form of communication for the women and that they had a lot of fun being part of the project. Maria's critique, however, that the photonovel needed to contain more information or be part of a series to add further content is also a valuable critique worthy of recognition. Maria's opinion that the photonovel have more information was also mentioned in James, et al.'s (2005) study set in South Africa, as they noted that the participants expressed positive changes in attitudes about condom use, but that there needed to be further educational strategies that encourage open communication about AIDS because awareness and knowledge about the problem may not be sufficient to create actual behavioural change. The following theme will relay some of the women's revelations about the photonovel as a health literacy tool.

THEME 5: THE PHOTONOVEL AS A HEALTH LITERACY TOOL

According to Wilde (1994), the majority of information absorbed by human beings is collected with our sense of vision. Thus, it seems logical to emphasize the development of visual skills as a way to deliver health information to others. Not surprisingly, the photonovel's visual elements and simplified English contributing to it being an effective health literacy tool emerged from the data. For example, the women were quite vocal about how the pictures in the photonovel helped them understand a health topic and about how the language within the photonovel is comprehensible to them and other ESL speakers because it is written at a low level of English. The following sub-themes give voice to the women's opinions about the visuals in the photonovel and the use of simplified English.

The Visuals are Effective for ESL speakers

The women's comments about the effectiveness of the visuals within the photonovel were mentioned spontaneously by the women when I asked them if they understood the language in the photonovel. In the initial focus group, Maasa (who used to be a nurse) said that she believes the photonovel will be effective because people will be able to visually understand clearly what the message is. After she and the women had actually created the photonovel, Maasa described again how having pictures in the photonovel could help all kinds of people learn about health:

I think that book [the photonovel] tells a lot about the good diet and the healthy diet. You can tell from the pictures who is going to be getting big and it doesn't look so good and not only that, but it's not good for your health. That means that that book will go to any kind of age groups. And everybody. Young and old

people. They just have to look at the picture and they have to think about it ... if people don't speak English out there they look and it gives you a story page by page. So, you understand it when you see it. ... you don't need English, you just have to point at the picture here and look at it.

Margherita (I2) also commented on the visuals in the photonovel and noted, "it's good that there can be materials that are available that if you don't speak a lot of English you can just read that and look at the pictures and understand what they are talking about". Later in her interview, she noted that the pictures would help other ESL speakers learn about health "because of the pictures because even if you don't understand the words ... but just looking at the pictures helps get the message across". Maria (FG2) also referred to the power of the visual within the photonovel when she said "I think you would understand it if you don't speak a lot of English, but you still have to speak some to understand. Actually, you know what, because of the pictures that probably helps a lot too to portray the message of the pictures".

In their individual interviews, the women also spoke to the positive impact of having photos in the photonovel. For example, Maria noted that:

the pictures help you a lot. For me I feel like a little child learning English ... like when you learn to read ... you start with little ... small words ... and everything and big pictures ... it's the way you learn and start to read ... it's the way that Angelita [her daughter] is starting to read ... or not starting, but I read for her.

When I asked Maasa if she thought that other women would understand the language in the photonovel, she replied, "yeah, yes, I think so, yeah. Some people have no idea what somebody is talking about, but maybe next to somebody can explain to them slowly and

then give you a kind of object or book or picture and they will understand that”. Maasa also noted that when we showed Angelita the photonovel she understood it right away.

Maasa then drew on her experience as a nurse and stated:

every human being needs to have a good diet ... and then you can see the book and it will tell you all about it and that is it. Because this teaches you and you don't have to understand English and it will tell you some ideas.

Most interestingly, Maasa (FG2) also voiced her opinion on the culturally competent aspect of the photonovel when she said that “it's just an ordinary person in the picture, but that story gives you some idea how to cook with healthy foods”. Thus, Maasa's comment alerts us to the fact that the ordinary person (in this case a character from Hong Kong) in the photonovel is somebody who can teach others about being healthy, which alerts us to the fact that perhaps having characters that seem ‘normal’ to immigrants is appealing to them. Margherita (I1) noted:

the photonovel is a great idea and I think Canadian people will read it ... cause you know its amazing because we think that because we are immigrants that we are different, but the cultural differences only go so deep. They don't mean everything. I mean we are human beings.

Margherita commented in her individual interview that the pictures are helpful in being able to understand the message. Even though she is blind, she stated that she believes the pictures would help ESL speaking immigrant women learn about health “because the pictures ... because even if you don't understand the words ... but just looking at the pictures ... you can get the message”. Actually, in our first interview, I showed Carole a photonovel titled *You are Not Alone* about spousal abuse and compared

it to a regular health pamphlet. She pointed to the word ‘isolating’ in the *You are Not Alone* photonovel and asked what that meant. I answered, “to be removed from other people, so you feel alone and lonely”. She then said, “yeah, you are not alone” [pointing to the photonovel] and added:

yeah, we have the right to live without violence ... yes. It’s safer here in Canada ... you know. I don’t have a man no more, so I don’t worry about the violence or something. You know they hit. A long time ago I was like that and my husband was just like this ... that is why I came to Canada with my daughter. For a year and before I went back he passed away. He like women and flirting with women so ...

Laura: Gosh, that is tough. So, do all of your kids live here in Canada?

Carole: No, my kids ... 4 of them live in Indonesia and one in Louisiana. Now they have the problem cause they are close to New Orleans. And one in Duncan.

Laura: That is nice and lucky.

Carole: I don’t have the violence and I don’t have abuse.

Laura: You must feel a lot more at peace.

Carole: Yeah, I like listening to music and singing and I have a good voice.

Laura: Really inspiring. So, with a pamphlet like this (photonovel) is it easier to understand the message?

Carole: Yeah, this is easy to understand (the photonovel). So, something happens and you just dial 911.

The photographs in the spousal abuse photonovel were powerful and obviously triggered some emotion for Carole.

In summary, the visuals in the photonovel were regarded by all of the women as being a very important component for comprehension. For example, a lot of the women mentioned how the pictures can help ESL speakers understand the message within the photonovel. Furthermore, it was mentioned that, in lieu of the photos, the photonovel would appeal to all ages and also is engaging because it has images of ordinary people. Thus, the visuals within the photonovel are an important component in its effectiveness as a health literacy tool. Participatory photonovels also contain language that is accessible to other ESL speakers, which is discussed in the sub-theme below.

Lower Level English Speakers Can Understand the Photonovel

I hypothesized that the photonovel would be an effective health literacy tool because it used the women's own words, which would make the language accessible to other ESL speaking immigrant women. The women had their own opinions to share in the final focus group and in their final individual interviews on this topic.

In the final focus group, Maasa expressed how the usage of minimal text was effective and that "some people who are never interested in English then look at the book because there is very little English on it, so they can understand it". Maasa made a comment in her final interview that illustrated how effective the photonovel could be to a wide population of people when she said:

the book was just to play. But, when you created this book where you meant it it was fantastic. I had no idea it would come up like this. *I think that book is useful everybody* [italics added]. You have to do that again.

Maasa seemed surprised at how professional the final photonovel was because even though the process was a lot of fun, the final product was seen as being serious. Maasa

seemed to be very pleased with the final product of the photonovel and spoke to the simple language within it (however, note again, that she refers to it being ‘my book’ instead of ‘her’ book) when she said:

this is totally different and the story is very good with a nice meaning. *Your book* [italics added] is very simple and then when you see it you can tell ... I have to do this. You don’t have to explain in difficult words. It’s the best one I know. You should sell it as a book.

Actually, Maasa’s own low level of English perhaps enabled her to be in the shoes of other low-level, ESL speaking immigrant women because she had a lot to say about the effectiveness of the photonovel for ESL speaking women. For example, Maasa suggested that we donate the book at locations where ESL speakers go (which is what I did when I distributed it to two urban areas) because “there are so many organizations with no English people out there and they can really use this. It’s very useful”. She later said “this is very nice, when you see it you know right away ... Oh, I have to do this and I have to do that. If you don’t speak English this is the best way to educate”. Maasa also noted that she knows some people who come to Canada:

who don’t speak any English ... not very much English when they come over and then some people have no English when they come over to Canada and then nothing but trouble for themselves. And other people try to help them, but they have no idea what they are talking about ... but these kinds of things [the photonovel] can help a lot.

Maasa (I2) told the story of knowing a woman from Ethiopia who had been trying to learn English, but she was a very slow learner. This woman had lived here for four

years and had a lot of difficulty communicating and learning English, but when she saw the photonovel she understood it right away. She then said that she thought "...those kinds of people they need one". Margherita (I2) also noted how it really helps to have materials that are adapted to your level of English and that it makes adjusting to being in Canada easier. She noted that at first you go through a honeymoon period living here and that you want to be Canadians. Then within 6-7 months:

everything starts to go downhill and then you realize that you are a minority and that you have an accent and you are learning a new language and in some cases you look different. ... so, um, it really helps to have materials that are adapted to your level of English.

All of the women noted that they found the photonovel easy to read. For example, Maria noted that the simple language in the photonovel would make it comprehensible to other immigrant women. She also, however, pointed out that it was helpful when we changed some of the words that she didn't understand to simpler words and that she also learnt new words from the other women in the group.

Discussion of Theme 5: The Photonovel as a Health Literacy Tool

Visuals are Effective for ESL Speakers

As stated in the literature review, the effects of concreteness and imagery on reading and text recall have been revealed by researchers such as Paivio, Welsh, and Bons (1994) who found that concreteness and imagery effects have been found to be among the most powerful in predicting performance on a variety of language tasks because they are imaginable, comprehensible, memorable, and interesting to the reader. Furthermore, Finan (2002) noted that the results from her study proved that the value and

success of health education materials could be considerably enhanced by adhering to a semiotic framework. Actually, the women's comments about the use of visuals within the photonovel connected to a lot of the research that supports the use of visuals as a means to enhance health literacy comprehension with an ESL population.

There were a lot of comments that confirmed that visuals help ESL speakers understand health information. For example, when Maasa noted that having pictures in the photonovel could help various people learn about health, it reminded me of Vahabi and Ferris's (1995) comment that pictures "help aid poor readers to comprehend health education materials" (p. 103). The women's positive comments on the visual aspects of the photonovel are also confirmed by Michielutte, Bahnson, Dignan, and Schroeder (1996), who investigated the use of illustrations and narrative text style to improve readability of a health education brochure and found that among poor readers comprehension was significantly greater for women who read the brochure with illustrations and narrative text, with no difference in comprehension of the two brochures for better readers. This finding illustrates that ESL learners benefit from reading health education materials with illustrations because of their lack of English language vocabulary. Levin's (1996) research also confirmed the value of symbols as a means of promoting healthy food choices in the cafeteria at an urban work site. For example, Levin noted that one of the most positive features of this promotion was its application to populations with low literacy skills because it used no written materials other than a poster with minimal words and relied primarily on a single symbol to draw attention to recommended foods.

On another note, another mentionable aspect of this sub-theme was Maasa's comment that she could relate to the photonovel story because the main character in the photonovel is an immigrant. Actually, Maasa's perspective ties into research that suggests that health education materials should "include simple, meaningful and culturally sensitive graphics. Thus, it is important that artwork include a variety of races and cultures; particularly a variety of ethnic and cultural groups" (Mayeaux, et. al, 1996).

Something else I would like to discuss derives from when I showed Carole the photonovel about spousal abuse. When Carole saw the pictures illustrating spousal abuse, it triggered some strong memories of her own experience of being in an abusive relationship. Conversations such as the one in the response section above made me feel that I had formed a relationship with the interviewees, which was based on trust, sincerity, and openness. As noted in Chapter 3, a believed interviewee is likely to trust the interviewer and is likely to disclose "the truth" (Reinharz, 1992). In fact, according to Reinharz, "women can become like friends with the researcher because they feel valued as individuals rather than being data providers. Being listened to and respected leads to a kind of bonding" (p. 28). Furthermore, because women participants identify more readily with women researchers, it can be easy for participants to reveal the intimate details of their lives (Fonow & Cook, 1991). As hypothesized, however, this openness, however, could also be attributed to the isolation of many immigrant women who have few opportunities to talk about their needs with others (Meyer, et al. 2003).

In short, the women's comments about the effectiveness of the visuals within the photonovel are similar to Leibtag and Rigby's (1990) comments that some of the advantages to using photonovels for health education are that (a) stories can hold readers'

attention and be remembered, (b) people can identify with the characters in the stories, (c) they are popular among many age and literacy levels, and (d) having the characters match the target minority populations will help them identify with the characters. It was also interesting to see how powerful the images within the photonovel can be when Carole spontaneously looked at the pictures about spousal abuse and then told me her story of a similar tale. The women also were positive about the use of low-level English in the photonovel.

Lower Level English Speakers Can Understand the Photonovel

One definition of health literacy is “the ability to obtain, interpret and understand basic health information and services needed to make appropriate health decisions” (Ratzan & Parker, 2000). Based on research that states that many ESL speakers face barriers obtaining health information because it is incomprehensible to them (Wilson, 2003; Simms, 2003; Canadian Institute for Health Information, 2004), it was interesting to listen to the women’s opinions about whether or not the use of simplified language within the photonovel was effective.

Maasa’s comment about how the effectiveness of the simple language within the photonovel ties into research that states that patient education materials need to be made easier to understand for ESL speakers. For example, Mayeaux, et al. noted that simplifying the language in patient education materials would make them more comprehensible for learners. However, Weiss (2001) noted that, although there is research suggesting that patient education materials should use simplified language directed at second language speakers, there is minimal evidence these interventions have any effect on the health status of these individuals. Thus, as we saw in the literature

review, alternative approaches, such as including visuals (Paivio, Welsh, & Bons, 1994) and culturally competent techniques (Horner, Surrat, & Juliusson, 2000), are ways of enhancing ESL speakers' health literacy comprehension and are, indeed, found in the photonovel.

Another interesting angle that surfaced about the use of simplified language within the photonovel came from Margherita when she noted that, after someone immigrates and the "honeymoon" period is over, that person starts to realize they are a minority within Canada and, thus, it helps to have materials adapted to their level of English. This is a powerful comment because it reminds us that language is one door to access power as an immigrant woman (Mohab, 1999). Also notable was Maria's comment that she appreciated it when the women changed the words that she did not understand to more simple words, which will inevitably help other low-level ESL speakers understand the photonovel. Maria also commented that she learnt new words from the women when creating the photonovel. Actually, Maria's social interaction takes place in cooperative group learning and interactive discourse, which is the basis of participatory education. According to Vygotsky (1978), when peers are working together, they will draw on each other's language and cultural understanding to create new knowledge, which, as we can see from Maria's comment, did in fact occur in the participatory photonovel process.

It is apparent that the use of visuals and simplified language within the photonovel contribute to it being a comprehensible health literacy tool for a population of Canadians that have difficulty understanding mainstream health information. Although having health literacy materials directed at ESL speaking immigrants within Canada is

crucial to the wellbeing of this population, there is also another powerful aspect of the photonovel project that needs to be discussed: the process of empowerment that the women experienced through engaging in this project.

THEME 6: EMPOWERMENT THROUGH THE PHOTONOVEL PROJECT

According to Wallerstein (1992), the term ‘empowerment’ has increasingly appeared in the public health literature during the past decade. However, she noted that casual use of these terms has led to a lack of theoretical clarity and measurement problems. In fact, the author pointed out that the health outcomes of powerlessness and empowerment are often unrecognized despite the considerable research that documents the role of powerlessness in disease causation and, conversely, of empowerment in health promotion. She also pointed out that empowerment becomes the avenue for people to challenge their internalized powerlessness while developing real opportunities to gain control in their lives and transform their various settings. The following sub-sections all fall under the theme of empowerment and has been divided into two parts in order to show the shift in the women’s responses prior to and after creating the photonovel. The initial sub-themes of emotions and health, nutrition in Canada, and taking responsibility for one’s health illustrate what the women had to say about these issues before they created the photonovel. However, humour and community building, culturally relevant health literacy tool, increased self-esteem and feelings of importance, and comments about being responsible for nutrition after creating the photonovel illustrate the shift in consciousness that the women had and the process of empowerment that the women experienced through participating in the photonovel project.

The first sub-theme *Emotions and Health* discusses the women's general comments around their emotional experiences around accessing health care here in Canada prior to creating the photonovel. Later, however, the women showed different emotional responses related to self-esteem and self-worth in having participated in this project that helped create changes in critical consciousness and give the women a voice about their worlds.

In the following sub-theme, Margherita was by far the most open about anything that was connected to her emotional experience here in Canada and around her experiences with health. Even though her voice tends to dominate in the following section, what she says is of value and maybe true for the other women as well.

The Women's Comments Prior to the Photonovel Project

Emotions and Health

In the initial focus group, I asked the women if they thought getting health information in Canada is harder or easier than in their previous countries. Notably, almost all of the women expressed some frustrations about around this topic. For example, Margherita noted, "it is hard for immigrants ... the health part, yes". Maria then continued the conversation and said, "it is very difficult. But, if you have somebody to help. ... Two months ago I came to the ICA and they had *Nobody's Perfect* [this is a parenting education and support program for parents of children from birth to age five that is funded by Health Canada] and they gave me a book and showed a film. It is hard though". Furthermore, when the women spoke about a change in diet having moved to Canada, they stated that it impacted how they felt about themselves. For example, Margherita noted that "I was eating so much starch and sugar and feeling exhausted and

tired all the time ... and yes, getting fat and that alone is terrible”. It was also fascinating at the end of the initial focus group because, when I asked the women whether or not they felt that not having their normal social support system (friends, family, etc.) had affected their health at all, the group became awkwardly and completely silent. I was not sure if this silence was due to the fact that the women had not considered how a lack of social support affects their health or if it was too sensitive of an issue for them to discuss openly. In fact, I had to ask the question twice and, finally, Margherita (who was by far the most outspoken of the group) spent some time reflecting and answered:

it could affect your emotional health. At the beginning I had a lot of homesickness, but now not so much. So, it doesn't get to your body ... if I get sad or whatever and go home sick for a little while, but try not to do it cause it affects my health and doesn't change my situation ... I try not to dwell on it.

Even after Margherita said this comment, everyone was still completely silent so I changed the topic by asking the women a different question because I sensed the sensitivity around this issue.

Margherita, however, later in her initial individual interview with me, which was of course more private, noted that it is stressful not having your normal support system around. She said, “it is also probably emotional. ... You know emotional health has a lot to do with physical health and if you are stressed out you are going to see it in your body. You can only be emotionally strained for so long that can have an affect too”. Maria also speaks of a time when her husband was very sick and how it was terrible because she did not know what to do. She also told me that she worries a lot that her baby will get overweight being in Canada. She then expressed how she speaks with family members in

Colombia a lot to get health information because she trusts them and that here it is very difficult for her to trust people enough to accept their health advice.

Margherita also spoke to the fact that she thinks Canadians have a lot of stress and illness, which she was perplexed about because she perceived Canadian life as being “easier and more convenient and less work oriented” than in Chile. Most interestingly, however, Margherita (I1) noted that she thinks she is healthier here and not as stressed emotionally. This is a comment worth paying attention to because Margherita likely does not have the same social support of family and friends as she did in Chile. However, she has lived here for five years and is married to a Canadian, which may contribute to her having a social support network in place. I also observed in the group dynamics that Margherita was taken care of by the other women because of her disability (blindness). For example, at snack time someone would always ask her what she wanted to eat and bring her some food. Furthermore, whenever Margherita would enter the room for the project session, someone would go over, hold her hand, and walk her to the table. I often wondered how her disability perhaps helped her feel nurtured by others here in Canada and gave her an advantage in terms of her emotional wellbeing over the other immigrant women.

Margherita told me a story about how she experienced her childhood in a way that did not involve her having the nicest clothes or fancy things. She told me she lived in a shack and that she was happy because her family gave her a strong foundation and she thought she was “rich”. She then gives a critical perspective of Canadian culture when she said:

then you have kids here that have everything, but the parents are divorced and separated and there isn't the same concept of stable families. The kids have to deal with the whole baggage that comes from it. I mean ... it doesn't matter how good of schooling you have and how many places you go for recreation. If you don't have a stable family then forget it. That is the foundation. ... There are so many people who are lonely here. Even older people they are all lonely and families ... the culture isn't conducive to families.

Margherita spoke freely about some of the emotions she experienced around accessing health care here in Canada. For example, she spoke about the embarrassing experience she had of seeing a doctor in Canada about a genital disease she had (which is also mentioned in the first theme *Cross-cultural Differences pertaining to Health*) and her doctor's disbelief that she had never had sexual contact. She then stated that "she wouldn't believe me that I had never had sex before and I felt so *ashamed* [italics added] ... so that was the most *shocking* [italics added] thing that I had to encounter and I didn't want to go back there, of course". Margherita also emphasized low-level ESL speakers and their difficulties comprehending English health information and said "I can imagine for people that don't speak English that it must be really scary ... I don't think it has prevented me, but I think for other people it has been something hard". However, in her initial interview, I asked specifically if her level of English has affected her health here; and she told a story about her first immigration exam that she had to do when she was new to Canada and could not understand the doctor very well. She noted that the doctor was not very understanding about this and it was "very frustrating and frightening" for her "especially when the other person is not patient about you not understanding". She

continued her train of thought and said that when you are sick “you are not feeling like trying to communicate to someone in a foreign language. ... When I have a terrible headache or whatever I am not feeling like trying to speak the best English ... so it affects you”. Maria (I1) also spoke to language barriers affecting her emotionally when she said that she did not feel comfortable going to see a doctor because of her low-level English skills and she said, “it’s a scary feeling”.

Margherita also referred to her own frustrations around her immigration status. She said that her immigration status has certainly affected her because she has no access a family doctor or dentist. She noted that health benefits and avenues for non-status immigrants should be expanded. Margherita then said, “if you don’t have the opportunity to access it, it is very stressing ... and that contributes to the stress besides the sickness”. Maasa (I1) also noted how she finds it difficult that she can’t afford private health insurance and this leads her to sometimes feel pain for several days, which she told me was not easy for her.

Nutrition in Canada and Women Taking Responsibility for Their Health

If the baby doesn’t cry, it doesn’t get nursed.

Margherita (I1)

Nutrition in Canada

There was an overwhelming amount of discussion from the women about nutrition in Canada. The women were also encouraged to choose any health topic they wished to learn about and make the focus of their photonovel; all of the women chose nutrition as their main health concern living in Canada. In the initial focus group, the women brought up the topic of nutrition in Canada, which was before the women had

chosen the topic of nutrition for the photonovel. I noticed that once the topic of nutrition was brought up by the women then a whole stream of conversation flowed constantly around this topic for the rest of the project. It was by far the health issue that the women had the most to say about. In fact, the women would get so heated up about this topic that they would often talk over each other in group meetings and in the focus group because they had so much to say. Margherita was the first woman to speak when I asked the women in the initial focus group if they felt they had noticed any changes in their health since they had been here. In the following verbatim, note how the dialogue moves freely and there is a lot of back and forth between the women. This was probably the only part within the first focus groups where there was a lot of dialogue between the women and a lot of excitement about the topic. As the women were shy and awkward in the first focus group, I was relieved when this topic came up and there was so much to say, illustrating its importance to the women and the authority and knowledge that the women had around the topic of nutrition.

Laura: Have you noticed any changes in your health since you have been in Canada?

Margherita: Yes, my weight. It has to do with diet.

Maria: [over talking Margherita] In my country there is a lot of fruit and here it is only one or two or three no more. I miss that because fruit is very healthy and delicious. And the others ... oranges or bananas ... we have a lot of fruits.

Carole: The food here in Canada is very difficult. It's not healthy. No, it's not healthy. Cause everything is frozen ... everything frozen.

Everyone: Yeah ... everything is frozen.

Maria: Everything has sugar.

Margherita: You are right, Maria ... it's terrible.

Carole: [cutting in over Margherita] Everything sugar ... everything sugar.

Jacky: I used to get a live chicken and go home and kill it and cook it.

Carole: The fish and special meats you could buy every day. Here it is more expensive. But you have to go everyday.

Margherita: One thing I noticed when I came here is that everything is so sweet.

There is sugar in everything ... even things that aren't supposed to have sugar.

There is lots of sugar. And in Chile, like in other countries, everything was fresh.

And most of the stuff was fresh. We weren't used to the habit of freezing stuff

and it was actually not very culturally appropriate ... it's not part of the culture.

Margherita (FG1) also noted that a lot of the fruits and vegetables bought at the grocery store have a lot of preservatives on them because in the winter they are imported. The women in my study also commented that a lot of the food we eat in Canada isn't organic and is 'fast food' and there was the perception that Canadian people do not care what they eat. One of the women noted that in Canada supper is the most important time to eat, but that in her country people think it is unhealthy to eat a lot and go to bed. Margherita (I2) also noted that here "there is a culture of junk food and it's the same in Chile, but here it's cheaper and more accessible ... there is a culture of food and people eat out much more and restaurants are always with people". She also told a story of her first dining experience in Canada:

when I met my husband here in Canada, he introduced me to the eat out lifestyle.

We never did that in Chile, there was no need for it and I remember the first time

we went for a date and he took me to this restaurant and I asked for a chicken quesadilla and it was a Canadian style quesadilla and it was a huge plate and I ate half of it and I was so full. My husband ate his plate and ate my half. Then, after a few years here ... I would say after maybe two years, I was eating the same amount as him and I thought oh wait a minute. Something is wrong here and the same quantity of food ... you go to a restaurant and it's just a huge amount of food on the plate ... I feel into it too. I am not pointing my fingers at anyone. I got used to it ... I got 'Canadianised' too.

Maria also noted that "everyone here eats hamburgers and fries ... my little girl says: 'I want fries, I want fries'".

Jacky said that she believes that her mothers' health has deteriorated since she has been in Canada because of the food. Her mother eats "a lot of sweet cakes and cheese. She eats hamburgers and doesn't eat a lot of nutritional food and eats a lot ... and cake. Margherita also notes that, besides the nutritional aspect and the fact that she feels she has gained weight living in Canada, she has not had any health problems big enough to need assistance from a doctor. In fact, she mentioned that one of the major issues facing immigrants in Canada, along with poverty and discrimination, is nutrition. Margherita actually noted at one point (FG2) that when she had her last immigration exam the doctor said to her that immigrant women who come to Canada probably put on at least 10 pounds or more. When I asked Margherita about why women's health might decrease upon moving to Canada, she mentioned nutrition and said:

at the beginning there is weight increase and different foods. Also, I think that nutrition is a big thing because food here is not as fresh and there are a lot of

chemicals in it and preservatives and you know for fruits and vegetables that are imported from other countries you know they have preservatives and a lot of canned stuff and frozen stuff, but you get used to it and you go through a transition where you get used to things like that, but after a while you know it just deteriorates normally, just like a Canadian person's health would.

Actually, Margherita feels that her health struggled when she first arrived in Canada due to the nutrition but now she feels she has control over her health because she has worked hard to exercise and eat well and taken her health into her own hands and maintained some of her Chilean nutritional habits. Maria (I1) also pointed out that in Colombia everything is organic and that here we have a lot of fruits and vegetables that have pesticides on them. Maria also noted "in the US, when you go to the parks at Disneyland, you think that the people are soooo big. It's amazing. You can't believe that. You never saw those people in Colombia and people here are so tall ... they are huge".

Carole noted that here people eat a lot and that "the more you eat the more you fat". She contends that the Canadian perception that you need to eat three times a day is wrong and that this will make you overweight. She mentioned, however, that in Indonesia a lot of her friends buy takeout food and never cook at home and that is why she thinks a lot of them died young. When I asked Carole what reason she would give to the statistic that says when women move to Canada they are healthy and within several years their health gets worse, she said "cause they go out and eat hamburgers and McDonalds".

Jacky notes that in Hong Kong she did not have Tim Hortons and that she never ate McDonalds. However, now that she is in Canada she follows her parents and sometimes they go to McDonalds and she thinks it is easy to gain weight because of that.

She also states that here in Canada the oils that they put in the restaurants can be very unhealthy. She believes that in Hong Kong people are healthier than they are in Canada “because maybe the foods changed so much ... they go to McDonalds and in Hong Kong ... we just ... we will go to ... we went to the coffee shop for some noodles and Chinese food and rice ... so in Canada we changed”. When I asked Jacky why immigrant women’s health might decrease upon moving to Canada, she said, “I don’t know ... maybe they eat more unhealthily”. She also believes that the government should provide food for poor people in Canada as they do in Hong Kong. The following illustrates some of the comments the women had about taking responsibility for their health and nutrition before they created the photonovel. Later, however, in the sub-theme *Comments about Being Responsible for Nutrition after Creating the Photonovel*, we will see how the women’s perceptions about taking responsibility for their nutrition changed after having participated in the photonovel project.

Taking Responsibility for One’s Health

Unlike the other women, Carole spoke from the onset about taking responsibility for one’s health and continued discussing her initiative throughout the research project. She noted that her doctor told her once that she takes very good care of herself, and she told me that initiative over her own health is what has helped her remain so healthy having lived in Canada for 20 years. Again, in her individual interview, she said that she takes care of herself by exercising and not eating a lot, noting that she never eats pasta or bread. She also said, “I need for my bones to take more calcium and I take the Chinese herb because I have the broken hip. I take the Chinese herb a lot”. In fact, when I asked Carole what advice she would give to improve the health of immigrant women she spoke

of women taking responsibility and said, “Don’t eat out. It’s better to cook at home so you know what you are cooking”. It is quite apparent that Carole believes that if women take responsibility for their health then they will not face any major health obstacles here in Canada. She believes that if you go out to eat and you do not know what is in the food then this will affect your health. Carole actually never goes out to eat, cooks everything herself, and always washes her hands; she attributes these self-reliant health behaviours to her good health here in Canada. By far the topic she spoke to the most, Carole showed a lot of pride around the way she cooked for herself here in Canada and because of this maintained good health.

Maasa (I1) did point out, however, that she took care of herself by quitting her job, at one point, because it was too stressful because she was working seven days a week and doing more than her energy level could take; she also told me she put all of her money into her daughter. Maasa suggested, however, that women take responsibility over their health by buying health insurance. She said, “the government isn’t going to cover you ... you have to help your body ... human body ... but the government isn’t going to cover it”. She says you have to be very, very poor and then the government will help you, but for someone like her who is an average person or a “borderline person” as she puts it, she never gets anything: “to me it’s nothing”. In fact, when I asked Maasa what advice she would give to new immigrants to Canada, she said, “I would say you have to look after your health yourself. Then I say ... sleep well, eat well, and exercise”.

Furthermore, when I asked Margherita (I1) what she would advise immigrant women who come to Canada, she spoke a lot about the issues around having a lack of access to health care due to status reasons; however, she also noted that immigrants

should be “pushy about getting information and finding out things and not just being contained by fear or communication because that is the big barrier. But, if you don’t conquer that fear you will never get anything”. She then said that most Canadian people would not come out and ask immigrants what they need. She said, “it’s you that needs to mention what you need. Like we had this saying in Chile that says if the baby doesn’t cry it doesn’t get nursed ... so, we are going to have to do that more and get your voice heard and questions heard that things like that”.

The Women’s Comments after Having Participated in the Photonovel Project

*I think the photonovel project is going to be a good way to communicate
the realities of immigrant women in a really simple way.*

Margherita (I1)

According to Ellis (1992), there are some relatively new theories in the field of health promotion that indicate that a lack of empowerment in a person’s life and in their community contributes to unwellness. In fact, she noted “it appears that feeling a sense of personal empowerment as well as a sense of community empowerment is an important aspect of wellness” (p. 22). Because empowerment is closely associated with good health, I asked the women after they had completed creating the photonovel what this experience was like for them. A lot of their answers touched on feelings of empowerment. For example, the women spoke of the use of humour, community building, that the photonovel was a culturally relevant health literacy tool, feelings of increased self-esteem and importance, and comments about being responsible for nutrition after creating the photonovel.

Humour and Community Building

One aspect of empowerment that the women spoke of was related to community building and the use of humour through creating the photonovel. I found that there was a shared sense of humour between the women that slowly evolved throughout the project and was ignited when the women created the photonovel. By the end of our project, we were laughing all the time together and there was a genuine sense of community within the group. Actually, I remember when the graduate student, who was hired to help with the technology aspect of the project, came into one of the later meetings found it a little bit hard to concentrate with Margherita playing the piano, Maria's daughter dancing around the room, and all the conversation going on between the women and myself. I welcomed the sense of disorder and chaos because I felt it was a lively and creative environment and one in which there was laughter and energy. The graduate student was soon laughing along and having fun with everyone else in the group, and we managed to accomplish a lot in that session. Furthermore, in the final focus group, there was a lot of laughter within members of the group, which helped me realize that community was built between the women and also myself through humour. For example, Margherita said that the photonovel that they created should be put in a gym and read on a treadmill and the other women laughed and laughed at this joke. The sense of community can also be seen in the comments below, which are taken from the final interviews with the women.

Jacky (I2) noted that "this experience was positive for me because I met a lot of women in the women's group and we join something in the same group and we learnt in different ways". Jacky pointed out that she will remember, in particular, "discussing together and taking many pictures ... how to take the pictures ... how to be, which people

will do the main actress or the nurse or other ... or other ... we just get together and it's good to create a book". Jacky pointed out how much the group laughed together and how good that felt. She also told me she felt a part of creating the book.

Maasa told me in our second interview how much of a bond was formed between us. When we sat down together, she genuinely told me that she was already missing me. She noted that "this has been really nice and particularly you. You always support me ... it's been very nice ... I am glad to be here with you". Maasa also mentioned that she wanted me to come back and do the project again.

Maria (I1) pointed out that she enjoyed meeting a lot of people in the photonovel group. She had just moved to Victoria and did not know anyone in the city. She told me that it was so much fun for her and funny and that everyone laughed so much and that it was very positive for her to be in the photonovel group. Maria told me that her little girl enjoyed it too and that her daughter would say to her when she got home "mom, please sing like Margherita" referring to the song that Margherita sang for Angelita every week, which made Angelita jump and laugh around the room full of life and energy. She told me that what she would remember the most is me teaching the women new ideas and the joy in making something together. Maria also stated, "everyone taught something to improve the photonovel and that was nice", referring to the fact that everybody made a contribution. In fact, everyone (FG1) noted that they felt they contributed a lot to creating the photonovel and that it was a collaborative effort. All of the women also made me feel that I was part of their community by announcing in our final meeting they wanted to come and cheer me on at my defence, and when they brought Christmas cards for me and each other at our final group meeting.

In her second interview, Margherita noted that she learnt a lot making the photonovel and, in particular, she learnt a lot about teamwork. There was certainly a bond made between Margherita and I because there was a lot of laughter between us. She also noted that she enjoyed the teamwork and getting to know the other women a little better because the project gave them that chance. Margherita said that it was empowering to be involved in teamwork and for her “just bringing up the results [the photonovel] is really empowering and it gives you a lot of confidence”. She said it is important to feel you are working with people and that you have the same idea and vision and are working for the same goal. She noted that forming better connections with other women helps with

this whole sense of community ... it helps because ... one thing that I noticed when I came to people is that ... there are so many people alone here ... and not only alone, but lonely ... if you have immigrant women that don't speak a lot of English ... one of the things that can happen is that they can be isolated and that is very sad.

In the final focus group, Maria noted that she enjoyed taking the pictures and sharing ideas because everybody was able to say and do something. She said, “it was wonderful because everybody gave their own ideas”. Margherita then added, “I agree 100% with her. Totally, the same thing. I enjoyed creating the story too, the same thing. It was fun”. Again, Maria made everyone in the group laugh when she told a story. Before she left Colombia, her family warned her that she might get fat and that when she recently went back to Colombia everyone was surprised because she was so thin. On a more serious note, Margherita then mentioned that she doesn't even want to see her parents because she doesn't want them to see her fat: “I am fat ... you know what I

mean”. Maria says she is afraid of this. Miller and Pumariega (2003) argued that cultural change itself might be associated with increased vulnerability for eating disorders, especially when values about physical aesthetics and gender roles are involved. The authors noted that such change might occur across time within a greater society or on an individual level when an immigrant moves into a new culture. Actually, Lee and Kwok (2005) attributed the rise of eating disorders around the world to the influx of Western cultural values that privileges slimness and weight control.

Culturally Relevant Health Literacy Tool

It was also, interesting to take note of the comments the women made about the cultural relevancy of the photonovel and how it ties into empowerment. There were a lot of comments from the women about how good it made them feel to have themselves represented in the photonovel. For example, Maria (FG2) noted, “it’s just regular people [in the photonovel] and not stars or somebody that is on TV. It’s just real people ... you can relate because it looks like you”. In fact, Margherita noted:

it really helps to have materials where you can see other immigrant people portrayed there. Because when you watch TV you don’t see a lot of immigrants being portrayed on TV, but it’s just ... if I am watching the news you can’t see anybody that is an immigrant first generation. It could be a second-generation immigrant, but not a first generation. Somebody who has just come here and has been her for five or ten years and who has an accent. It’s really hard to see something like that. So, you don’t see that and you feel, for example, I guess in my case ... it could be a little bit ... you know I am dark haired ... or whatever ... and I watch TV and I see these most of them are you know blond ... or not blond

... but white ... not that I have anything against that, but it's just you don't see yourself there. But, if you see a photonovel or a film or a movie where the people ... the actors and the people that sort of look like you and speak like you and feel like you so ... it makes a big difference and gives you a little bit of comfort in those stages.

Maria (I1) also touched the notion of cultural relevancy when she said that it is better to have pictures of immigrant women in the photos that look like you because “you always look at these things and the people look so Canadian, but ours looks so immigrant”. The women also mentioned some positive emotions after participating in the photonovel project, such as increased self-esteem and feelings of importance.

Increased Self-Esteem and Feelings of Importance

Another empowering component of the photonovel project was the women's comments around increased self-esteem, confidence, and feelings of importance. These are significant sentiments because the women mentioned in their interviews how they often felt silenced in terms of not being able to access health care (due to financial reasons or immigration status) and minimized by rarely seeing themselves represented in Canadian media. Gallo (2001) described that, when she worked with immigrant workers to help them express themselves through photography, it became a way for the participants to make meaning and voice their concerns and sources of pride, which helped them move from being silent observers to outspoken and active participants in their new culture. I found that the women in my research were also able to voice their opinions through creating the photonovel and that this made them feel good about themselves and as important members of the group.

Margherita noted in the final focus group that it made her feel good and important to have their words and pictures published and said, “you know ... it’s not a matter of if you want to be a rock star or anything, but it’s just nice”. In fact, Carole alluded to how special it made the women feel by having their pictures in the photonovel when she said that Jacky was like a movie star because she was the main actress. This comment shows how important the final product of the photonovel made her feel. Margherita then noted, “when you take her pictures and say your story you feel important”.

Maasa said to me that I should put my name and email address on the photonovel because according to her “this is a real history book, it is going to be”. So the women saw a lot of importance in the photonovel and took it seriously even though it was fun. They felt empowered because it helped them feel special and helped them feel like they have an impact on the people who will read it. In fact, the women wanted me to distribute the photonovel not only to where immigrant people would read it but where all kinds of people would read it. Margherita noted:

I guess they have to know a little bit about immigrants too, because they don’t know people who come here. I don’t know if Canadian people are aware of anything about immigration ... and they don’t know anything about what happens to people when they come here. They think everything is easy and we should be happy to be here. Well, they think that people come here and take away their jobs; there are a lot of misconceptions because people just don’t know. So, I think that distributing it in various places is important.

Margherita then continued her thoughts by saying, “it’s always good to keep it in the eyes of the people. And do you think that Canadian people eat well? That is why it is a good

idea to pass this on Canadian people”. Maria told me (FG2) that she thinks it is good to share something with other people, especially if you have knowledge about the foods and healthy foods. She told me that when she came here she did not know anything and now she knows a little more and noted: “it’s good for me and everybody”. Maria then said that it makes her feel good to help people and share her story. Margherita said that she thinks “it’s a great responsibility” to have the photonovel distributed and read by others.

Margherita noted:

it really puts you on the spot there although in this case it’s not going to be so much because nobody is going to know our names or anything, but ... whenever you communicate a message there is a responsibility that comes with it. Because you are giving certain knowledge to somebody and some people that read this are going to believe it. And maybe some people that read this are going to apply it. Some. We don’t know. So, I think it’s a big responsibility that is also great, because it is great to share. You know we are not the only ones who are doing it anyways. ... Because the thing is in print and the other thing is that people think it’s in print. For example, if you are a singer and you record a CD, well now you are a professional. If you didn’t record a CD you are not a professional, which is not true. But, you know it doesn’t have anything to do with your talent or anything. It has to do with the fact that you are getting the message out there and that keeps you in another sort of a different position I guess.

Maria then said she agreed with Margherita and said, “if you publish something then you have to tell the truth”. Then Margherita replied that peer communication is something that is going to help other immigrant women and “help us too, it’s not that we know

everything, it's just that we communicate something that is good instead of something that is not good".

In her final interview, Maasa said that doing the photonovel helped her feel more confident in understanding nutrition. She also said that she thought the project helped shy people feel more confident in being a part of things. She said:

some people are very shy. But, what you did was no use in thinking about shy or afraid or something ... I think you are a different kind of a different person than other people I know. Because they boss you around and tell you what to do. But, you never did that to anyone. So, other people think 'oh, she is doing it today ... I'll come back'.

She also said that she feels 100% that the process of creating and sharing the photonovel with other women is empowering because it made her feel good to know that other people will read it. Maasa mentioned again how she wanted me to come back to another class and said to me: "I want you to know that everyone likes you and you did a good job". In fact, after the project was completed, Maasa decided that she did not want the money and instead donated it to the women's group. Also, a few weeks after the project was done, I got a call from the ICA and was told that there was something left for me at the front desk; when I got there, I found a beautiful, hand knitted, pink scarf that Maasa had made for me for Christmas. Maasa's generosity helped me see that she was genuinely touched by the project.

Maria (I2) also noted that the photonovel helped her feel more confident about eating well. Jacky (I2) also said that she felt a lot more confident now in understanding things about nutrition after making the photonovel. She said, in her quiet demeanour, that

it makes her feel “okay” and “good” to know that other women are going to read it and see her face and read the story. Jacky told me at one point that she feels really good about the final product. Although she was not a woman of many words (for example, she would answer ‘I don’t know’ to many of the questions I asked her), I believe that the few things she said are quite revealing in terms of how the photonovel impacted her positively. She pointed out in her second interview that she liked how everyone laughed a lot in the photonovel group. In fact, I noticed in our final interview that she was a lot more upbeat and funny, in terms of her interaction with me.

Carole said that the photonovel the group created made her feel good because she thinks that women who read the photonovel will say, “wow ... and they will change their eating habits. It’s very good ... a very good novel”, which shows her pride and belief in the photonovel that she helped create. There was also, notably, a lot of joy and laughter in the final meetings when the women got to see the final product. One woman said: “I am so glad I get a booklet copy ... this is the first one!”.

Margherita noted that she felt like she could tell her own story and that this “took a weight off of [her] shoulders”. She also said it increased her confidence in understanding more about nutrition. She then said, “I was quite surprised, actually, because I thought I was the only person that was going through that thing, but it turns out that many women are going through it”. She also said that the photonovel should be available to a lot of people because “it’s good to have something to warn people when they come here”. She then proposed that it be available at immigration, recreation centers, and immigrant societies. She illustrated her sense of voice being acknowledged around the photonovel when she said, “it would be good to put it in many places for

people to read”. She also believes that it gives her a little bit of comfort just to see something like this photonovel. Margherita said that she contributed to coming up with the story line because of her experiences moving here and she thought, “hey ... that is what happened, maybe other people are going through the same things ... so it wasn’t difficult”. She also noted that the project would be empowering for anybody because of the teamwork and creating the results, which gives you a lot of confidence. She said, “When you see a product done, it’s just amazing. It’s great ... oh yeah ... and it’s really empowering”.

Margherita (I1) also thought it was great to be able to distribute the photonovel not just where immigrants go because she thinks “there is something new and different and plus they will learn about the immigration and immigrant people cause there is a lot of myths that Canadian people have who are not from a different country or who are not second or third generation immigrants”. It was also interesting to observe shifts in the women’s comments around taking responsibility for nutrition after they had created the photonovel.

Comments about Being Responsible for Nutrition after Creating the Photonovel

In the second focus group when I asked the women what immigrant women could do in the future to feel they have more control over their health, there was a shift in the women’s answers. For example, in her first interview Maasa spoke a lot about women taking responsibility for their health by getting health insurance and by living a balanced life and not working too hard. However, in her final interview she spoke only about how it is important to have food at home and to not eat out of the house. Maasa’s thoughts on the importance of eating well shows a subtle but significant change in her focus for

maintaining wellbeing and illustrates the effect the photonovel project had on her consciousness. For example, Maasa said, “you have to cook yourself or somebody had to cook for you. And to use variety. And in the mean time you can learn how to cook, which is a good thing”. Margherita noted after the photonovel was completed (I2) that for women to have more control over their health when they come to Canada they should keep their food habits from home because:

most of the time they are really healthy ... most of the time they eat healthy ... it's not that I want to put Canadians down ... I don't think so ... I would say it's more an American thing that has filtered to Canada and even into Latin America ... even though Americanization there is slower. ... You know probably I should have just keep something that I have not done, but would have saved me is to keep cooking the food that I used to have in Chile and probably that would be a good idea is to keep your food as much as possible ... if I could have kept my Chilean way of cooking and food and provided everything in the right proportions and everything it would have helped me. That would be a good point and not to be seduced by the Western habits so much because it's really hard not to be. I think if you can keep your cooking for your country. Or even if you want to bring recipes from your country and use them here and try them here. Cause when you are there you don't value what you have until you come here. And when you come here you value what you have from home. And many, many people come back to their roots and one of the ways they come back to their roots is with food. And that would be a good idea and a good incentive for immigrant women to stay away from getting into problems and to keep their diet as much as possible. (FG2)

Most interestingly, in the beginning project meetings and in her initial interview and focus group, Margherita focused a lot on how her frustrations around her non-status situation inhibited her access to medical care. However, after we had done the photonovel and in the later sessions and final interview and focus group, Margherita's focus shifted and she started to talk more about taking responsibility for her health by eating more Chilean meals and by not eating out as much. Of course, both issues were important; but it was interesting to observe how Margherita's thoughts became more centred on her taking action with her health, rather than her feeling disempowered by the restrictions she faced with accessing health care in Canada.

Furthermore, Jacky (I2), who was generally quite quiet during the focus group, also noted in her final interview that you need to eat well and exercise to be healthy. At one point she reflected and pointed out that she has maybe stayed healthy here in Canada because she only eats Chinese food and cooks all of the time at home. Jacky (FG2) mentioned that she learnt from the participatory photonovel project not to eat too many McDonald's foods because she thinks she will gain too much weight. She also said out of the blue in her final interview when we were chatting: "just don't eat too much oil ... the high-calorie foods ... just choose some healthy foods". Obviously, nutrition was on Jacky's mind most likely because of the impact project had on her; as it is apparent in her random statement that some of the learning around nutrition had been fully absorbed by her.

When the women's group facilitator asked Maria what it feels like to have created a health material for other people to read, Maria (FG2) answered, "It's good to check some things. Especially if you know the food or the healthy food ... cause I came here

and like I said ... I didn't know anything and now I know a little more. It's good".

Actually, her off-topic answer tells me that she was thinking more about what she learnt than about the question that the women's group facilitator asked her, which may illustrate the impact that the photonovel had on her consciousness and learning. Maria then noted that she learnt a lot from the nurse:

especially the four food groups. That is nice to know. And if you don't eat healthy and when we eat we need to remember to eat more cookies because you don't have sometimes and we think 'we eat a lot of food', but we have to eat more and complete the right portions.

Maria also said that she would remember the exercise worksheet because "it's amazing ... to do this at breakfast at the morning, and lunch time and dinner. I remember that, but I don't remember a lot of things she said. But, I remember that". She believed that the photonovel helped her remember what the nurse taught them. Maria (I2) also noted that she enjoyed learning about eating well and exercising from the nurse and doing the photonovel, but that the photonovel really just reinforces things as opposed to introducing a lot of new information. She noted that when she saw the final product of the photonovel her reaction was that she:

thought it was hilarious ...!!! It's better to eat fruits and vegetables, and when you go to the supermarket and you want to buy something like that ... because my mother-in-law ... ah ... she have chocolate ... and I say "no please". They have a lot of things and she stayed here for one month and everything she bought was full of these things ... and my husband ... we ... I suppose I won one or two

pounds of weight with her. Because here you have a lot of things like that and it looks so nice.

Maria (I2) told me that she prefers to cook and doesn't like junk food. She also said that she swims here in Canada and that she thinks these factors will help her be healthy. When referred to the Canadian Institute for Health Information (2004) statistic that when immigrant women move to Canada their health deteriorates after time, she noted that "no in five year ... no worse for me".

Carole stated (I2) that she has understood a lot about nutrition for a long time and said, "look at me ... I am not fat. I lost some pounds ... yeah, from 154 to 132". After we created the photonovel, however, Carole admitted that until we created the photonovel she sometimes ate hamburgers and hot dogs. Then when the women's group facilitator asked her what she would do differently next time around eating well, Carole said, "next time ... we need to remember that we shouldn't eat until we are full. ... I say don't eat too full you know. Only 70% full and not 100% full. If you eat too much, you will just want to lay down and you will get fat". Actually, it seemed to me that the women, in general, seemed to have more authority and confidence talking about nutrition. Carole also pointed out that she thought other women would change their eating habits after viewing the photonovel. (I2)

It's important to remind them that it's not only junk food. I suppose that McDonalds has the salads and different healthy foods. Because people are always in a hurry and it's easy to get a hamburger, but at the same place and the same time you have a salad and chicken and vegetables and everything. It's okay.

Maasa (FG2) showed authority over her nutritional knowledge when she stated, “you can eat things that are bad for you, but you have to exercise”, while another woman then pointed out that “you can anything you want . . . you can have a drink, some of the sweeter stuff, wine and chocolate, but not too much. You need a portion for one meal, once a day or one week. You can have anything you want. But, you have to think about variety”.

Discussion of Theme 6: Empowerment through the Photonovel Project

According to Moffit and Vollman (2004), the theoretical underpinnings of the photonovel technique lie in empowerment education, feminist theory, and documentary photography, which authors like Wang and Burris (1994) connected in turn to health policy and health promotion principles. The authors added, “Freire proposed the building up of social equity through a process of educational empowerment and consciousness-raising among ordinary people, compelling them to be agents of policy change by using photography to reflect the realities of community life”. Actually, the authors believed that photography, critical reflection, and dialogue could serve to reveal significant social and political issues. Freire (1970) also suggested that it is important that people learn to not only decode and think critically about the written word but also to learn to do this with visual messages. It is apparent in the above results section that by taking photographs together and creating a ‘code’ of their reality the women were able to think more critically about their situation and become agents of change by thinking of ways to take action to change their realities. Based on the women’s comments prior to and after creating the photonovel, it is clear that there was shift in their consciousness as they experienced a process of empowerment through participating in the photonovel project.

*The Women's Comments Prior to the Photonovel Project**Emotions and Health*

This is a very important sub-theme because the women are engaging in a consciousness-raising process about their reality here in Canada by just talking about their emotional experiences of being here with me and the other women. The women expressed many of their feelings around issues related to health here in Canada. For example, some of the women noted a change in diet upon moving to Canada and how it impacted their self-esteem. For example, Margherita noted that she felt exhausted and tired all of the time because of her diet. Thus, Margherita's adjustment to Canada was partly an adjustment to the mainstream food diet here, which affected her emotional wellbeing significantly.

Furthermore, Margherita and Maria's comments about a lack of social support in Canada affecting them emotionally are aligned with the research of Lee, et al. (2004) who argued that social support is pertinent to being healthy. They noted, "more than two decades of research have proven that both seeking and receiving assistance from other people constitute major forms of coping behaviour" (p. 1313). Also, the fact that Margherita and Maria can share their similar stories helps them validate their own emotional reality. It was also interesting when Margherita spoke about how she felt "rich" as a child, even though she was poor, because of the family network she had. She then pointed out that in Canada, even though people are wealthy, they can be lonely and unhappy. Actually, Margherita's comment does not really surprise me. I remember when I lived in South America being really impressed by the strong family values and my realization that many people who were very poor seemed perfectly happy and well

balanced. I also often wondered what has gone wrong in our culture where, in general, we tend to place less value on family, relationships, and spirituality and a higher value on materialistic acquisition, which creates a sense of loneliness, individualism, and isolation within our culture. I remember thinking when I lived in Ecuador that the people there had a lot to teach us about living a well-balanced life and being happy.

Margherita and Maria made comments about feeling frustrated and scared about going to see a doctor in Canada or trying to obtain health information, which has been validated by researchers who note that ESL immigrants experience other emotions, such as embarrassment and shame, due to the fact that they can not communicate well enough in English to properly access health care (Parikh, Parker, Nurss, Baker, & Williams, 1996; Mayeaux, et al., 1996). The women also thought critically about nutrition in Canada and spoke about how they go about taking responsibility for their own health.

Nutrition in Canada and Taking Responsibility for One's Health

It was interesting when Margherita observed that a lot of the fruits and vegetables found at the grocery store have a lot of preservatives on them because they come from other countries. Welsh, et al. (1998) validated her comment because they found that finding familiar, culturally acceptable, and fresh foods was reported as being an important issue by the Canadian immigrants in their study. The authors noted that, in particular, “freshness” was a recurring theme among many different groups. This ranged from lack of familiarity with frozen foods and a longing for the tastier and fresher fruits and vegetables of their home country.

The women also made astute observations that people in Canada eat a lot of fast food, don't care what they eat, and that junk food is more accessible here than it was in

their previous countries. Actually, Maria even made a comment pertaining to the influence of Canada's fast food culture on her little girl. A recent article in the *Globe and Mail* titled "Fat Nation" had the author boldly stating that Canadians are overweight and unhealthy (Sampson, 2006). According to the author, half of all Canadians are overweight because we are consumers of fast food, junk food, and processed food. Another revealing fact made by Sampson was that Canadians spend only 10% of disposable income on food, which globally speaking is low. Actually, Sampson writes that Canadians are overweight because they eat too much and our food portion sizes are huge, which ties into Margherita's comment about her initial surprise at the quantity of food we eat here in Canada.

It was also informative when Margherita articulated that she thinks one of the major issues facing immigrants in Canada is nutrition, along with perhaps more expected issues like poverty and discrimination. Actually, Margherita's insight is backed by research by Welsh, et al. (1998) and Hyman, et al. (2002) who noted that nutrition is a crucial health issue for immigrants to Canada. Some of the struggles that the women have around nutrition here in Canada can be related to research by Hyman, et al. who found that immigrants hold different beliefs about health and health care practices from those prevalent in North American culture. One of these practices is around food consumption. For example, the authors noted that the traditional Asian diet is based on rice and vegetables and that meat and processed food consumption is limited. Hyman, et al. noted, however, that Asian immigrants reportedly consume more meat and fats compared to natives in their countries of origin upon living in Canada. The authors contended that nutritional issues with immigrant women in Canada must be addressed if they are to

achieve optimum health status for themselves and their families since women represent the principal food purchasers and meal preparers in Canada. They noted that, unfortunately, interventions grounded in majority-culture-based research do not necessarily apply to new immigrant women.

The concerns the women have about gaining weight from eating unhealthy foods in Canada are interesting. The questions surface after reading these comments whether or not the women have been affected by the mass media here in Canada, which infamously correlates thinness with beauty, or if the women have carried concerns about their weight from their own cultural ideals of beauty. A *Globe and Mail* article, written by Mundy (2006) is quite revealing in terms of, globally, women's concepts of beauty. The article discusses a survey that asked 3,200 women in ten countries if they are beautiful and found that less than 2% of women throughout the world thought of themselves as beautiful. Women around the world were also asked whether or not they were satisfied with how the media represents beauty in their countries, and female respondents apparently said that "the media did not portray the true diversity of beauty and sets up an unrealistic vision for women". Furthermore, according to the article, the statement "I wish media could portray beauty as more than physical" was endorsed by women in every country. In another article, however, Miller and Pumariega (2003) argued that societies in the process of approaching Western values appeared to be increasing in their levels of body dissatisfaction. Thus, it is hard to say if women from countries affected by Western media have insecurities about their own physical attractiveness or if insecurity about physical attractiveness is a sentiment that affects women all around the world regardless of whether or not Western values infiltrate their culture.

The women also spoke about the responsibility they have for looking after their own health. Actually, Carole was the only woman who spoke about eating well as a means to achieve good health. Maasa spoke more about the importance of having health insurance and not working too much, while Margherita believes that one should be “pushy” about obtaining health information. Thus, aside from Carole, the women did not talk about taking responsibility for eating well as a means to achieve good health. We will see, however, that there was an obvious shift in consciousness as the women spoke about being responsible for nutrition after they had created the photonovel. The following will discuss the women’s comments pertaining to empowerment after having participated in the project.

The Women’s Comments after Having Participated in the Photonovel Project

A few researchers before me who have used the participatory photonovel as an educational tool also found that it was empowering for the participants. For example, Wang and Burris (1994) commented that through a photonovel project the women’s images and words formed the curriculum, which challenges the traditional educational approach that fosters dependency or powerlessness. Thus, in their study, the photonovels remained congruent with Freire’s theory of participatory process by occurring in the reality of the participants’ experience and encouraging them to think more as powerful subjects as opposed to passive objects about their world. Wang, Yi Kun, Tao Wen, and Carovano (1998) noted that this type of research provides a way to affirm participant’s ideas through using creativity and problem-solving abilities. They also noted that this approach to research gives explicit priority to the community’s agenda rather than to the researcher’s needs. Furthermore, Moffitt and Vollman (2004) noted that the participatory

photonovel enabled the Tlicho women in her study to reflect on and promote dialogue about their health beliefs and health promotion practices in the context of their own lives. She noted that the photonovel is a technique based on empowerment and is a culturally appropriate method for conducting rural and remote health research. The following illustrates how the use of humour and the participatory process can build community amongst participants.

Humour and Community Building

Graban (2001) noted that power could be gained by relying on humour as a method of interaction. She noted that not only does humour help break the ice in a group but it also helps to create an atmosphere that can catalyze a growing sense of community and empower people to want to learn. Furthermore, Graban noted that humour helps build trust and acceptance in a group. However, the author pointed out that there needs to be a shared chemistry within a group for humour to have transformational powers in a group dynamic, which I believe the photonovel group had.

The women also felt as though they got to be part of a team and got to know each other better by participating in the photonovel project. Forming community for immigrants to Canada is an important social issue that has been recently discussed in national media. For example, this past March in the *Globe and Mail*, Reinhart and Rusk (2006) wrote an article about how immigrants can suffer in silence within the walls of Canadian suburbs. The authors noted that many immigrants comment that they come to Canada and “live within walls” instead of “living within the people” (p. A7). The authors noted that women in particular could go into a depression because they tend to not be working, like their husbands might be, and are thus isolated and living a

compartmentalized life with a lack of social networks. Reinhart and Rusk interviewed one woman who works with immigrant community groups near Toronto and said “it was life altering for me to really hear, particularly in rapidly growing suburban communities, how much this loss of a sense of community really, really impacted people in a deep and spiritual and quality of life kind of way” (p. A7). Thus, in lieu of the sense of isolation many immigrant women may experience upon migrating to Canada, it seems that forming community amongst immigrant women is pertinent to their overall wellbeing.

Culturally Relevant Health Literacy Tool

Many researchers believe that health materials should be created so that they are culturally relevant. For example, Singleton’s (2002) opinion was that PEMs should be culturally sensitive and that ESL learners should be consulted when discussing or creating health materials. Furthermore, Horner, et al. (2000) not only suggested simplifying the language to improve the readability of patient education materials but also that PEMs should use examples that are culturally relevant to the target population. Thus, it was fascinating to listen to Maria’s comment, for example, that she can relate to the photonovel because it’s a real-looking person in the picture. Sissel and Hohn (1996) noted that in the USA many written health materials often assume that readers’ worldwide views, cultural orientations, and health needs will reflect a white, middle-class perspective, which makes this information of little relevancy to a wide range of the population. Marghertia’s comment that in the media usually only second-generation immigrants are represented and that it could give others comfort to see an immigrant in health material was powerful. This actually helped me raise my own consciousness because I had never noticed that in the media there are no representations from first-

generation immigrants. In the spring of 2006 when I was writing this thesis, I was on a train in Eastern Canada and sitting next to the CBC broadcaster for classical music. He is a young man of Caribbean descent but told me he speaks “the Queen’s English” and that is why he thinks he got the job at CBC. Despite his incredible qualifications, he told me that he thinks if he spoke with a Caribbean accent he would not have gotten the job at CBC and this lay heavy on his shoulders. When I told him about my photonovel project and the comment that Margherita had made about the under-representation of first generation immigrants in health materials and the media, we got into a long discussion about how, perhaps, the young generation of Canadians (like myself and the CBC broadcaster) might, in our own way, see to it that more first-generation immigrants with accents and who ‘look different’ are portrayed where there are representations of Canadians, such as in the media and in health materials (A. Craig, personal communication, June 22, 2006).

Increased Self-Esteem and Feelings of Importance

As noted earlier, there are many times in their interviews that the women touched on feelings of being minimized in our society through their comments pertaining to such topics as to a lack of being represented in the media and in society, not being understood empathetically by health professionals, and not having access to medical care because of immigrant status. Thus, it was significant to hear the women describe how important and special the participatory photonovel project made them feel. According to Sissle and Hohn (1996), participatory theory embraces a deep belief in the capacity for humans to reflect, learn, and grow and promotes the idea that people matter more than institutions. People most affected by a problem must be involved in solving that problem in a manner

that respects their needs, dignity, and intelligence. The researchers also drew on Frierian (1970) thought when they stated that “participatory research extends these beliefs in their insistence that social problems have their roots in organizations and systems and not people” (p. 62). By being the subject and creator in the learning process rather than the object and the receiver, the women, in turn, experienced feelings of-self worth.

Margherita commented in the results section that we should distribute the photonovel where “Canadian people” go because there is ignorance on the part of many “Canadian people” about the immigrant experience. On the one hand, I thought it was interesting that Margherita seemed to divide in her mind a ‘Canadian’ and an ‘immigrant’, which many of the women did throughout their interviews and I even, ashamedly, caught myself doing, and that I will discuss in the final chapter. However, this was also a notable revelation because it shows that she feels the photonovel has the power to educate other people and give voice to the immigrant experience within Canada. Not surprisingly, Mojab (1999) pointed out that the transition to Canada is not easy for many immigrant women. According to the author’s research, many women feel they have to start their lives over from scratch despite high levels of education in their former country.

The sense of voice that the women articulated from being involved in the participatory photonovel project has been noted by other participants in other health education programs that are participatory. For example, in a community and participatory health education program led by Sissle and Hohn (1996), participants “found their power and their voice, articulating to the outside world what they had learned about themselves, about health and about the role of culture in health” (p. 66). Thus, the women in this

project also became advocates for health education and made presentations of their ideas and materials that they developed in various health projects across a state in the USA. Furthermore, the authors found that it is empowering for people to address issues of health and well being in their own lives and to, in a certain way, confront the health care system that ignores their informational needs.

Comments about Being Responsible for Nutrition After Creating the Photonovel

Although the women did speak of having self-reliance around their health in the initial interviews and focus groups, I noticed that in the latter interviews this became more prominent in the discussions and, actually, was almost the focus of the later interviews. I thought it was fascinating to observe how Maasa, Carole, Margherita, Maria, and Jacky all had a shift in consciousness about eating well, which was clearly illustrated by their responses and through their sometimes-offhanded thoughts about eating well within the final focus group and individual interviews. Based on the women's comments, it seems as though the photonovel project encouraged the women to think about taking more action and responsibility around eating well. According to Freire (1970), by becoming a knowing subject and engaging in authentic dialogue with the educator, the learner can become critically aware of her or his oppressive situation. In other words, Freire proposed dialogue that allows students to analyze aspects of their existential experience in a way that allows them to confront their cultural reality.

On another note, it was interesting when Jacky, after the project had been completed, pondered that maybe she has been in good health in Canada because she maintained her traditional Chinese eating habits. Actually, Tong (1986), who studied the food habits of Vietnamese immigrants in the United States, found that Vietnamese

immigrants should be encouraged to maintain their food dietary habits because their traditional diet is a healthy one. Furthermore, Pan, Dixon, Himburg, and Huffman (1999), in their research on Asian student's eating patterns after living in the United States, found that the participants' health was affected by their change of diet upon living in the US. The researchers proposed that Asian immigrants should be encouraged to maintain their good dietary habits by preparing food at home in a traditional manner.

CONCLUSIONS

The women had very positive feelings about creating the photonovel, and they believed the photonovel could function as an effective health literacy tool for other ESL speaking immigrant women. Most importantly, however, the five women who participated in the photonovel were engaged in an empowerment process by building community, improving their feelings of self-worth and self-esteem, and raising their consciousness about their reality and about eating well here in Canada. The final chapter of this thesis will discuss the implications of this research and recommendations for future research and practice.

CHAPTER 6

CONCLUSIONS

Freedom is when there is equality of each member with every other as subject.

Immanuel Kant (1793)

EQUALITY AS AN ACT OF FREEDOM

Empowerment and the fight for equality amongst social groups has for centuries been a topic of debate and speculation. For example, Kant noted in his work *Theory and Practice* (1793) that freedom is when “there is equality of each member with every other as subject” (p. 72). Participatory education and the photonovel project can contribute to ‘free’ participating members of society by ensuring that participants are seen as equal. They are subjects and not objects in the research and educational process. As Freire (1970) noted, “education as the practice of freedom – as opposed to education as the practice of domination – denies that man is abstract, isolated, independent, and unattached to the world; it also denies that the world exists as a reality apart from people” (p. 81). Most interestingly, Jean-Jacques Rousseau (1755) stated in *Discourse on The Origin and Foundations of Inequality Among Men*, “equality is the original state of man, and that this is only the spirit of society, and the inequality that society engenders, which thus changes and alters our natural inclinations” (p. 8). Rousseau viewed man’s natural disposition being one that does not perpetuate inequality even though our contrived society has perpetuated inequality. Thus, perhaps in a research situation where participants are given the opportunity to enter into dialogue together and with the

researcher about their reality, a more natural flow of understanding may occur that may not exist outside of the research setting. Adding to the debate, Friedrich Nietzsche in *Beyond Good and Evil* (1886) wrote that human beings create values, whether they want to or not: “if we fail to see that, we are not only confused about the nature of our relationship to the world, but we also are likely to take a specific attitude to the world that is damaging and that makes us smaller” (p. 20). By creating opportunities for people to talk to each other about common values they share as human beings, people may come to see one another as an equal. Thus, by allowing opportunities for participants to enter into a dialogue with others, which in this case includes other participants, myself the researcher, and you the reader, there is an opportunity to come to see one another as an equal by a shared sense of reality and perhaps even an awareness of the subtleties of a shared human experience.

Freire’s work also deals in large with inequalities in society. He is not only a philosopher who has continued the ongoing debate about the source of inequality in society but he has implemented a plan of action to challenge this problem through participatory education. Friere (1996) believed that “no reflection about education and democracy can exclude issues of power, economics, equality, justice and its application, and ethics” (p. 146). Because of Freire’s work, researchers may now follow in his footsteps and facilitate in developing each participant’s critical thinking about their world. These researchers undertake the responsibility to strive for dialogue amongst people within an environment that promotes respect and egalitarian thinking. Essentially, small steps towards equality in the research process, such as the photonovel project, can lead to larger effects in real life.

SHIFTS IN CONSCIOUSNESS

One of the main aims of this investigation was to empower the ESL speaking immigrant women in the study by raising their critical consciousness. One can see that this did in fact take place. The women experienced a shift in their consciousness about eating well.

I found that relationships within the group started from when the women wrote the photonovel and created it. Before that, the women were more strangers to one another even though some of them had been in previous women's groups together. Also, the women commented on positive feelings about their self-worth, improved confidence, and their sense that a sense of community was formed. By the time the photonovel project ended, comfortable relationships between the women had been established. They laughed together and argued good naturedly about editing the photonovel.

The deeper conceptual shifts in understanding within the women became obvious to me in situations where I would be talking to the women about something and they would randomly bring up eating well or something else they learnt in the middle of a conversation we were having on another topic. For example, Margherita spoke most frequently. Her experience in the photonovel group offered her a powerful opportunity for praxis to the extent that the research process allowed her to change by encouraging self-reflection and a deeper more critical understanding of her situation (Lather, 1986). Margherita's shifts are noted in the fact that she came into the project with frustrations around health limitations due to her position as a non-status immigrant. Leaving the project, she had a deeper focus on nutrition and eating well in Canada. Actually, it could be said that Margherita's shift is in fact more empowering for her because eating well is

something that she can take control of as opposed to her immigration status, which is beyond her control. Not only did we see a shift in her consciousness around health issues, but we also saw that Margherita felt she formed community, that the photonovel project made her feel important, and that sharing her story took a weight off her shoulders. Margherita pointed out that the photonovel project was done within “the eyes of the people”, which she believed was positive because it helps alleviate misconceptions “Canadians” have about immigrants. Margherita said she wanted to share the photonovel with other Canadians, as she believes that “Canadian people” do not eat well and noted the great responsibility attached with having this message printed and distributed to others.

This critical perspective that Margherita has about mainstream Canadian food culture offers us a consciousness-raising perspective about our own eating habits here in Canada. Not only did this research enable the women who participated to raise their consciousness about their experiences with health in Canada, but it also helps us raise our critical consciousness about our own unhealthy cultural practices here in Canada. The fact that these women come here with ‘fresh eyes’ is a valuable contribution that allows me, as the researcher, to engage in a dialogue with the participants so that there is consciousness-raising on both sides and not just one. Freire (1970) proposed that reality, which has a fluid nature and is constantly in transformation, should be pondered critically by the oppressed in order for them to become fully human. As a result, revolutionary educators must interact in a partnership with their students by trusting in their creative power and encouraging critical thinking. Considered to be the opposite of ‘banking education’, ‘problem-posing education’ enters the teacher and student into dialogue

where both learn from the other and where critical reflection occurs. Feminist researchers argue that the traditional research process reinforces the oppression of women, and instead they suggest that a dialectical relationship between the subject and object of research ties results in a truly participatory form of research. Thus, one way I tried to overcome the traditional division between researcher and participant was to encourage the participants to talk back to me in the interview process and engage in more of a dialogue with me.

Thus, as this thesis progressed, I realized that the focus of this research was not only about whether or not the process of creating and using a photonovel empowers ESL speaking immigrant women by raising their critical consciousness and how this tool helps them understand a specific health topic. It concerned whether there is a three-way dialogue amongst the reader, the women, and me to engage in a consciousness-raising process. As noted, the dialogical interaction that Freire (1970) spoke to, for example, is about every participant becoming active in the consciousness-raising process.

I, for one, have most certainly raised my consciousness through being engaged in this project. I have learnt more about ESL speaking immigrant women's experiences with health in Canada, I have understood a more critical perspective that the women offered about eating habits in Canada, and I have heard the women's voices about their experience with learning about health and becoming more empowered through the photonovel project. I even had to think critically about smaller perspectives that were raised within the project. For example, after listening to the women's comments about the lack of family values in Canada, I had to think critically about this observation. Furthermore, I had to, at one point, to consider what it means to be 'Canadian'. In the

interviews, I noticed I and some of the women were often referring to Canadians as non-immigrants, and when this was pointed out to me I was very ashamed and had to reconsider that an immigrant is, of course, a Canadian. I got caught up in biased language myself that I was not conscious of. In short, when I began the project, I had understood intellectually the concept that “in naming their world, people can transform it and achieve significance as human beings” (Friere, 1970, p. 109); but it was not until I actually experienced the participants create a photonovel, which involves the naming of and sharing of their coded realities that would later be disseminated into the world around them, that I truly understood the power of the participatory process and later understood how it transformed myself as well.

A SMALL STEP IN A BIG ARENA

The power dynamic between researcher and participant has been discussed by countless researchers along with debates about appropriate distance taken by the researcher from the participant. As I have noted, I saw myself more as a participant observer in the research process. I was also a facilitator in an empowerment process for the participants. Thus, I felt I was engaged in the research process and built a relationship with the women; but I also was critically conscious of how I experienced the research process and created my text around this act of reflexivity. I believe, however, that my data was richer because I had built a relationship with the women and came to understand them in a more meaningful way than if I were merely at a distance. According to Patton (1990), when thinking about the issue of closeness to the people and situations being studied, it is useful to remember that many major contributions to our understanding of the world have come from scientists’ personal experiences. The author noted, “there are

actually many examples throughout history in which closeness to the source of data has made key insights; such as Piaget's closeness to children, Freud's proximity to and empathy with his patients, Darwin's closeness to nature, and even Newton's intimate closeness with an apple" (p. 48). As Patton noted, closeness does not always create bias and loss of perspective just as distance is no guarantee of objectivity. Actually, to fully understand a qualitative case study, it needs to be understood from the perspective of those involved (Gillham, 2000). Qualitative research is less about being at a distance and more about giving up authority over the people being studied, but not the responsibility of authorship over their texts (Richardson, 1990).

I would like to acknowledge, however, that although my aim was to avoid power imbalances within the research process, it was not always so. At one point in our final interview, Maasa noted that *I* [italics added] had done a very, very good job, which was an interesting comment that exposes the inevitable power imbalance that exists in researcher-participant dynamics because she acknowledges *me*, the researcher, as having created the photonovel and not herself and the other women, even though I acted only as the facilitator in the creation of the photonovel. Also, at the end of our final interview, Maasa made a point of saying to me "I hope that *you* [italics added] can take the pictures, so that every country people can use it". The power imbalance researchers face when working with immigrant women is also noted by Mojab (1999) whose research focused on immigrant women and who pointed out that "the unequal distribution of power between researcher and researched is always present" (p. 124). As noted in Chapter 3, ultimately "the researcher is free to leave the field at any time and is generally the final author of any account" (Fonow & Cook, 1991, p. 9). Undoubtedly, the researcher is given

a lot of power in the research process along with inequities, such as my social status and education level.

IMPORTANCE OF PHOTONOVEL INVESTIGATION

Although the photonovel project acted as a catalyst towards empowerment for the women, it is just a small step in the empowerment process of a cohort of women in our country who experience marginalization on a daily basis. It is, however, important in the development of health education.

The relevance of this thesis within Canada was acknowledged from its conception when it was funded by BC TEAL's (The Association of BC Teachers of English as an Additional Language) Aids and Health Education Grant. The funders believed that the project would create a health education material that would reach a wide variety of immigrant people in the province of BC. Furthermore, this project was awarded the Population and Health Student Award by the Canadian Public Health Association and was presented at the 97th Canadian Public Health Association Conference with a description published in the *Canadian Journal of Public Health*. The reviewers who chose this project for the award claimed it to be "very creative approach to health promotion; showing evidence of a likely impact both in terms of health literacy innovation and new tools, as well as impacting users". The reviewers also mentioned that the photonovel is transferable to similar populations, making the project appealing to various health care workers and health education researchers, which illustrates, in part, the need for health literacy strategies directed at ESL speaking immigrant women in a Canadian context. The award recipients are deemed to be up and coming researchers in Canada who are viewed to have the potential of making a future impact within the

country within health promotion. The project was chosen out of 88 applicants across the country from graduate schools researching within the area of health.

Since the project at the ICA was completed in December 2005, I have distributed about 35 of the women's photonovels to different organizations within BC. Since then, I have had an overwhelming amount of requests to come in and do photonovel workshops at immigrant organizations with staff that work with ESL speaking immigrant women, which I have done and will continue to do. I have also had several publications about the project in provincial immigrant and refugee society newsletters. This research not only contributes to an academic forum where there is a lack of research on immigrant women and health but also has been acknowledged as being valuable within the reality of the people who work daily with ESL speaking immigrant women.

As noted previously, the CIHI (2004) found that immigrant women often experience a decrease in their health when they move to Canada. As "there is also growing concern in Canada that immigrant and minority women are not always included in health research" (Anderson & Hatton, 2000, CIHR), my findings are significant because they add to the body of knowledge about immigrant women's experiences with health in Canada. Thus, based on the women's initial interviews and focus group, they said that financial struggles, poor nutrition, and a lack of social support can all be contributing factors to ESL speaking immigrant women's health decreasing once in Canada. I discovered that the women experience cross-cultural differences in lifestyles and in accessing health information and care here in Canada, which can be due to issues such as frustration with their level of English and struggles with the limitations that are tied to immigration status.

The thesis also adds to the body of knowledge around effective health literacy strategies for an ESL speaking population. As seen in Chapter 5, the women not only had very positive things to say about the creating the photonovel and being involved in the process but they were also very adamant that it would reach an ESL speaking population because of the visuals and low level of English within the photonovel. Thus, it is brought to our attention that the photonovel can be an effective health literacy tool for this ESL speaking population in Canada. When we are reminded that, according to Simms (2003), the inability of large numbers of immigrant women to speak English well is a major obstacle to them accessing services like health, we can see that a tool like the photonovel should perhaps be used more frequently within Canada as a health literacy strategy with an ESL population as opposed to more mainstream health strategies.

Aside from the very valuable information gathered about ESL speaking immigrant women's experiences with health here in Canada and also the effectiveness of the photonovel as a health literacy tool, this thesis also looked at the photonovel process as a catalyst for empowerment. As noted in the introduction, immigrant women, even though they may be highly educated, often struggle to find employment, face financial issues, and often live in low-income situations (Meyer, Torres, Cermeno, MacLean, & Monzon, 2003). Furthermore, immigrant women's specific conditions are also heightened by other systems of oppression such as class, race, and ethnicity to further increase women's feelings of vulnerability (Menjivar & Salsido, 2002). Thus, not only are we aiming to find ways to inform ESL speaking immigrant women about staying healthy here in Canada but, at a deeper level, there is a more profound goal to empower this

cohort of Canadians so that they can achieve social significance in our country and have more control over their realities.

The evidence in this project suggesting that the photonovel project helped empower the women involved is a very important implication. As noted, not only is health literacy defined as “the ability to read and comprehend prescription bottles, appointment slips, and other essential health related materials or the capacity to obtain, interpret and understand basic health information and services needed to make appropriate health decisions” (Ratzan & Parker, 2000), but it also involves the ability to analyze information critically, increase awareness, and participate actively to use information to exert greater control over one’s life, which allows for personal empowerment (WHO, 1998).

The photonovel not only helps reach a population that normally is not able to understand mainstream health information but also reaches into the more profound challenge of enhancing the women’s critical consciousness. Based on the women’s voices in their final interviews and focus group, we can see that the process of reflecting collaboratively about their reality and taking some control by engaging in cumulative action about a common health concern (in this case, poor nutrition) and creating the photonovel was empowering for the women. As VanderPlaat (1998) pointed out, empowerment becomes the avenue for people to challenge their internalized powerlessness while also developing real opportunities to gain control in their lives and transform their various settings, which is what occurred in this project and is also apparent through the shifts in the women’s consciousness about being responsible for their nutrition here in Canada. In short, when the women expressed feeling good about

themselves, that they formed a community through the project and that they became more aware of being responsible for eating well in Canada, it implies that the project not only is relevant to the functional health literacy arena but moves beyond this into critical health literacy where the aim is empowerment.

RECOMMENDATIONS FOR FUTURE RESEARCH AND PRACTICE

According to Statistics Canada (2005), about 60% of adult immigrants have difficulty with reading and numeracy tasks commonly encountered in everyday life, which compares to 37% of the Canadian-born population. Although there is a lack of information on the effects of high health literacy numbers on health expenditures, the magnitudes suggested by the few studies available alert us to the importance of addressing limited health literacy from a financial perspective (Nielsen-Bohlman, Panzer, & Kindig, 2004). Considering that groups with limited English proficiency, like recent immigrant women, contribute to the high rates of health illiteracy and the probable financial burden of this issue on our health care system and the projected rapid increase of immigrant numbers over the next decade (Statistics Canada, 2005), I recommend that education and health-related government agencies put more funding into research studies that focus on effective and empowering health literacy strategies for ESL speaking immigrant women. More funding should be given towards participatory research to ensure that ways to address the health literacy needs of ESL speaking immigrant women in Canada matches their needs. This means researching ways to create health literacy materials that have visuals that are representative of the diverse population of Canadians and with language that can be understood. In order to ensure that health literacy materials are going to be effective, it is essential that the participants are involved in the process.

Not only will having the participants involved predict effective health literacy tools but also it also simultaneously helps empower this population living within Canada. When we draw on the participants' expertise and voice, it sends a message that their perspectives are not only of value and importance but that we rely on their voice to be able to access other Canadians like them. Furthermore, I also recommend educators and health practitioners should be educated about research findings about the health literacy needs of this population of Canadians and be informed about appropriate ways to actively implement these findings in real life. It is important that research be done within this area in the academic forum, but that there also be creative solutions given to those who are working with ESL speaking immigrant women on a daily basis.

FINAL THOUGHTS

Although creating a society where everyone has the skills they need to obtain and understand health information in meaningful and empowering way is an immense and complex challenge, I think it is possible to progress towards achieving this vision. Meeting this challenge perhaps requires researchers to think outside of the box and come up with creative solutions in collaboration with ESL speaking immigrant women themselves. Traditional health literacy strategies are, frankly, not working with this population. The participatory photonovel is one way we can address this challenge and meet the health literacy needs of ESL speaking immigrant women in Canada while also empowering the women involved in the process. This research study is just a step towards investigating an empowering way for ESL speaking immigrant women to access information. This area warrants further exploration. Within health literacy's many facets, there is a dire need for research that focuses on an often-overlooked population within

health research in Canada. The photonovel technique gives us an empowering tool that allows us to intervene and act quickly now while we continue to open multiple dialogues on ways to access the dynamic health needs for specific immigrant populations in Canada.

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APPENDIX D

CREATING A PHOTONOVEL

STEP 1: PLANNING

- What are the objectives of the project? Clearly define these objectives.
- What is the topic?
- Who is the intended audience?
- What is the literacy/educational level of this population?
- What is the audience's sex/income/age?
- What is the audience's awareness of the topic?
- What is their level of visual literacy or familiarity understanding photographs or symbols?
- What is the audience's familiarity with the format of photonovels?
- What customs or culture of the audience?

Once this information is gathered, you can decide on the message to be conveyed and the audience you are targeting.

STEP 2: DESIGN

The plot, or storyline, should be developed with the message woven in as part of the story (remember that photonovels are popular forms of literacy because the stories contain action and emotion). In order to help the reader understand what is happening in the story, the scene changes need to be clearly marked.

STEP 3: DIALOGUE

The dialogue is the discussion between characters of the story, which takes place within the white balloons or captions. The dialogue consists of short sentences and vocabulary familiar to the audience.

STEP 4: CHARACTERS

The characters should be developed carefully and thoroughly because the personalities in your story can play critical roles in making your message understood.

- Consider: What are the characters' past, thoughts, dreams, family background, etc. Discuss this in your group.
- The audience must be able to relate to the characters in your story.

STEP 5: VISUAL CONTENT

- Attractive photographs motivate readers to pick up the photonovel in the first place.
- The important aspects of visual content are:
 - Cover: The reader sees the cover first and makes a quick decision whether or not to pick up the book. The cover must be interesting, and it has to compete with other educational materials.
 - Symbols: Photonovels add a good opportunity to tie in visuals. You can use logos, uniforms, signs etc. But be careful to consider if the audience is familiar with these cultural symbols.

STEP 6: REVISION

- Do you like the cover?
- Do you like the story?
- What happened in the story?

- Will the audience understand all of the words?
- Did you learn anything from reading this?
- What have you learned?
- Is there anything you think isn't true?
- Is there anything that could be offensive?

Also, be sure that the reader can follow the scenes and that the time sequence is clear.

STEP 7: OTHER THINGS TO CONSIDER

- Make sure that the character's names are culturally appropriate.
- Make sure that the actors are dressed in clothes that the audience would wear.
- Remember you cannot pretend to be of an ethnic origin if you are not.
- What is the title of your photonovel? The title should be brief, catchy, and at the same time give an indication of the audience that has been targeted and the content of the material (i.e., having a hysterectomy [with a picture of a Hispanic woman on the front]).
- Are the colors in the photonovels attractive?

STEP 8: DISSEMINATION

- Imagine where this would be disseminated and how (i.e., newsstands, in clinic waiting rooms, at the university, restaurants, etc.)
- How many copies will we make?

Liebttag & Rigby (1990)

APPENDIX E

FOCUS GROUP AND INDIVIDUAL INTERVIEW QUESTIONS

Questions about Experiences with Health in Canada

1. How did you find health information in the country you lived in before you came to Canada?
2. If you had a health problem, what would you do? Would you go to the doctor?
3. Is getting health information in Canada easier or harder than in your own country?
4. Have any of you been to see a doctor here? Do you have a family doctor?
5. Do any of you feel afraid to go to the doctor because you do not speak English well?
6. Did you ever ask friends and relatives about health information?
7. Was health information in your countries mostly spoken or was it something that you read? Do any of you watch TV or use the Internet to get health information?
8. Have any of you been given health information in a written form, and did you understand it?
9. Is it easier to understand health information if there are pictures?
10. How has your health been since you have been to Canada? What kinds of things have affected your health?
11. Have you noticed any unhealthy behaviour in Canadian people?
12. Do you think it is a good idea to create a photonovel for other women to read?
What do you think is a good way to teach ESL speakers about health information?
13. How does living here away from your family, friends, or community affect your health?

INITIAL INDIVIDUAL INTERVIEW QUESTIONS

Demographic Questions

1. What is your name?
2. Where are you from?
3. How long have you been in Canada?
4. Are you single or married?
5. Do you have children?
6. Do you feel you speak English well? Did you speak it before you came to Canada?
7. How much education have you had?
8. How many languages do you speak?

Questions about Experience with Health in Canada

9. Have you ever felt that money was a factor in being healthy here?
10. Do you have any stories about any experiences of health care in Canada?
11. Have you ever found you could not find information about a health topic here that you needed information on?
12. Where do you get your general health information? Do you ask friends, or the doctor, or watch television?
13. Do you ever give health advice to people?
14. If you could give advice to immigrant women who come here, what would it be?
15. Do you think your level of English has affected your health here?
16. In your opinion, what is a good way to teach people about health?

17. There is a statistic from the Canadian Institute for Health Research that states that when women come to Canada their health becomes worse after several years of living here; why do you think that is?
18. Do you feel you have enough control over your health here?
19. Do you think that the government could do anything to help immigrant women with health?
20. Would you say that you are more healthy here or less healthy than when you were in your previous country? Why?
21. Do you feel you have control over your health?
22. Do you think creating the story for the photonovel and doing it will really help you learn about nutrition more? Why?

FINAL FOCUS GROUP QUESTIONS

Questions about What was Learnt about Health and Feelings of Empowerment

23. What did you enjoy most about creating the photonovel?
24. Did it make you feel important to create the photonovel?
25. Is there anything you would change about the process of creating the photonovel?
26. If this were at a doctor's office, would you read it? Why?
27. Some of you have mentioned distributing the photonovel where non-immigrant people go for services; what do you think you have to teach non-immigrant Canadians about health?
28. How does it feel to know you created a health material for other people to read?
29. What do you mean when you say creating the photonovel gives you a "responsibility"?

30. In your opinion, is the photonovel a good tool to learn about health?
31. Do you all feel you contributed to the photonovel and had a part to play?
32. The first part of this project we were sitting down and learning, and the second part of it we were creating a story, making a photonovel and taking photographs. Do you see a difference between these two ways of learning?
33. Did you learn anything about nutrition during this process?
34. Did the photonovel help you remember information that the nurse taught you? Why?
35. Would you advise your friends to take part in the photonovel project if it was offered again?
36. What could immigrant women do in the future to have more control over their health?
37. Do you think it helps to have materials like this to read if you do not speak English very well?

FINAL INDIVIDUAL INTERVIEW QUESTIONS

Questions about What Was Learnt about Health and Feelings of Empowerment

38. Tell me what you learnt about health by doing the photonovel?
39. When you saw the photonovel, what was your reaction to it?
40. Was the photonovel a reflection of your own cultural health values? Why?
41. Did you understand the language in the photonovel? Do you think other immigrant women will too?
42. Was creating the photonovel a positive experience for you? Why or why not?

43. Did creating the photonovel increase your confidence in understanding more about nutrition and your experience being here?
44. Do you think being able to better understand health information would make your experience living here easier?
45. When you think about this experience in a year or so, what will you remember about it?
46. Does it matter that when you read a photonovel or health material that the people in the story are like you?
47. Would you tell a friend to participate in the photonovel project?
48. Did you feel you played a large part in choosing the topic and making the photonovel?

From Junk Food to Healthy Eating



Tanya's journey to a better life

Acknowledgements



From left to right: Marcelina and her dog Reeses, Maki, Ana Maria and her daughter Laurita, Group Facilitator Laura Nimmon, Sindy and Joyce.

Thank you Alvaro and Steve at the Inter-Cultural Association (ICA) for all of their generous support for this project.



Thank you also to the ICA Women's Group Facilitators, Carla and Alegha, for helping this project run so smoothly.

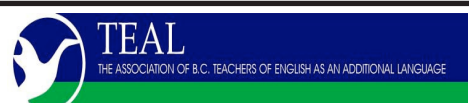
Thank you Kim, the project's nurse who helped inform the women about the health topic they chose to learn about. Thank you to Towah Behr for his graphic design work and to my supervisor Dr. Deborah Begoray.

This project was produced by a group of wonderful immigrant women for my Master's degree in Language and Literacy Education. Research suggests that when immigrant women move to Canada their health decreases after several years (Canadian Institute for Health Information, 2004). There are a lot of theories about why this happens and one of the main ones is that low language levels prevent them from accessing Canada's health care system and standard health information. My research showed that the photonovel technique was a very effective way for ESL speakers to learn about health. It's effective because it uses the women's own language levels, it's culturally relevant and it's highly visual. It is also

an educational process that has the learners as the main participants in the learning process. Together the women chose nutrition and exercise as their main health concerns since arriving in Canada. After learning about these health topics from a public health nurse they developed a storyline and characters and then directed, photographed and acted in the story. We all hope that this story helps you learn a little more about being healthy here and that you are not alone if you feel you could be eating healthier foods here in Canada. Hope you enjoy reading the photonovel! Eat well and be healthy!

Sincerely,
Laura Nimmon

This project has been funded by BC TEAL (The Association of Teachers as an Additional Language) Charitable Organization through an Aids and Health Education Grant





Tanya immigrates to Canada from Hong Kong.

**Mmmm... Yummy!
The food in Canada is so good and so cheap!!!**



Tanya emails her friend at home.



Dear Yee,

I'm having such a good time here in Canada. I can't wait to tell you how cheap food is here and how good it tastes. Every day I can eat out and I don't have to cook at home. I don't have to walk much because I can take the bus everywhere.

I'm making new friends from different countries but I miss you a lot.

Love,
Tanya

3 MONTHS LATER...

Hey Susan, I don't feel very well these days. My clothes are too tight and I'm tired all the time. I feel bloated and depressed.

That's strange I feel the same way.



I think you should go talk to your teacher.

Yeah?



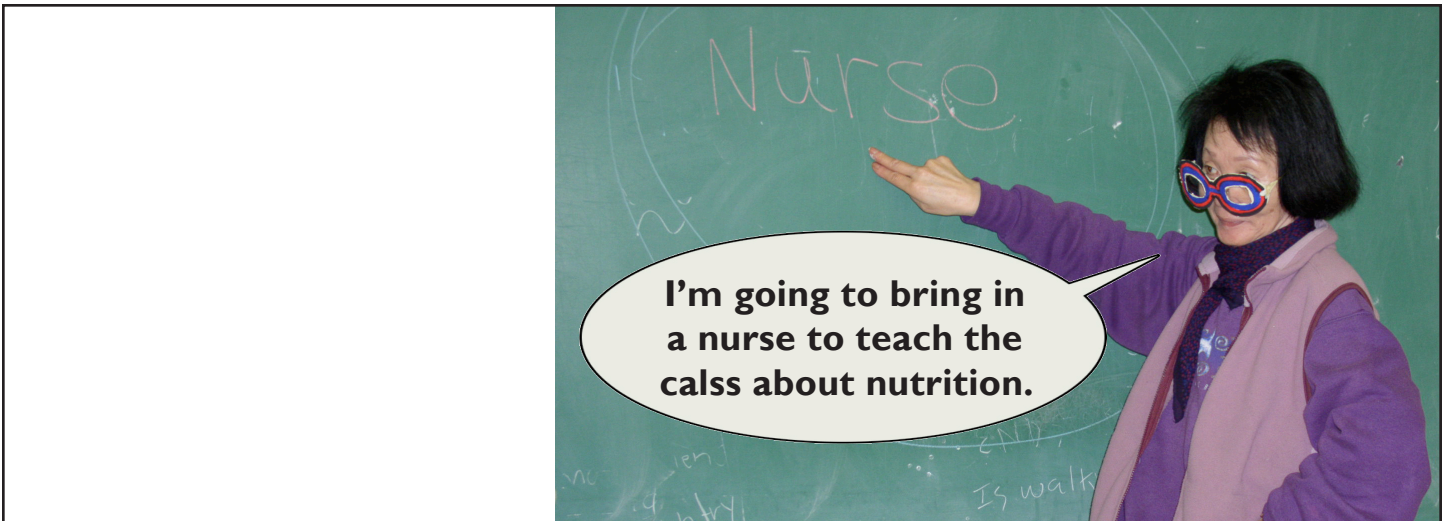
Why am I feeling so bad?

Hmmm... Maybe because you are not eating well.



But I am eating Canadian food.

But you need to eat healthy Canadian food.



I'm going to bring in a nurse to teach the calss about nutrition.



Hello everyone!
I am Janice the nurse.





Eating is good as long as it's good food.



Like eating an apple when you are hungry instead of chips.



You can eat sugar but you also need to eat a balanced diet from the four food groups.



The four food groups are grain products, vegetables and fruits, milk products, and meats. Healthy foods are actually cheaper to buy than junk food.



You will feel better if you exercise and don't just sit around.



Come on ladies!



We should be eating more fruits.



Yeah no wonder I felt so bad.



Good bye junk food!

I should change the snacks I give my daughter.

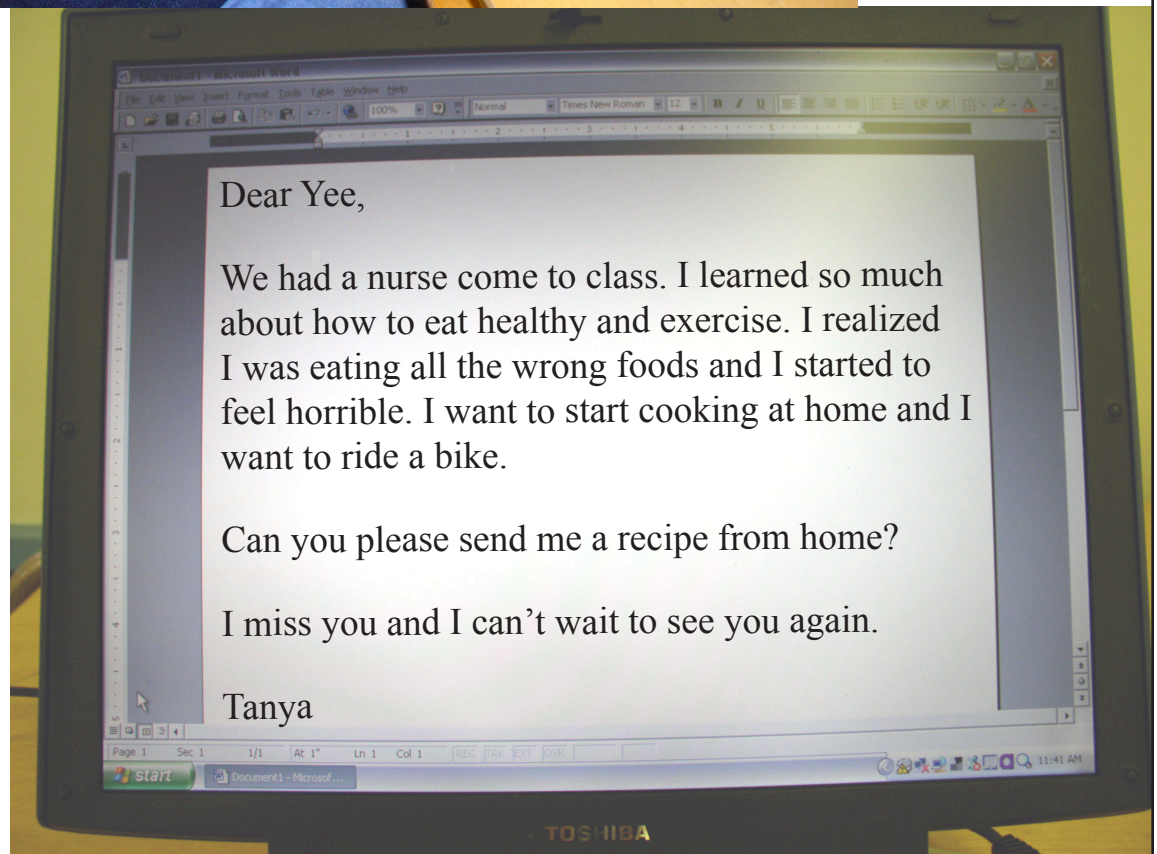
I think I am going to change some of my eating habits.



2 WEEKS LATER...



Tanya emails her friend in Hong Kong again.





**I just love riding
my bike and fruit
tastes so good.**



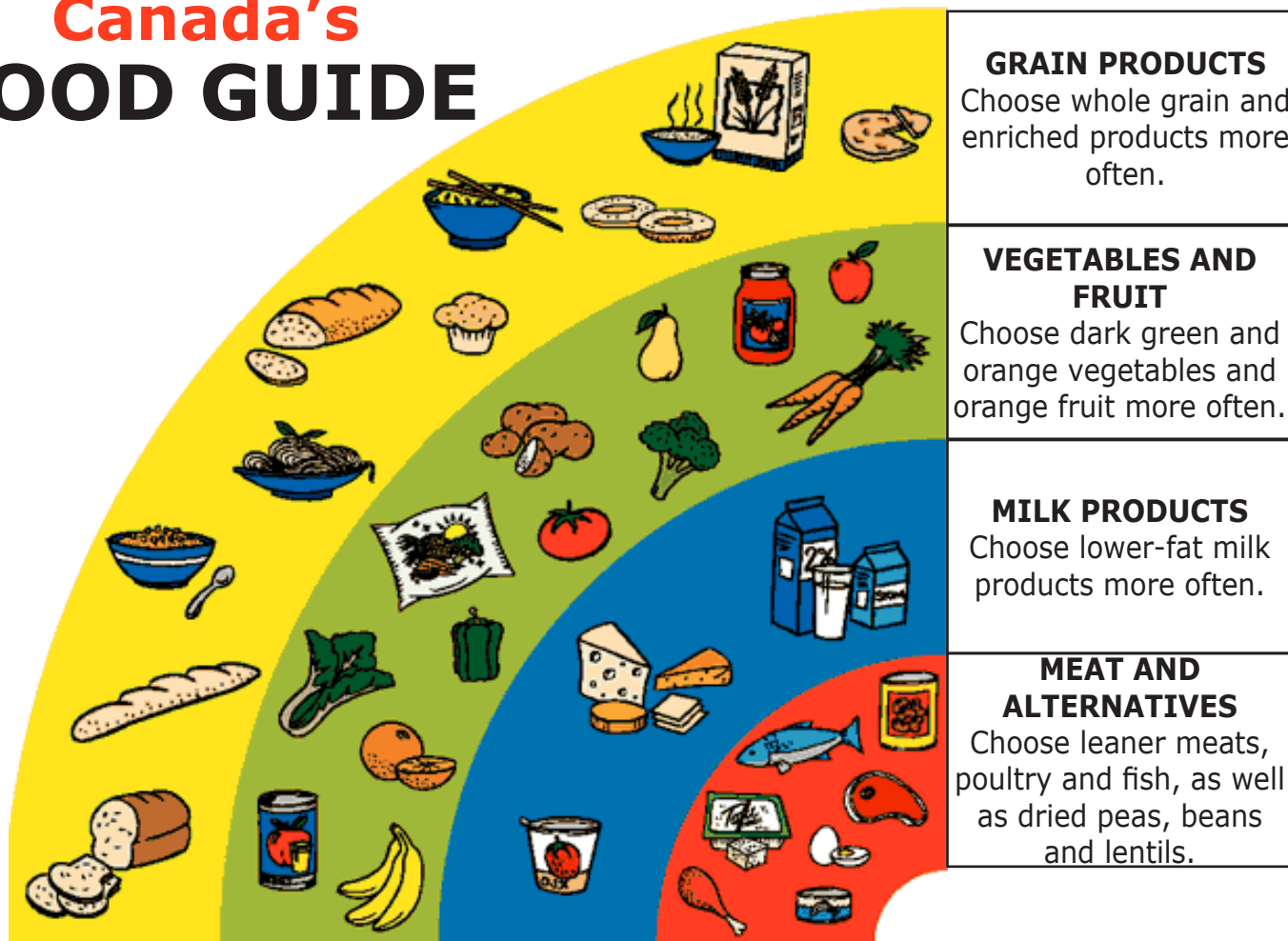
**We feel so good!
We should share
this with other
immigrant women.**





— THE END —

Canada's FOOD GUIDE



Resources

- **Canada's Guide to Healthy Eating and Physical Activity**
(gives information about the four food groups)
http://www.phac-aspc.gc.ca/guide/he1-as1_e.html
- **The Government of Canada-Food and Nutrition**
(a good source of nutrition information for Canadians)
http://www.hc-sc.gc.ca/fn-an/nutrition/index_e.html
- **Public Health Agency of Canada**
(has a great physical activity unit)
<http://www.phac-aspc.gc.ca/pau-uap/paguide/index.html>
- **Dietitians of Canada**
(promoting health through food and nutrition)
<http://www.dietitians.ca/>
- **Nutrition and Food**
(this Canadian website has many links to great links to websites about nutrition)
<http://www.sfu.ca/~jfremond/consumer.html>
- **Nutrition, Health and Heart Disease**
(gives tips on how to have a healthy heart)
<http://www.health-heart.org/>

For more information about From Junk Food to Healthy Eating: Tanya's Journey to a Better Life or to order copies please contact:

Laura Nimmon

email: laura@photonovel.ca

webpage: www.photonovel.ca