

Multiple Exposures: Racialized and Indigenous Young Women Exploring Health and  
Identity through Photovoice

by

Alison Sum  
B.H.K., University of British Columbia, 2003

A Thesis Submitted in Partial Fulfillment  
of the Requirements for the Degree of

MASTER OF ARTS

in the School of Exercise Science, Physical and Health Education

© Alison Sum, 2008  
University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy  
or other means, without the permission of the author.

SUPERVISORY COMMITTEE

Multiple Exposures: Racialized and Indigenous Young Women Exploring Health and  
Identity through Photovoice

by

Alison Sum  
B.H.K., University of British Columbia, 2003

**Supervisory Committee**

Dr. Patti-Jean Naylor, School of Exercise Science, Physical and Health Education  
**Supervisor**

Dr. Jo-Anne Lee, Department of Women's Studies  
**Co-Supervisor and Outside Member**

Dr. Sandra Gibbons, School of Exercise Science, Physical and Health Education  
**Departmental Member**

## ABSTRACT

**Supervisory Committee**

Dr. Patti-Jean Naylor, School of Exercise Science, Physical and Health Education  
Supervisor

Dr. Jo-Anne Lee, Department of Women's Studies  
Co-Supervisor or and Outside Member

Dr. Sandra Gibbons, School of Exercise Science, Physical and Health Education  
Departmental Member

This study explores the health and well-being of eight racialized and Indigenous women between the ages of 21 and 28, who live in Victoria, BC. Participants use Photovoice, a participatory research strategy, to examine and discuss their intersecting everyday realities in the contexts of health, well-being and identity. Through this project, I aim to provide an in-depth understanding of social exclusion, as a social determinant of health, and investigate the micro-social processes that occur at the intersections of race, class and gender, among many other social relations. I draw upon transnational feminist, anti-racist and postcolonial theories to shed light on the complexity of our shifting and emergent identities. The stories that participants share indicate that historical processes of colonization, daily forms of racism, migration, nationalism, citizenship and cultural essentialization are key contributors to their processes of identity formation and subsequently, their experiences of health and wellness.

## TABLE OF CONTENTS

SUPERVISORY COMMITTEE .....	ii
ABSTRACT.....	iii
TABLE OF CONTENTS.....	iv
LIST OF TABLES.....	vii
LIST OF FIGURES .....	viii
ACKNOWLEDGEMENTS.....	ix
DEDICATION.....	x
PREFACE.....	xi
CHAPTER ONE - INTRODUCTION.....	1
Race, Ethnicity, Class and Gender - Rethinking Approaches to Health and Wellness.....	1
Problem Statement.....	3
Research Objectives.....	4
Goals of this study .....	5
Making space for racialized women: A critical approach to health and wellness .....	6
Operational Definitions.....	7
CHAPTER TWO – LITERATURE REVIEW .....	8
Introduction.....	8
Race as a “risk factor” or biological variable .....	8
Psychosocial perspectives on racism and negative health outcomes.....	10
Cultural explanations for coping with racial discrimination.....	12
Biomedical views on racial discrimination and health .....	13
Physiological impacts of racial discrimination .....	15
Social determinants of health.....	17
Social Exclusion.....	18
Racialized women and mental health in Canada .....	24
Moving towards an Intersectional Approach to Health .....	25
Transnational Feminist Theories.....	27
Hybrid and Diasporic Identity Formation.....	28
Poststructuralist Critiques of Essentializing Discourses.....	29
National Identity and Citizenship .....	31
Postcolonial Perspectives.....	33
Building Solidarity.....	35
Deconstructing Canadian History .....	36
Canadian Anti-Racist Feminist Theory .....	39
My Critical Theoretical Framework .....	40
CHAPTER THREE - METHODS.....	42
Research Design.....	42
Feminist participatory action research framework .....	45
Data Collection.....	46
Participants and Recruitment .....	49
Overview of Procedures.....	52
Other Data Collection Instruments.....	65

Field Notes .....	65
Interviews.....	65
Data Analysis .....	65
Ethical Considerations .....	67
Trustworthiness .....	69
RESULTS AND DISCUSSION .....	71
Introduction to Chapters 4, 5 and 6.....	71
CHAPTER FOUR Race, Racialization and Everyday Racism: Impacts on health and well-being .....	72
Introduction.....	72
Black or White? The Politics of Skin Color .....	72
Everyday Racism .....	77
Cultural Essentialization .....	80
Contending with Stereotypes .....	84
Taking on the tools of the oppressor.....	86
Chapter Summary .....	87
CHAPTER FIVE Living Between Worlds: Exploring Health, Identity and Belonging ..	89
Introduction.....	89
The social construction of the “immigrant woman” .....	89
Living a “double life” .....	91
Liminality and Health .....	94
Multiple Identities, Finding Balance and Self-Acceptance .....	95
Multi-National Upbringing .....	97
Assimilation Anxiety .....	102
Ambivalence .....	104
A search for certainty.....	106
Citizenship, Social Exclusion and Health.....	112
Chapter Summary .....	117
CHAPTER SIX Breaking down barriers: Strategies for achieving health and wellness	119
Introduction.....	119
Revisiting the past.....	120
Reclaiming Lost Identities .....	122
Identifying Loss .....	126
Naming Privileges.....	129
Chapter Summary .....	132
CHAPTER SEVEN - CONCLUSION .....	134
Summary of Key Findings .....	136
Reflections and Other key findings.....	139
Abandoning assumptions .....	139
Battling against positivistic tendencies.....	142
Wearing multiple hats .....	143
Working against time.....	144
Directions for future research.....	145
Conclusion.....	146
REFERENCES .....	148
Appendix A About Anti-Dote.....	171

Appendix B Letter of Information .....	173
Appendix C Guide for discussions and Photovoice workshop activities .....	175
Appendix D Invitation to participate .....	177
Appendix E Information on Photovoice .....	178
Appendix F Participant consent form .....	179
Appendix G Image release form for participants' images .....	183
Appendix H Image release form for images created by participant .....	184
Image Release Form for images created by participant .....	184
Appendix I Image release form for subjects of participant's photos and accompanying letter of information .....	185
Appendix J Anti-Dote Board Approval .....	189
Appendix K Point-form contents of ongoing verbal consent script .....	190

## LIST OF TABLES

Table 1 <i>Participant Background Information</i> .....	51
Table 2 <i>Outline of Procedures</i> .....	52

## LIST OF FIGURES

<i>Figure 1.</i> Photovoice piece by Jenna, entitled “Trifle.” .....	76
<i>Figure 2.</i> Photovoice piece by Rebecca, entitled “My Reflection.” .....	84
<i>Figure 3.</i> Photovoice piece by Dawn, entitled “Compass in the Sky.” .....	92
<i>Figure 4.</i> Photovoice piece by Rebecca, entitled “Love Me If You Dare.” .....	95
<i>Figure 5.</i> Photovoice piece by Sushma, entitled “The Romantic Associate.” .....	100
<i>Figure 6.</i> Photovoice piece by Susan, entitled “Mum and Dad in a Frame.” .....	105
<i>Figure 7.</i> Photovoice piece by Jessica, entitled “Privileges.” .....	114
<i>Figure 8.</i> Photovoice piece by Rebecca, entitled “Empty Bottle.” .....	120
<i>Figure 9.</i> Photovoice piece by Monica, entitled “Longing.” .....	122
<i>Figure 10.</i> Photovoice piece by Monica, entitled “Home.” .....	125
<i>Figure 11.</i> Photovoice piece by Rebecca, entitled “In My Bed.” .....	130

## ACKNOWLEDGEMENTS

I would firstly like to acknowledge my two supervisors, Dr. Patti-Jean Naylor and Dr. Jo-Anne Lee, for their guidance over the last couple of years. Jo-Anne, your incredible mentorship has given me the confidence to think in new ways, and PJ, your endless energy and support have been instrumental throughout this long journey. Thank you also to Dr. Gibbons and Dr. Lauzon for your encouraging words of wisdom along the way. I would also like to thank the Gurlz, Sistahs, Aunties and allies of Anti-Dote, who have provided me with the inspiration, courage and strength to write this thesis. I would especially like to thank and congratulate the Sistahs who so courageously brought their personal stories, insights and knowledge to this project. Your voices are so powerful and wise. I would like to acknowledge Jin-Sun, who kindly brought me into her office one rainy day, and Ros, who has graciously sat down with me many times to help flesh out this thesis. Next, I would like to thank my family members, who are so embedded into my life and my identity. Mom, Dad, Andrea and Nicole, thank you for caring for me so much. I would also like to thank my wonderful friends and colleagues for keeping me balanced and in good humour. And finally, thank you, Rob, for being with me every step of the way. Your love, strength and patience have been tremendous over the last three years.

## DEDICATION

This thesis is dedicated to the Sistahs of Anti-Dote, who made this thesis come to life.

## PREFACE

This thesis represents the voices of nine racialized young women, including myself, on issues of health, wellness and identity. To situate the research topic and thesis, I would like to give some background information on how this project began and why I feel there is such a need to explore the intersections of gender, race, class and health through a critical lens.

I was born and raised in Burnaby, BC, and consider myself a second-generation Chinese-Canadian, a hybrid. My ancestors have been in Canada since the late 1800's, during the times when the Canadian Pacific Railway was being built and their homeland, the Canton (*Guangdong*) province on the south-east coast of China, was struggling economically and socially after Britain's defeat over the Qing dynasty in the first Opium War (1839-1842). After the railroad was built, the men on both sides of my family spent their adulthoods working menial jobs as cooks, tailors, launderers and house boys in Canada and the United States, to support their families in China. The Head Tax and Chinese Exclusion Act imposed by the Canadian government prevented their wives and children from immigrating to Canada, so the women in my family spent the majority of their lives raising their children in economic hardship in China, bearing a new child each time their husbands came to visit them. In 1942, after World War II, the Chinese Exclusion Act was dismantled, and the dependent family members of Chinese migrant workers were allowed to reunite with them in Canada, although immigration policies still favoured Europeans over Asians.

My mother was born in a Cantonese village outside of Hong Kong and arrived to Vancouver in 1959, at the age of nine, with her mother, grandmother and three siblings.

Her father, my *gung-gung* had arrived to Canada seven years earlier, and was working as a cook at a Chinese restaurant. My mother's grandfather (her *gung-gung*) had been working in Canada since the early 1900's, and was managing a rooming house in downtown Vancouver at the time.

My father was also born in a village in the Canton province and arrived to Canada in 1957, at the age of eight. His grandfather had been working as a tailor in Canada since he was 18, then owned a laundry/dry-cleaning business in his later life. My father's great grandfather had also lived in Canada since his teens, and helped to build the railway.

My parents pride themselves in having worked their way from poverty to success. They are well-educated Canadian citizens who have provided well for their three daughters. We grew up in a suburb of Vancouver and my sisters and I attended French Immersion schools. Although I was usually one of the few racial minorities amongst my peer groups, I did not question my race or think of myself as "different" from any of White friends until I was about 10 years old. This "coming to consciousness" about being Chinese brought along shame, denial and confusion. In the early 1990's, Vancouver received a sharp influx of wealthy immigrants from Hong Kong. Between 1986 and 2000, the years leading up to and surrounding the 1997 hand-over of Hong Kong from Great Britain to China, around 20 per cent of all overseas immigrants into BC and Vancouver were from Hong Kong (Edgington, Goldberg & Hutton, 2003).

During this time, I became very confused about who I was in relation to the swarms of new Chinese immigrants. The major economic and social changes that occurred during this period of immigration brought forth racist and ignorant attitudes towards Chinese people. "Go back to China!" and "They're taking all our jobs" were

typical phrases that I heard and that I took personally. Rude jokes about Asians and stereotypes, such as “Chinese people are bad drivers” and “Chinese people are all rich” angered me, firstly, because I did not quite comprehend why there was so much Asian immigration at the time, and secondly, because I felt I was being unjustly categorized into a large group that was stigmatized by society, even though I was born and raised in Canada like the majority of my friends. I struggled with feelings of worthlessness and shame over my Chinese ancestry for many years, never really understanding, expressing or critically analyzing why I felt this way.

The need to unpack the internalized pain and struggles surrounding my racial identity, and allow others to do the same, is the main rationale for undertaking this project. I have always felt that my health and well-being are affected by racism, prejudice and discrimination, but until I came to Victoria to start this Master’s degree, I had never attempted to make connections between health and identity, nor had I met others who shared similar realities to my own. I have always thought of myself as an extremely “healthy” individual, according to North American standards. I am physically fit, strong, free of disease, and according to the Canadian Food Guide, I eat a relatively well-balanced diet. Yet, I now realize the limits of physical health as a measure of overall wellness.

Throughout my post-secondary studies in the health sciences, I have rarely seen my own realities represented or prioritized in the fields of health promotion, health psychology or human wellness and potential. Seldom do I encounter studies that speak of racialization in the ways that I know and feel it. Instead, I see race, ethnicity, gender and class being used as unitary, categorical variables that correlate with certain illnesses and

diseases. These are the same types of variables that allow people to define me and place me into categories of “Otherness.”

Despite Canada’s adoption of multicultural policies, I feel the effects of racism on a regular basis, especially in Victoria, a city with a colonial legacy that sits on Coast Salish lands. Victoria’s demographic population is predominantly Euro-Canadian (White) (Statistics Canada, 2008a). According to Statistics Canada (2008b), only 10% of Victoria’s population is visible minority, compared to 25% in all of BC and 16% in all of Canada (Statistics Canada, 2008c). Although most people are conditioned to believe that we are all equal and we all have access to the same rights, many people are disadvantaged by the systemic racism, sexism and classism that exist in full form in Canada (Singh, 2005). Racism is defined by Augie Fleras (2004) as:

those ideas or ideals (ideology) that assert or imply the superiority of one social group over another because of perceived differences, both physical or cultural, together with the institutionalized power to put these beliefs into practice in a way that exploits or excludes the ‘other’ because of who they are or what they do. (p. 434)

Some types of racism are difficult to uncover because they are so embedded within the systems and structures that inform our beliefs and behaviours (Fleras, 2004). Yet the liberal multicultural discourse which ingrains in us that Canada is a tolerant, accepting nation of all cultures, sexualities, religions and ethnicities often masks these disadvantages (Fleras, 2004; Singh, 2004). The realities and voices of marginalized people are not legitimized because this liberal multicultural discourse does not leave much room for them to be heard (Singh, 2004).

I have gotten used to White people on the streets thinking that I am tourist and yelling out “Konichiwa” or “Ni Hao” as I pass by. When an old White man in a bakery tells me out of the blue that he was once married to a Chinese woman, or when a German man in a bar asks me to translate something for him in Japanese, or when one of my best friends cannot understand why my grandmother, who has been in Canada for 50 years, cannot speak English that well, I feel angry inside. I do not feel that it is my duty as a racialized person to inform others of their ignorance, yet the responsibility to do so falls on my shoulders when people make assumptions or comments that I must defend. People who make me feel this way usually do not intend to be hurtful. Most do not realize they are in positions of White privilege.

White privilege can be described as White people’s power and belief that they “think, feel and act like and for all people” (Dyer, 2002, p. 12). Dyer states that whites are often unable to see their particularity while they “create the dominant images of the world and don’t quite see that they thus construct the world in their own image” (p. 12). He argues that “white people set standards of humanity by which they are bound to succeed and others bound to fail,” not by maliciousness, but by power difference (p. 12). Whites are seen as non-raced, while non-whites have adjectives such as “Black” or “Asian” attached to their names (Dyer, 2002). When one is in a position of privilege, they are often blind to the fact that we are not all “the same.” The question of privilege is not something that is raised amongst those in positions of privilege because doing so would garner fear of having to give up power (Moraga, 1983). bell hooks’ (2002) quote below demonstrates the fury and shock that ensues when white liberals’ whiteness is noted by non-whites:

Often their rage erupts because they believe that all ways of looking that highlight difference subvert the liberal belief in a universal subjectivity (we are all just people) that they think will make racism disappear. They have a deep emotional investment in the myth of ‘sameness’, even as their actions reflect the primacy of whiteness as a sign informing who they are and how they think. (p. 21)

I raise the issue of White privilege and the liberal notion of “sameness” because I believe that these are good starting points for understanding why I end up feeling resentful towards racist comments, attitudes and systems that are often not overtly racist. “Race” is a socially constructed variable that has been imposed upon me, distinguishing me as exotic, foreign and inferior. Without critically examining why, I have based my self-worth on characteristics of Whiteness. The lighter my hair was and the less I looked and acted Chinese, the worthier I felt. I would compare myself to other Asians and feel superior to those who could not speak English or who were not born in Canada. I have only now begun to realize that I have very much been caught up in hegemonic discourses for all my life. Instead of questioning them, I accepted them as universal truths, and lived my life trying to suppress feelings of injustice and frustration. Rather than claiming a space, I tried harder to fit into spaces that were already created. I had gained several tools for surviving and succeeding, and capitalized on the talents that placed me into higher positions in mainstream society. For instance, I chose to pursue playing sports rather than the piano, even though I was privileged to learn both as a child. Whereas piano playing was seen as a typically “Asian female” endeavour, I saw sports as a venue for resisting the stereotype that Asian girls were weak and fragile. Sports became a physical outlet for expressing my frustrations as well as a place where I could hide from myself. Sports

provided me with a social status that I could not have attained within the White mainstream had I focused on piano or academics. It allowed me to fit in with the White kids, and it further separated me from my Chineseness. I chose to assimilate, rather than face my discomforts, understand why they existed, and critically analyze the dominant norms that ruled my life and my health.

It was not until the end of my Bachelors degree in Human Kinetics that I started to question my false identities, my lack of depth and love for myself, and my health and wellness. After I graduated, I went to Asia to “find my roots.” I chose to go to Taiwan to teach English, even though my ethnic roots are from Canton, China. Over the two years that I spent in Taiwan and other parts of Asia, I continued to feel the effects of discrimination, the main reason being that I was not the type of Canadian that people expected to meet. Most schools wanted to hire white, blonde-haired, blue-eyed teachers who exemplified power and Westernization, not someone who looked like themselves. While overseas, I had a lot of time to reflect on the concept of “race” and I became fixated on finding a place of belonging. I felt ready to unpack this feeling and start afresh in Canada.

My first year of graduate studies at the University of Victoria was a time of adjustment and searching. I felt that Victoria was quite mono-cultural and I was feeling somewhat lost, out of place and isolated. It was not until the summer before entering my second year that I encountered Anti-Dote Multiracial Girls’ and Women’s Network (Anti-Dote), a grassroots organization made up of over 100 women and girls from various ethnic and racial backgrounds on Southern Vancouver Island. Anti-Dote is based on an intergenerational framework of self-identified Gurlz (ages 8-17), Sistahs (aged 18-

30) and Aunties (usually aged 30+) and is committed to increasing the psychological and social well-being of racialized minority and Aboriginal women and girls in the community. Anti-Dote is also committed to “promoting community development and social change through participatory action approaches at the local level, [and placing] decision-making and planning in the hands of those who will participate in and who will be directly affected by the initiative” (Anti-Dote Web site, 2007).

It was within this intergenerational group of women that I found a sense of community, understanding and solidarity around issues of exclusion, belonging and identity. For a year prior to the conception of this study, I had been involved with Anti-Dote in various capacities. I first started out as a volunteer mentor for the Gurlz Club, where racialized and Indigenous girls, aged 8-16, were working on a digital video media project exploring their health and identity. What I soon realized was that the Gurlz were mentoring me. Their ability to apply postcolonial, anti-racist feminist theories to their lived realities at such a young age was inspiring. Through further involvement in Anti-Dote, I was elected onto the Board of Directors as a Sistahs’ representative. I helped to form a Sistahs’ space, where young women could share stories and give support to one another. Each time we met for meetings, Sistahs expressed how envious they were of the Gurlz, who have been given a space to explore concepts such as racialization, racism and colonization so early in their lives. There was a clearly expressed desire from the Sistahs to conduct a project focusing on their own lives, because many had never deconstructed their realities in such a supportive environment. As I began to feel comfortable in this space and got to know the Sistahs, I proposed this research project, which would serve both as my Master’s thesis and as a means of addressing the need for a Sistahs’ project.

I enter this thesis as a young, middle-classed, heterosexual, Chinese-Canadian woman, an athlete, a health researcher, a feminist and an anti-racist activist. I am a Sistah to the participants of this study, and a partner to Anti-Dote Multi-racial Girls' and Women's Network. This thesis would not be possible without having this multiplicity of roles. It is driven by a collective desire to achieve social justice and to explore health and well-being in relation to race, gender and class and other social influences. The women who participate in this study are not helpless victims who suffer from illness, disability or under-privilege. They are women, like me, who are coming forward to share their stories and explore their intersecting realities in relation to multiple dimensions of health and wellness.

## CHAPTER ONE - INTRODUCTION

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). This definition of health and other holistic wellness frameworks help to foreground the need for a social analysis of health that integrates an intersectional outlook on race, ethnicity, gender, class, sexuality and citizenship, among other social forces. I draw on this understanding of health in this research study, while exploring the concepts of social exclusion, identity, and belonging as they relate to health and well-being in the lives of young racialized women—women like me. My own search for selfhood and belonging informs every aspect of this study.

### *Race, Ethnicity, Class and Gender - Rethinking Approaches to Health and Wellness*

As I began my Master’s degree, I focused on finding out about how race, ethnicity and gender were related to health and well-being. Population health research has confirmed links between the minority status of ethnic, immigrant and racialized groups and low health status (Bolaria & Bolaria, 1994; Dunn & Dyck, 2000; Hyman, 2001; Marmot & Wilkinson, 2006). However, most “health” problems are expressed in terms of quantifiable, epidemiological indicators of mortality and morbidity, such as chronic disease, physical illness and suicide rates (Noh, Beiser, Kaspar, Hou & Rummens, 1999; Lin & Kelsey, 2000; van Ryn & Fu, 2003; Williams, 2002). These types of data do not capture the significance and complexity of daily manifestations of social exclusion, discrimination and oppression that can contribute to the social, emotional, mental, spiritual and psychological well-being of racialized women in Canada.

The population health and health promotion literature that I encountered tends to use an additive approach to race, gender and class, separating each variable and correlating them to objective health measures. “Ethnic minority” groups are generally considered vulnerable populations, which I instinctively found disturbing since this image does not reflect how I see myself, my family or my community. Furthermore, “ethnic” groups are often “examined” from a top-down perspective, whereby “they” (read non-whites) are labelled as “target populations.” This can set up an “us and them” framework and perpetuate the exclusion of these “at risk” groups (Reimer Kirkham, 2003; Weber, 2006).

I found few studies that spoke to my health and well-being as a Canadian-born racialized woman. The studies that focus qualitatively on race, class and gender often do so in terms of access barriers to physical activity and leisure, such as language and cultural differences (Taylor & Doherty, 2005; Tirone & Pedlar, 2000). Moreover, much of the literature that critically analyzes race, class, gender and health comes from the United States, where the demographics, history and politics are very different from Canada’s. Only recently in Canada has race become an issue of concern in the health literature, with much attention being paid to Aboriginal and immigrant groups (Pederson & Raphael, 2006). Oftentimes, health research focusing on racialized groups takes a gender-neutral or male-centered approach (Varcoe, Hankivsky, & Morrow, 2007). This can create significant oversights, inconsistencies and simplifications in women’s health issues and ignore crucial daily experiences in women’s lives (Reid, 2002). At the same time, women-centered approaches to health have been criticized for their inadequacy in

addressing racial, class, ethnic, sexual orientation and cultural differences between women in health care issues (Morrow, 2007).

As I searched for frameworks and literature that would help me in my journey, I found myself drawn into the field of feminist research, an area that I felt validated my experiences and allowed me to explore my health and well-being on a more political and critical level. I began reading works by well-known feminists of color such as Chandra Mohanty (2003), Gloria Anzaldua (1987) and Cherrie Moraga (1983), in the second year of my Master's program. This has been challenging, not only because I have been introduced to a whole new body of theoretical literature in a field of study that I am unfamiliar with, but also because I have had to completely shift paradigms and put much of my previous training in positivist and androcentric ways of thinking aside. This has been a rather frustrating and confusing process; however, it has brought me closer to addressing some of the gaps that I observed in the population health literature.

The body of health literature that I found to be the most receptive to the integration of feminist perspectives is the social determinants of health discourse. I was immediately drawn to it because of its acknowledgement of the overarching systemic factors that contribute to racialized and Indigenous women's multiple exclusions and broader inequalities in health (Galabuzi, 2004; Reimer Kirkham, 2003).

### *Problem Statement*

Although the social determinants of health discourse is a relief from the traditional biomedically focused health paradigms, it tends to view the macro-social, structural and systemic determinants of health in the absence of the corresponding micro-level issues that pertain to human agency (Essed, 1991). Essed (1991) posits that in order

to understand the experience of racism, we must consider both macro- and micro-level issues.

The social determinants of health approach to social exclusion does not go much further than identifying social and systemic factors that contribute to poor health outcomes amongst Canada's most "vulnerable" populations (Aboriginal peoples, immigrants, refugees, racialized women living in poverty). This approach can often overlook the complexity of the micro-social processes that occur in the daily lives of racialized women, especially those who do not identify as being "vulnerable." It is clear that critical theories that incorporate feminist, anti-racist, transnational, intersectional and social constructionist perspectives would complement the social determinants of health discourse by examining in more depth the micro-level mechanisms and processes of social exclusion, discrimination and marginalization that can affect the health and well-being of racialized and Indigenous women on a day-to-day basis.

To study macro-social health trends in the absence of contextualization and an intersectional lens runs the risk of generating the same types of stereotypes and assumptions as do other forms of population health research (Browne, Smye, & Varcoe, 2007). Moreover, there is little representation by women of colour in the health literature (Ro, 2002).

### *Research Objectives*

To this end, my research addresses the absence of health research on the intersections of race, class, gender, ethnicity, age, among other important social factors as they work together to influence racialized women's health. Given the dearth of micro-level research into the lived realities of racialized young women using participatory and

ethnographic methodologies, I aim to explore these intersections in women's own voices as they are lived in everyday life. In particular, I would like to provide an in-depth examination of social exclusion, investigate ways in which it occurs on an everyday basis and understand the mechanisms and pathways of social exclusion that impact the health and well-being of racialized and Indigenous young women in Victoria.

### *Research Questions*

In light of these objectives, I framed my study around the following research questions. These questions served to guide the workshop activities, interviews, group discussions, Photovoice assignments and analysis of the data:

- 1) How does social exclusion act as a social determinant of health amongst racialized and Indigenous women living in Victoria?
- 2) How do the intersections of race, gender, class and other social variables impact the daily experiences of health and well-being amongst racialized and Indigenous young women in Victoria?

### *Goals of this study*

In addition to this study's specific research objectives, I aim to extend the definitions of health and well-being beyond biomedical, behavioural and physical parameters, and to bring issues that are not easily quantifiable into critical dialogue. I am trying to break down the borders and limitations that leave racialized women with few options other than "fitting in" to categories of hegemonic Whiteness, or moving into the margins. I hope that this thesis will help to open up critical pathways for cross-disciplinary analyses of health, gender, race and class, and voice the perspectives of this powerful group of racialized young women. As I seldom see my own realities represented

in the literature on ethnicity and health, I want to bring the lived experiences of racialized women to the forefront of health literature.

*Making space for racialized women: A critical approach to health and wellness*

In order to achieve these goals and objectives, I feel it is important to situate the participants' voices within a health concept that incorporates transnational feminist, intersectional and anti-racist approaches. I attempt to draw upon these critical perspectives to diversify and expand upon mainstream understandings of health, race, gender and class.

I set out to open a space for young racialized women to engage in conversations around health and well-being in terms of their own realities. In doing so, I also opened a space for myself to explore my own realities and multiple identities as a researcher/participant, as an insider, a facilitator, a co-researcher, a Sistah, and a student.

Our voices represent an emergence from silence and a willingness to become active subjects in a participatory research process. By honouring their/our/my voices, I am hoping that other racialized women and minorities in Canada will have the courage to stand up and claim their own space, and make their own conclusions about their own health and wellness. The stories that the participants in this study share represent a bridge between knowledge that is not often legitimized as "true," and knowledge that is produced for the benefit of all people residing in Canada. I am hoping that the findings from this study will broaden the scope of the field of health and wellness to include the perspectives of those who reside in the margins of Canadian society.

### *Operational Definitions*

My use of the term *racialized* refers to non-White populations that are categorized as “Other” by the dominant group based on perceived socio-cultural and physical characteristics, among other factors. *Racialized* individuals hold a socio-cultural, demographic and political minority status due to the historical processes that have constructed categories of “race” (Lee, 1999). Since many health researchers view “race” or “ethnicity” simply as biological indicators of disease susceptibility, it is important to emphasize that *racialization* is not a characteristic, but rather, a process of imposition and oppression (Galabuzi, 2004; Pederson & Raphael, 2006).

The term *Indigenous* includes First Nations, Native, Inuit, Métis, status and non-status Aboriginal peoples in a Canadian context, as well as First Peoples worldwide. *Indigenous* people are also racialized in that they are subject to racism and made to feel different because of their racial/ethnic background (Canadian Research Institute for the Advancement of Women [CRIAOW], 2002).

The terms *wellness and well-being* characterize how you feel about yourself, your health and your life situation. Subjective feelings of self-esteem, happiness and mastery can be used as measures of well-being. Wellness can also include knowing and taking pride in who you are, enjoying life, being able to form and maintain satisfying relationships, coping with stress in a positive way, striving to realize your potential and having a sense of personal control (Health Canada, 2007).

## CHAPTER TWO – LITERATURE REVIEW

### *Introduction*

This chapter reviews selected literature to support my argument that there is a need to deepen and expand upon the social determinants of health approach so that we can better understand the micro-social complexities that occur at the intersections of race, class and gender. This chapter will first review the dominant theories and approaches that stem from mainstream biomedical and psycho-social paradigms. I critique several of these approaches and set up an argument for the need to draw on alternative approaches that do not treat race, class and gender as independent variables or as homogeneous demographic population categories. I also highlight key perspectives in the critical women's health literature and introduce alternative theories that argue for the intersecting, shifting, changing and emergent nature of these socially constructed categories. Drawing from these various bodies of literature, I introduce the critical theoretical framework that guides this study.

### *Race as a “risk factor” or biological variable*

Epidemiologists and population health researchers commonly treat “race” as a predictor or correlate of health status, as determined by morbidity (prevalence of illness or disease) and mortality (death rate). Large-scale population-based studies often aim to identify cause-and-effect relationships between people's racial characteristics and their health outcomes. From an epidemiological point of view, using a racial classification system that is parallel to that of the government provides important etiologic leads which help to “target high-risk groups for public health and policy interventions and to uncover

the economic, cultural and behavioural contributions to health and disease” (Lin & Kelsey, 2000, p. 189).

Although this type of research acknowledges the interaction between “race” and health at multiple levels, it can also mask the health concerns of those who are deemed of “lower risk,” according to statistics (Gee, 2002). For example, Asians in Canada have been stereotyped as a "model minority," and are therefore excluded from many statistical surveys on health issues such as substance abuse (Currie, 2001).

Recent Canadian population health studies have used the following eight racial categories to examine the relationship between ethnicity and the level of self-reported physical activity behaviours among Canadians: 1) White, 2) Black, 3) West Asian/Arab, 4) South Asian, 5) East/Southeast Asian, 6) Latin American, 7) Aboriginal, 8) Other (Bryan, Tremblay, Perez, Ardern & Katzmarzyk, 2006; Tremblay, Bryan, Perez, Ardern & Katzmarzyk, 2006). While systems of racial classification are often intended to inform and develop targeted health policies and programs, the results from population health studies and surveys should be interpreted cautiously (Bryan et al., 2006). Studies that apply health statistics to entire populations of pre-determined “ethnic” or “racial” groups without prior explanation of how these groups were defined in the first place can form vast generalizations on the basis of socially constructed, homogeneous conceptualizations of “race” (Kaplan & Bennett, 2003). By explaining “racial” or “ethnic” disparities in health without considering the effects of racism and racialization, epidemiological studies can perpetuate the false notion that “race” is a biological variable that is inextricably linked to certain negative health outcomes (Krieger, 2003).

At the same time, recent suggestions to “abandon” the use of racial or ethnic categories in public health literature should also be carefully considered (Krieger, 2003). Social definitions of “race” have already been set into place, and have affected the way individuals view themselves and others around them (Krieger, 2003). Social variables are just as real as biological variables, and although “race” may not be a scientifically valid concept, it needs to be acknowledged in order to realize and validate the lived experiences of those who have been affected by the negative effects of racial discrimination (Krieger, 2003).

*Psychosocial perspectives on racism and negative health outcomes*

In the 1950’s and 1960’s, the biomedical paradigm began to converge with psychosocial theories, spawning a new field of empirical research called social epidemiology (House, 2002). Social epidemiology, which is essentially the study of psychosocial factors in physical and mental health, has led to the linking of psychosocial processes, such as perceived racial discrimination (Karlsen & Nazroo, 2002; Gee, 2002) and health practitioner bias (Snowden, 2003) to physiological and mental health outcomes, such as depression (Noh & Kaspar, 2003), high blood pressure (Harrell, Hall, & Taliaferro, 2003) and stress (Williams, Neighbors, & Jackson, 2003) amongst visible minority and immigrant groups. In a review of the most commonly measured mental health outcomes of racial discrimination, Williams and colleagues (2003) found that psychological distress, happiness, life satisfaction, self-esteem, perceptions of mastery or control, depression, anxiety disorder, early initiation of substance abuse, psychosis and anger were the most prevalent (Williams et al., 2003). Although it is important to acknowledge the negative impacts of racial discrimination and other consequences

relating to processes of racialization and racial discrimination, these kinds of studies often end up “blaming the victim,” or attributing negative health outcomes to personal coping styles (James, 1994; Noh & Kaspar, 2003), genetic predisposition (Kessler, 1997) or psychological dispositions (Williams et al., 2003). For example, James (1994) links racial and ethnic health disparities to the concept of "John Henryism," named for the legendary African-American steel driver who died after competing fiercely with and defeating a steam-powered machine to drive steel railroad stakes. This psychological mechanism is explained as a “strong behavioral predisposition to cope actively with psychosocial environmental stressors” (James, 1994, p. 163). The construct is characterized by three major dispositions: efficacious mental and physical vigor; a strong commitment to hard work; and a single-minded determination to succeed (Bennett, Merritt, Sollers, Edwards, Whitfield, Brandon, & Tucker, 2004). James (1994) found a significant inverse gradient between socio-economic status and the prevalence of hypertension among a stratified sample of African-Americans who used the John Henryism coping style. His explanation for this trend is that the lower SES groups lack adequate social and psychological resources to buffer their coping efforts. The emphasis on this psychological coping mechanism suggests that if low-SES Blacks could change the way they cope with stressful life events, there would be less of a health discrepancy between Blacks and Whites in the United States. This hypothesis tends to “victim blame” rather than examine the broader systems, attitudes and behaviours that serve to perpetuate racial discrimination.

*Cultural explanations for coping with racial discrimination*

The John Henryism hypothesis is an example of how inequalities in health are attributed to both psychological disposition and to inherent “cultural differences.” Several authors have used cultural orientation theories to explain health discrepancies between “racial” groups (Noh et al., 1999; Noh & Kaspar, 2003; Williams, Spencer & Jackson, 1997). For example, Noh and Kaspar, (2003) examine the moderating effects of acculturation, personal coping styles and ethnic support on the relationship between perceived racial discrimination and depressive symptoms amongst Korean immigrants in Canada. They found that active, problem-focused coping styles were more effective in reducing the impacts on depression of perceived discrimination, while frequent use of passive, emotion-focused coping had debilitating mental health effects (Noh & Kaspar, 2003, p. 232). Under the cultural maintenance hypothesis, which posits that one’s cultural orientation is predictive of which style of coping they are more likely to use, Noh and Kaspar (2003) assert that members of collectivistic cultures, including Asians and Latin Americans, prefer to resolve interpersonal conflicts in a way that reflects concern over consequences for others. In an earlier study, Noh and colleagues (1999) found that forbearance, or emotion-focused (passive) coping decreased the strength of the link between discrimination and depression. Noh’s cultural maintenance hypothesis is based on studies by American researchers, Krieger, Williams and their colleagues. In 1990, Krieger found that among Black women living in the United States, passive responses to racism were associated with high blood pressure, while using direct approaches such as taking action or talking to others, was related to lower blood pressure. Williams and colleagues (1997) reported similar findings, that in comparison to White women, Black

women coped with sex discrimination more often in a passive manner. Their findings suggest that women who adopted an active coping style to sex discrimination had the largest gains in levels of well-being, whereas those who exhibited passive coping styles received the least gains in well-being. These findings suggest that problem-focused or active styles of coping with discrimination, which predominate amongst Euro-North Americans, lead to less detrimental mental health effects. They also suggest that the more assimilated “racial minorities” become, the less susceptible they will be to racial discrimination, hence reducing racial health discrepancies. Not only does the analysis of “cultural orientation” dichotomize Western/North American culture against “other” cultures, they create stereotypes that racial minorities are submissive, avoidant of conflict, repressed and accepting of racial discrimination. Moreover, this understanding of “race” and “culture” takes the emphasis away from the examination of inequalities within social policies and systems, thereby allowing them to remain unchanged (Williams, 1997).

#### *Biomedical views on racial discrimination and health*

There is a large body of biomedical literature that examines health in relation to racial discrimination. The contexts in which racial discrimination and health have been examined throughout this literature include unintentional biases and unequal treatment within the health care and human service sectors (Reimer Kirkham, 2003; Snowden, 2003; van Ryn & Fu, 2003) and the perpetuation of racial stereotypes by biomedical researchers, themselves (Kaplan & Bennett, 2003).

Drawing upon various domains of health literature (e.g. public health, nursing, health promotion), I found several studies that critically analyze the pathways that

systematically lead to poor health status amongst racialized individuals. These pathways often begin by health researchers who reinforce the belief that genetic differences account for the health disparities that exist between “racial” groups (Kaplan & Bennett, 2003). Researchers often fail to emphasize that there is more genetic variation within socially defined racial groups than between them (Kaplan & Bennett, 2003). Racial stereotypes, which are based on superficial health statistics, can be implanted subconsciously into the minds of practitioners, who may then reflect or reinforce the societal messages that continue to marginalize the patient (van Ryn & Fu, 2003).

There is evidence that health care providers often make unwarranted judgments about patients on the basis of race or ethnicity (Snowden, 2003). In the U.S., non-White patients are more likely to receive inadequate or no pain assessment or pain control than Whites in the emergency department (van Ryn & Fu, 2003). In addition, African Americans and Latinos are less likely than Whites to receive guideline adherent treatment and follow-up because they are considered less likely to adhere to treatment (van Ryn & Fu, 2003). This disadvantage can diminish patients’ expectations and feelings of self-worth for future treatment, lower their self-efficacy during recovery, and cause further stigmatization in other aspects of their lives (van Ryn & Fu, 2003).

Even in Canada, where the health care system is considered to be of equal access to all, its usage varies on the basis of class, gender, ethnicity, race and age (Comeau & McMullin, 2004). There is an under-usage of specialist services, such as surgery, by people from lower income neighbourhoods, even though their frequency of hospital visits is higher than people from higher income neighbourhoods (Comeau & McMullin, 2004). This could be due to better access and stronger communicative relationships between

patients with higher socio-economic statuses and the referring physicians (Comeau & McMullin, 2004).

*Physiological impacts of racial discrimination*

Other studies have examined the direct impact of racial discrimination on physical well-being, assessed through surveys and laboratory studies. Correlations have been made between self-reported measures of racial discrimination and objective measures of physical health, such as global self-rated health, chronic conditions, disability, blood pressure, hypertension, low birth weight, heart disease, atherosclerotic disease, cigarette smoking and alcohol use (Williams et al., 2003). Surveys that ask participants to use self-reported measures of racial discrimination are often criticized for the “invalidity” or “exaggeration” of responses (Harrell et al., 2003). Researchers’ concerns over the subjective nature of reports is problematic, in that it limits the validity of individuals’ experiences to what is comprehensible and analyzable by the researcher.

To avoid “confounding variables” such as neuroticism and dispositional optimism, which are said to prevent “accurate” perceptions of racial discrimination, some survey designs enquire about acute acts of racial discrimination, such as unpredictable physical attacks, harassment and lewd remarks (Comeau & McMullin, 2004). However, it is often the more subtle forms of discrimination (e.g., structurally limited opportunities) and antecedents to chronic stressors (e.g., financial strain), which are more difficult to respond to or account for through experimental studies (Williams et al., 2003; Comeau & McMullin, 2004). Furthermore, survey designs that oversimplify people’s experiences of and reactions to racism can be potentially disempowering to the study participants.

Another direct form of examining the harmful physiological effects of racial discrimination has been through laboratory study. Researchers have attempted to replicate racial discrimination by asking participants to recollect racist experiences (Bowen-Reid & Harrell, 2002), showing materials depicting racial harassment (Armstead, Lawler, Gorden, Cross, & Gibbons, 1989; Fang & Myers, 2001; Morris-Prather et al., 1996), requiring participants to debate on racially charged or nonracial issues (McNeilly et al., 1995), and asking participants to imagine or view scenes involving racism (Jones, Harrell, Morris-Prather, Thomas, & Omowale, 1996; Sutherland & Harrell, 1986).

Participants' physiological responses to these variables are then measured by a variety of psychophysiological mechanisms. For example, Armstead and colleagues (1989) found that when participants viewed racist materials, their blood pressure changed at a higher rate than when they were viewing nonracist materials.

Physical performance outcomes have also been measured in relation to reports of racial discrimination. Bowen-Reid and Harrell (2002) found that participants who reported experiences of racism had lower performance scores on a mirror tracer task. Although experimental studies have found ways to demonstrate that experiences of racism have direct causal pathways to physiological arousal, which may contribute to stress-related diseases, they are limited to measuring immediate reactions to racism and short-term recovery (Harrell et al., 2003). More importantly, these studies do not take into account the institutional forms of racism that have an impact on health (Harrell et al., 2003). Furthermore, these studies often view race and gender as separate analytical variables, and do not often focus on the health effects of racial discrimination on women.

*Social determinants of health*

A population health or “health determinants” perspective has recently been adopted among Canadian health researchers, which elucidates the multi-dimensionality of factors that affect the health of particular groups and the variety of health concerns that can occur within these populations (Benoit & Nuernberger, 2006). The following conceptualization of the “social determinants of health” approach is provided by Raphael (2004):

Social determinants of health are the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole...Social determinants of health also determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment...An emphasis upon societal conditions as determinants of health contrasts with the traditional focus upon biomedical and behavioural risk factors such as cholesterol, body weight, physical activity, diet and tobacco use. Since a social determinants of health approach sees the mainsprings of health as being how a society organizes and distributes economic and social resources, it directs attention to economic and social policies as means of improving it. (p.1)

The *York University Social Determinants of Health Across the Life Span Conference* synthesized 11 key social determinants of health that were relevant to Canadians:

- 1) Aboriginal status
- 2) Early life

- 3) Education
- 4) Employment and working conditions
- 5) Food security
- 6) Health care services
- 7) Housing
- 8) Income and its distribution
- 9) Social safety net
- 10) Social exclusion
- 11) Unemployment and employment security (Raphael, 2004, p. 6)

Although I feel that all of these social determinants of health are interconnected, I am mostly interested in examining the mechanisms and pathways through which social exclusion influences the health of racialized and Indigenous women in Victoria.

*Social Exclusion. Social exclusion is seen as both a process and an outcome, which defines the inability of certain subgroups to participate fully in Canadian life due to structural inequalities in access to social, economic, political, and cultural resources arising out of the often intersecting experiences of oppression as it relates to race, class, gender, disability, sexual orientation, immigrant status and the like. (Galabuzi, 2004, p.238)*

Social exclusion is also characterized by unequal power relations among groups in society which give rise to unequal access to economic, social, political and cultural resources (Galabuzi, 2004). These power relations are largely dependent on the historical social relations in different societies (Galabuzi, 2004). Taking these historical factors into consideration, the Canadian Institutes of Health Research (2002) identified women, new

immigrants, racialized group members and Aboriginal peoples as being at special health risk due to their susceptibility to social exclusion (as cited in Galabuzi, 2004).

Much of the social exclusion literature focuses on the economic dimension of health inequalities between racial groups, conceptualized as the “racialization of poverty” (Galabuzi, 2004). Poverty is considered a major social determinant of health because of its complex interrelatedness with issues such as unemployment and poor working conditions and housing (Galabuzi, 2004; Kaplan & Bennett, 2003; Krieger, 2003; Reimer Kirkham, 2003). In 1995, 35.6% of racialized group members lived under the poverty line, compared with 17.6% of the general Canadian population (Galabuzi, 2004). Social determinants researchers attribute the racialization of poverty to “the deepening oppression and social exclusion of racialized and immigrant communities on the one hand, and the entrenchment of privileged access to economic opportunity for a small but powerful section of the majority population on the other” (Galabuzi, 2004, p.240).

Although income and socio-economic status are irrefutably important determinants of health, the social exclusion discourse has been criticized for its limited focus on the “generic low income experiences of social exclusion” (Galabuzi, 2004, p. 238). It has been argued that there is a need to investigate the multi-dimensionality of social exclusion and to recognize that each individual’s experiences are “differentiated by the nature of the oppressions they suffer” (Galabuzi, 2004, p. 238). The social exclusion discourse tends to pathologize racialized individuals by linking their experiences of social exclusion to conditions of unemployment, residence in low income neighbourhoods, violence, targeted policing, disproportionate criminalization and incarceration (Galabuzi, 2004). While these conditions are valid considerations that can affect health amongst

racialized populations, these explanations tend to falsely portray an extreme and generalized image of racialized people living in poor conditions and being involved in criminal activities, thereby rendering them marginalized and excluded from “full participation in the social, economic, cultural, and political affairs of Canadian society” (Galabuzi, 2004, p. 247). Furthermore, the references that are made to racialized individuals are generally gender-neutral, which serves to overlook the unique needs of racialized women (Varcoe et al., 2007). There is little focus on the experiences of social exclusion amongst racialized and Indigenous women, even though they are seen as “special risk” groups by Health Canada (Galabuzi, 2004).

#### *Critical perspectives on women’s health in Canada*

In Canada, there is an emerging body of critical women’s health literature that challenges biomedical, behavioural and gender-neutral approaches to health (Morrow, 2007; Varcoe et al., 2007). This field of study is premised on the belief that “social and health inequities persist for all women, and particularly for women disadvantaged by multiple forms of oppression” (Varcoe et al., 2007, p. 3). Several critical health researchers recognize that circumstances such as Canada’s colonial history, its liberal approach to “multiculturalism” and its increasingly transnational population, can have relevance to women’s health beyond our national borders (Browne et al., 2007; Varcoe et al., 2007; Vissandjee et al., 2007). According to Varcoe and colleagues (2007), stigmatization by issues such as racism, heterosexism, ableism and ethnocentrism can contribute to significant health inequities among women in Canada. They contend that gender “must be understood in relation to multiple intersecting categories of analysis,

including but not limited to, race, class, geography, ability, gender identity, and sexuality” (Varcoe et al., 2007, p.12).

According to Barnett, White and Horne (2002), women-centered health care models have been developed to encourage the involvement and participation of women in their own care, with respect to their social, political and economic situations. While these models recognize the differences in patterns of illness, disease, mortality and health system interactions between men and women, Morrow (2007) criticizes them for their tendency to homogenize women by prioritizing sex and gender over race, class and ethnicity.

Feminist frameworks and methodologies, which emphasize the importance of positionality and self-reflexivity in the act of knowledge production, are being applied to women’s health research (Morrow & Hankivsky, 2007). In particular, feminist postcolonial theories are recognized as critical to the analysis and theorization of women’s lives and experiences (Morrow & Hankivsky, 2007). Browne, Smye and Varcoe (2007) recognize the need for “critical analyses of people’s experiences of colonialism, and their continuing manifestations,” the “deliberate decentering of dominant culture so that perspectives of those who have been marginalized become starting points for knowledge development” and the need to “expand our understanding of how conceptualizations of race, racialization, culture and Others are constructed within particular historical and current neo-colonial contexts” (p. 125). They argue that postcolonial feminist perspectives are crucial for addressing health concerns amongst immigrant populations, women of color and Aboriginal women as well as Anglo-Canadians and health care providers (Browne et al., 2007).

*Aboriginal women's health in Canada.* Compared to non-Aboriginal women in Canada, Aboriginal women experience higher rates of circulatory problems, diabetes, obesity, hypertension and cervical cancer (Dion Stout, Kipling & Stout, 2001). In order to understand these current trends, it is important to contextualize Aboriginal women's health through a postcolonial feminist lens (Browne et al., 2007). For example, until 1985, the Indian Act stripped women and children of the inherent protections and rights of Native "status" upon their marriage of non-Indian or non-status Indian men (Stevenson, 1999). This has had several effects on Aboriginal women's social and economic capacities to support themselves and their families (Browne et al., 2007). The higher rates of HIV, substance abuse, obesity and diabetes amongst Aboriginal women compared to the overall female population in Canada are often misinterpreted as "lifestyle" issues arising from their "unwise choices" (Browne et al., 2007, p. 133). Browne and colleagues (2007) advise that postcolonial feminist perspectives are needed to critically assess health information, incorporate a wider historical, social, economic and political understanding of the circumstances that shape women's health and avoid the perpetuation of prejudice, stereotypes and marginalization of many Aboriginal and racialized communities.

*Immigrant women and health in Canada.* The changing patterns of immigration and Canada's multiculturalism policies have provided reason to study immigrant health (Pederson & Raphael, 2006). In 2006, 19.8% of Canada's population were immigrants (Statistics Canada, 2008d) and since between 1992 and 2006, more than half of all permanent residents have been women (Citizenship and Immigration Canada, 2007).

Despite the increasingly diverse demographics of Canada, health care policies and services do not comprise “an integrated approach to the needs and interests of women experiencing migration” (Vissandjee et al., 2007, p. 222). A common observation that has been documented in the immigrant health literature is the presence of a “Healthy Immigrant Effect” (Dunn & Dyck, 2000; Hyman, 2001; McDonald & Kennedy, 2005). When racialized immigrants first arrive to Canada, they normally demonstrate a higher health status than Canadian-born individuals, but as their length of residency in Canada increases, their health status deteriorates to the same level as the Canadian-born population (McDonald & Kennedy, 2005). Some of the possible reasons for the gradual loss of health status include healthy behaviours in the home country, health screening by immigration officers, and immigrant self-selection whereby the wealthiest and healthiest are more likely to migrate (McDonald & Kennedy, 2005). Furthermore, Kavar (2004) reasons that social factors such as isolation, the loss of social support systems, language barriers, unemployment, social insecurity and feelings of vulnerability due to poverty and discrimination are accountable for the deterioration of female immigrant health status over time (as cited in Vissandjee et al., 2007).

The problem with uncritical immigrant health literature is that it often essentializes newcomers, especially those who are women, as “others” and assumes that they face similar problems of adjustment and settlement (Lee, 1993). Moreover, migration and health are often contextualized in terms of acculturation and adaptation, concepts that are sometimes misunderstood to be the “exchange of old traditions and relations for new ones,” rather than “the sustained mutual interaction between newcomers and the societies that receive them” (Vissandjee et al., 2007, p. 227).

*Racialized women and mental health in Canada*

Varcoe and colleagues (2007) report that in Canada, women suffer from depression, psychiatric hospitalization and suicide attempts at higher rates than men and that racism and poverty can profoundly affect women's mental health. The Canadian Research Institute for the Advancement of Women (CRIAOW) (2001) explains that low self-esteem is linked to poor health behaviours, such as smoking, alcohol and drug abuse, violence and eating disorders. The CRIAOW fact sheet on women, health and action (2001) states that women and girls who experience racism and other forms of oppression are at particular risk of low self-esteem, leading to poor mental health. Furthermore, social isolation and loneliness are considered just as great at predicting disease and premature death as behavioural risk factors such as smoking and lack of exercise (CRIAOW, 2001).

In 2003, a study conducted by Women's Health in Women's Hands Community Health Centre (WHIWH) in Toronto found that many young racialized women could identify ways in which racism harmed health. Racism was seen as a source of stress and a risk factor for low self-esteem (WHIWH, 2003). Participants in this study also indicated that anticipated racism might cause people to fear using health care services (WHIWH, 2003). Furthermore, participants suggested that racist events could be emotionally traumatizing, leading to negative impacts on both mental and physical well-being (WHIWH, 2003). Research like this is useful for understanding that health extends beyond physical parameters, and lends itself well to intersectional analyses of health and wellness.

### *Moving towards an Intersectional Approach to Health*

Intersectional theories are based on the premise that race, gender and class all function simultaneously to produce systems of inequality (Dua, 1999). Theories of intersectionality were developed mainly by black feminist social scientists to emphasize that in any given situation, it is false to attribute the production of inequalities to merely race, class or gender on their own (Mullings & Schulz, 2006). Intersectional theories advocate that there is a multiplicity of social constructs that work simultaneously to produce differentials in health, disease and other outcomes of inequality (Mullings & Schulz, 2006). Accordingly, social constructionists theorize that it is not race, gender or class, in of themselves that predict health status, but that it is the inequality affiliated with the construction of these categories that do (Mullings & Schulz, 2006).

Mainstream public health paradigms often use an additive approach to conceptualize race, class, socio-economic status, gender, ethnicity and sexuality, treating each as having a separate relationship with health (Mullings & Schulz, 2006). These additive models often overlook the invisible determinants of health, such as discrimination and systemic racism, which can manifest all sorts of health inequalities (Mullings & Schulz, 2006). Furthermore, mainstream public health and biomedical frameworks often view gender, class and race as determinants of health without describing the complex social processes that are involved. This over-simplified view of race, gender and class can create stereotypes and essentialize people into vulnerable categories of health.

In terms of women's health, Hankivsky (2007) suggests that there is a need for understanding gender as a social determinant of health without privileging it over other

intersecting axes of discrimination. Furthermore, gender must be understood as “inseparable from other forms of social difference such as race, ethnicity, culture, class, sexual orientation, gender identity and ability” (Varcoe, et al., 2007, p. 3). Browne and colleagues (2007) argue that there is a need to recognize the complexity of people’s lives and relate the experiences of multiple locations to life opportunities and inequities in access to health.

Although the social determinants of health discourse acknowledges that structural inequalities in access to economic, political and cultural resources arise from the “intersecting experiences of oppression as it relates to race, class, gender, disability, sexual orientation, immigrant status, and the like” (Galabuzi, 2004, p. 238), there has been little discussion on *how* to study intersectionality (McCall, 2005). Weber and Fore (2007) insist that alliances, dialogue and collaboration across intersectional, critical public health and biomedical paradigms must be promoted in order to improve the scholarship on eliminating health disparities. However, there are challenges to doing this type of interdisciplinary work within frameworks that treat women/men, immigrants/Canadian-born, White/visible minority as binary opposites (Varcoe, Dick, & Walther, 2004).

The remainder of this literature review elaborates on the critique of traditional binary models and frameworks by drawing upon alternative theoretical perspectives. The theories I refer to relate back to the need for an intersectional approach in examining social exclusion as a social determinant of health amongst racialized and Indigenous young women living in Victoria.

*Transnational Feminist Theories*

According to Anne Sisson Runyan (2003), transnational feminism seeks to “address the concerns of women around the world in the historicized particularity of their relationship to multiple patriarchies as well as to international economic hegemonies” (p.71). She posits that transnational feminist practices compare “multiple, overlapping and discrete oppressions” rather than “construct a theory of hegemonic oppression under a unified category of gender,” which is often the approach that “global feminism” undertakes (p. 71).

Transnational feminist theories were produced in response to the processes of global restructuring, characterized by migration, the movement of capital, the penetration of new technologies, electronic information flows and outsourcing production processes (Anthias, 2002; Runyan, 2003). Because of cultural, social, political and economic shifts associated with the rise of globalization, Runyan (2003) contends that contemporary feminist theories must also shift in paradigm. With increased international mobility and “the gendered and racialized nature of such migrant flows,” new issues of citizenship are arising (Willis & Yeoh, 2000, p. xviii).

Transnational feminist theorists critique “traditional” migration research that focuses on issues of settlement and cultural adaptation in cases of more permanent international and rural-urban migration (Willis & Yeoh, 2000). Willis and Yeoh (2000) contend that “migration has become more transient and complex, with periods of ‘sojourning’ becoming more common” (p. xii). They also argue that since there has been an increased feminization of international labour migration, earlier research that assumes that all migrants, regardless of gender, have similar experiences of migration, must take

on a more nuanced approach. Furthermore, they suggest that migration research must reconsider the constructions of gendered, ethnic and national identities.

Benhabib (1999) observes that “fragmenting” or “culture clash” discourses that characterize the migration experience are being replaced by discourses of “hybridity” and “interstitiality,” meaning that there is no longer a need to choose between one culture and another (p. 336). Drawing on the work of Robin Teske (2000), Anne Sisson Runyan (2003) further explains that the “dual character of globalization as a simultaneously fragmenting and homogenizing set of forces is making it possible to see that the categories of sameness and difference are not necessarily oppositional” (p. 68). Runyan (2003) contends that this global transitioning complicates “the range of potential identity formations for women” (p. 70).

#### *Hybrid and Diasporic Identity Formation*

In *Re-thinking Anti-Racisms: From Theory to Practice* (Anthias & Lloyd, 2002), Floya Anthias postulates that the shifting transnational and transethnic societies are giving way to new identities that are characterized by hybridity and diaspora, rather than bounded by the nation-state form. She posits that fixed identity boundaries need to be dismantled, and that spaces need to be created to encompass “notions of multiple belonging” (p. 23). She resists essentialized notions of culture and problematizes its association with identity and community because of its tendency to characterize racist practice. Instead, Anthias focuses on new forms of identification that reflect “permanent transnational populations and their descendents” in Europe (and the West) (p. 24). Like Benhabib (1999), she criticizes the more traditional literature that analyzes migration as a

unidirectional process in which integration into mainstream society is juxtaposed against the extent to which immigrants retain their home culture.

Anthias (2002) highlights the work of Stuart Hall (1990), among other “New Hybridity” theorists, for his developments in anti-essentialist understandings of culture and identity. Hall’s (1990) rejection of the essentialized “black subject” was important in paving the way for “new ethnicities” theories to emerge. According to Hall (1990), ethnicity is reconfigured within diasporic spaces, allowing for it to relate to both place of origin and place of settlement. Anthias (2002) suggests that diaspora, which literally translates to the Greek word meaning “the spreading of seeds” is “the collective space or site within which hybrid social forms flourish” (p. 35). She also draws upon the work of Waters (1995) in suggesting that diaspora refers to “a population category or a social condition entailing a particular form of ‘consciousness’ which is particularly compatible with postmodernity and globalization, and, like hybridity, embodies the globalizing principle of transnationalism” (Anthias, 2002, p. 35).

#### *Poststructuralist Critiques of Essentializing Discourses*

In line with the emergence of hybrid and diasporic identity formation theories are poststructuralist theories that critique essentializing discourses. Poststructuralism attempts to destabilize meanings and language that tend to impose over-simplified models and ideas on the world (Scott, 2003). It rejects notions of universal truth and examines the political contexts in which meanings, discourses and principles are socially constructed (Scott, 2003). Furthermore, poststructuralist theory focuses on deconstructing the ways in which social constructs are related to each other through binary oppositions. Jacques Derrida, a key figure in poststructuralist theory, claims that there is

interdependence between concepts such as universal/specific and unity/diversity, whereby their meanings are derived from a hierarchical relationship that plots one term as dominant, and the opposite term as subordinate. He contends that these taken-for-granted meanings are relative to a particular history, and stresses the importance of deconstructing these binary oppositions (Scott, 2003).

In congruence with poststructuralist thought, Chandra Mohanty (2003) provides an anti-racist feminist critique of hegemonic “Western” feminisms for their portrayal of “Third World Women” as singular, monolithic subjects. Mohanty (2003) criticizes the use of “women as a category of analysis” for its assumption that “women, across classes and cultures, are somehow socially constituted as a homogenous group” (p. 22). She states that feminist analyses often characterize women on the basis of a shared oppression and define them in terms of their object status. She exemplifies this argument by providing examples of “Western” feminists who represent women as victims of male violence (Hosken, 1981), universal dependents (Lindsay, 1983) and victims of the colonial process after marriage (Cutrifelli, 1983). She suggests that these studies, and the work of other Western radical and liberal feminists often define power as something that is either possessed or not possessed, perpetuating the assumption that women are a homogenously “oppressed” group.

Likewise, Inderpal Grewal and Caren Kaplan (1994) criticize some feminist practices which tend to equate “colonized” with “women,” “creating essentialist and monolithic categories that suppress issues of diversity, conflict, and multiplicity within categories” (p. 3). They support the need to move beyond postmodernist critiques of

modernity that are founded upon binary oppositions such as “global-local” and “exotic-domestic” (p. 9).

Postmodernist perspectives should instead draw upon poststructuralist theories in order to see women’s identities and representations as not fixed nor given, and “continually being shaped by social forces” (Lee, 1993, p. 21). In a critique of community development amongst immigrant women, Lee (1993) argues that social practices and discursive strategies that are based on visible physical differences often “signify non-white women as ‘other’ and women of color as ‘immigrant’ regardless of true citizenship” (p. 25). She also cautions against essentializing assumptions that “all immigrants face similar problems of adjustment and settlement” (p. 25).

It is clear that transnational feminist theorization involves a paradigm shift in feminist discourse, “from an almost exclusive emphasis on differences among women to a more complicated story about our hybrid identities and our interdependencies” (Runyan, 2003, p. 82). Furthermore, there is a need to re-conceptualize socially constructed categories of race, ethnicity, gender, nation, culture and sexuality.

#### *National Identity and Citizenship*

According to Lee and Cardinal (1998), Anglo-Canadian nationalism has achieved “a more or less stable hegemonic status” (p. 215) claiming for itself an authentic universalism that paints an image of the nation as being naturally white, male, Christian, middle and upper class, English-speaking, British, and more recently Northern European in cultural heritage” (p. 218). Transnational and anti-racist feminists often critique this hegemonic nationalism and attempt to engage in the everyday struggle of those who do

not fit into this idealized Anglo-Canadian identity, and see it as being socially constructed and historically emergent (Lee & Cardinal, 1998).

Similarly, Stasiulis and Bakan (1997) argue that citizenship is commonly construed as an ideal type, whereby an individual is legally bound to a single nation state. This relationship is often understood as static, and passively granted to the individual by the state, creating an objectification of the citizenship experience (Stasiulis & Bakan, 1997). Stasiulis and Bakan (1997) challenge this mainstream understanding by asserting that citizenship should be re-conceptualized as a “negotiated relationship” that is acted upon collectively by individuals who exist within “social, political and economic relations of collective conflict, which are shaped by gendered, racial, class and internationally based state hierarchies” (p. 113). In other words, the complexity of the process of negotiation of citizenship must be recognized, since this process is mediated by conditions of global capitalism, class exploitation, racism and sexism that occur within and beyond the national borders of Canada (Stasiulis & Bakan, 1997).

National identity formation and the negotiation of citizenship are closely tied to the development of capitalism in Canada through the history of colonization, immigration policies and the construction of the Canadian nation (Ng, 1993). According to Mohanty and her colleagues (1991), the notion of citizenship was created by “liberal capitalism predicated on impersonal bureaucracy and hegemonic masculinity organized around themes of rationality, calculation and orderliness” (p. 22). Furthermore, the laws surrounding immigration and nationality are highly racialized and gendered, demonstrating the forces of white, colonialist, capitalist, masculinist state rule (Mohanty et al., 1991). Consequently, women of color in today’s society must challenge the borders

that are set in place to contain, breed fear in and “other” those who are not seen as “ideal types” of Canadian citizens (Mohanty, 2003; Stasiulis & Bakan, 1997). According to Mohanty (2003), anti-racist feminist frameworks must be anchored in decolonization and anticapitalist critique. In order to gain a deeper understanding of how gender and ethnic relations have been mediated by the Canadian state, both historically and in the present, I will next draw upon postcolonial theories, which ground themselves in decolonizing and anti-capitalist frameworks (Mohanty, 2003; Ng, 1993).

### *Postcolonial Perspectives*

In Canada, the racial, class and gender categories that exist today, root back to times of imperialism and colonialism (Yon, 2000). Yon (2000) states that these categories were invented by imperialists as a strategy for ordering, controlling and creating a social hierarchy, where they were placed at the top and the “culturally dissimilar” were deemed as inferior. This system of racial classification later gave rise to slavery, segregation and inequality, marginalizing people of color, while at the same time, creating a system of privilege, power and capitalism, which allowed those who were at the top of the social hierarchy to thrive (Mullings & Schulz, 2006; Dua, 1999).

Ania Loomba (1998) defines colonialism as “the conquest and control of other people’s lands and goods” (p. 2). Although the European imperialism that we know of today began in the 15<sup>th</sup> century (Smith, 1999), colonial conquest can be traced back to the second century A.D. when the Roman Empire expanded from Armenia to the Atlantic (Loomba, 1998). In the 13<sup>th</sup> century, Mongols conquered the Middle East and China. In the 15<sup>th</sup> century, the Ottoman Empire extended itself over the Balkans and Asia Minor. In the 18<sup>th</sup> century, the Chinese Empire was larger than any European empire (Loomba,

1998). Yet, the more recent European conquests have altered the entire world in ways that these previous colonialisms did not (Loomba, 1998). There have been several theories about why these differences exist. According to Bottomore (1983), Marxist theorizations suggest that earlier colonialisms were pre-capitalist, whereas modern colonialism paralleled Western European capitalism. Loomba (1998) states that “modern colonialism did more than extract tribute, goods and wealth from the countries that it conquered – it restructured the economies of the latter, drawing them into a complex relationship with their own, so that there was a flow of human and natural resources between colonized and colonial countries” (p. 3). This flow involved the importation of slaves, indentured labour and raw materials to the metropolis, the selling of manufactured goods back to the countries that produced the raw materials and the funnelling of profits back to the “mother country” (Loomba, 1998). Colonized peoples were moved around as slaves, indentured labourers, domestic servants and traders, whereas the colonizers shifted locations as administrators, soldiers, merchants, settlers, travelers, writers, missionaries, teachers and scientists. European colonialisms involved techniques of domination that produced an economic imbalance that could ensure the growth of European capitalism and industrialization (Loomba, 1998).

Imperialism, which is closely linked with colonialism, also has numerous definitions. Some associate imperialism with capitalist colonialisms, whereas others place it prior to colonialism (Loomba, 1998). Loomba (1998) indicates that whereas colonization involves the taking over of a territory, the appropriation of material resources, the exploitation of labour and the political and cultural restructuring of another nation or land, imperialism acts as a global system (Loomba, 1998). She further states

that “the imperial country is the ‘metropole’ from which power flows and the colony or neo-colony is the place which it penetrates and controls” (Loomba, 1998, p. 7).

Linda Tuhiwai Smith (1999) and others (Fanon, 1990; Nandy, 1989) argue that the impacts of European imperialism are still existent today, despite the supposed independence gained by former colonies. She describes four ways in which imperialism is “used”: 1) economic expansion; 2) the subjugation of “others”; 3) an idea or spirit with many forms of realization; 4) a discursive field of knowledge (p. 21). Smith (1999) draws upon her lived experiences as an Indigenous postcolonial subject to analyze imperialism and colonialism under a “decolonizing” framework, which is one that deconstructs history, reveals underlying texts and gives voice to things that are known intuitively, but not often spoken of. She suggests that people who have been affected by colonial practices should use a decolonizing framework to begin to understand the colonizer and seek self-determination.

### *Building Solidarity*

The decolonizing frameworks that Smith (1999) and Mohanty (2003) speak of are important in the formation of alliances between “Third World Women of Color.” In Chandra Mohanty’s *“Under Western Eyes” Revisited* (2003), she recognizes that not all Native or indigenous women’s struggles “follow a postcolonial trajectory based on the inclusions and exclusions of processes of capitalist, racist, heterosexist, and nationalist domination” (p. 228), although she justifies the notion that there is a common context for struggle among various black women, including Maoris, Asians and Pacific Islanders by arguing that “indigenous claims for sovereignty, their lifeways and environmental and spiritual practices, situate them as central to the definition of ‘social majority’” (Two-

Thirds World) (p. 228). Mohanty's social positioning as a Two-Thirds World woman in the privileged One-Third World informs her political choices, struggles and vision for change. From this location, she finds solidarity with "communities in struggle in the Two-Thirds World" (p.228).

I can relate to Mohanty's reasonings and feel that I, too, am situated alongside Two-Thirds World women, even though I am clearly a social minority in terms of my privileges. Naming my social location is my entry point into the discussion of racialized and Indigenous women's common contexts for struggle. In the writings of Indigenous feminists such as Linda Tuhiwai Smith (1999), Bonita Lawrence (2003) and Winona Stevenson (1999), I am able to understand how colonial history has shaped not only the lives of those whose lands and peoples were directly colonized, but how non-Indigenous women of color have also been differentially and unequally positioned in the formation of the Canadian class structure. In order for women of color in Canada to form alliances and build solidarity, I feel that it is important for us to recognize the specific and unique political, social and economic struggles that Indigenous women face, while acknowledging that not all of their struggles are the same. Much of the decolonizing anti-racist feminist literature that enables women of color to decolonize their histories stems from the acknowledgement of the oppression that Indigenous women have faced in light of European colonization. In the next section, I draw primarily on the work of Bonita Lawrence (2003) because of its significance to health and identity in this study.

#### *Deconstructing Canadian History*

An important part of reclaiming health and identity is to understand how colonial governments have regulated Native identity throughout history (Lawrence, 2003).

Lawrence (2003) claims that “identities are embedded in systems of power based on race, class, and gender” (p. 4). Since 1876, the Indian Act has controlled Native identity in Canada by creating the Status Indian as legal a category (Lawrence, 2003). Until recently, only those who were considered members of this category were allowed to live on lands that were deemed an “Indian reserve” unless it was leased to them as an “outsider” (Lawrence, 2003). Those who were not status Indians were not allowed to take part in their Native communities or have membership in their bands. The “colonial act of establishing legal definitions of Indianness, which excluded vast numbers of Native people from obtaining Indian status, has enabled the Canadian government to remove a significant sector of Native people from the land” (Lawrence, 2003, p. 6).

However, Lawrence (2003) suggests that the social control began much earlier than 1876. In 1763, when Britain proclaimed victory over France, it attempted to consolidate its imperial position by controlling Native nations who occupied the lands Britain claimed for itself. Between 1763 and 1860, the white settler population in the Canadian colonies multiplied greatly, while Indigenous nations were being devastated by European diseases and deliberately introduced to alcohol. In 1850, Canada legislated the creation of Indian reserves, which essentially reinforced the rights of settlers to land by restricting Indians to regions within it. This legislation began the debate on how an Indian should be defined. In 1869, the Gradual Enfranchisement Act was passed, whereby the definition of Indian was based on a blood quantum requirement. Only those who had at least one-quarter Indian blood were eligible to be considered Indian. (Lawrence, 2003).

The laws that governed who could retain status under the Indian Act and who could not were highly sexist. Until 1985, Native women who married non-status

individuals were forced to leave their communities. Simultaneously, white women who married status Indians were given Indian status. Between 1876 and 1985, 25,000 Indians lost status and were subsequently forced to leave their communities because of gender discrimination in the Indian Act. The creation of the “status Indian” can be considered a form of cultural genocide, since the offspring of those who lost status would legally be considered white. (Lawrence, 2003).

In 1995, Bill C-31 was passed, which allowed individuals and their children who had lost their status to regain their status. Although 100,000 legally regained status, there are generations of people who, for a century prior to 1985, are still no longer recognized as Indian. (Lawrence, 2003).

When the Indian Act was created in 1876, a provision was set in place that excluded “half-breeds” from being accounted as Indians. Those who were considered to be “living like Indians” in terms of lifestyle, language and residence, fell under the treaty, while those who did not live like Indians, or who knew some English, were considered “halfbreeds,” regardless of ancestry. The identity category, Métis, was arbitrarily assigned to the halfbreeds, and their Aboriginal identity was essentially “bought out” by the Canadian government. These treaties were instrumental in segregating halfbreeds from Indians, regardless of how individuals self-identified. Thus, the formation of the contemporary Métis identity does not necessarily reflect inherent cultural differences from Status Indians, but rather, a historically excluded group that was artificially created and maintained by the Indian Act. (Lawrence, 2003).

The acknowledgement of Canada's racist, patriarchal, imperialist history is a stepping stone for the theorization of anti-racist feminism and intersectionality in Canada, both of which will help guide my theoretical framework throughout this study.

#### *Canadian Anti-Racist Feminist Theory*

Traditional feminist theory aims to promote social justice and critique the "malestream" norms that have propagated the oppression of women and created privilege of the masculine over the feminine (Crow & Gotell, 2005). Anti-racist feminist theory, however, critiques the exclusive nature of traditional feminist theory, which has narrowly focused on white, middle-classed women in the past (Crow & Gotell, 2005; Dua, 1999). It stemmed from the experiences of women of color, who feel they have been "silenced" in much of the women's studies literature (Bannerji, 2005).

Anti-racist feminists draw upon theories of racialization and social constructionism, which understand race and gender to have been created through historical and social processes (Miles, 1989). According to Miles (1989), racism operates as a belief system that categorizes people into races of dominance and subordination, legitimizing the exclusion of people in terms of access to resources. The processes of "othering" and stereotyping have been around for so long that they are often not even seen as racism anymore (Miles, 1989). This type of racism is termed "common sense," "institutional" or "systemic" racism and it is founded upon norms that have been carried over from hundreds of years ago, during the times of slavery, colonization and neo-colonization (Miles, 1989). For example, in 1885, Canada imposed a head tax on Chinese people seeking to enter the country; in 1914, the government instituted the "continuous journey" rule in an effort to eliminate Indian immigration; and during World War II, the

Canadian government interned Japanese-Canadians within their own country (Ash, 2004). These past acts of overt racism have orchestrated the current demographics and political economy of Canada and have prevented a true system of multiculturalism from existing (Ash, 2004). Whereas overt or clearly stated racism still exists, common sense racism is a more problematic and pervasive form because it becomes embedded and institutionalized in our systems, and is often covered up by “political correctness” and “multicultural” policies (Miles, 1989; Teelucksingh, 2006).

Anti-racist feminists challenge the traditional feminist assumption that all women suffer the same oppressions and injustices, claiming that this assumption ignores the historical contexts that have shaped their own privileged status as White women in Canada (Dua, 1999). Anti-racist feminist theorists argue that by ignoring or omitting the realities of women of color, white women remain in a relatively privileged position, perpetuating a class and racial difference between women (Dua, 1999). It is through women of color’s attempt to theorize interconnections between race, class and gender that anti-racist feminist discourse and intersectional theories in Canada began.

#### *My Critical Theoretical Framework*

Having drawn from several bodies of feminist literature after identifying key problems within the population health and social determinants of health literature, I have developed a critical theoretical framework that attempts to understand and analyze the participants’ experiences and definitions of health and well-being, as having been influenced by the social, economic, political and historical processes of racialization. Rather than separating their gender, race, class, nationality and other identifying variables, I view each individual as having multiple, shifting and complex identities that

are formed by several intersecting and interrelating factors. The primary reason for adopting this critical perspective is that I have not found health and wellness literature that sufficiently reflects my realities as a racialized, second-generation Canadian woman. I hope that this critical framework and the voices of the eight participants in my study will generate critical dialogue amongst health researchers, and bridge the previously separate disciplines of women's studies and health sciences in order to further explore the intersections of race, gender, class and health.

## CHAPTER THREE - METHODS

In light of the research that I reviewed in Chapter two, I feel that a participatory approach is the most effective way of addressing the goals and objectives of this study. The method I chose to satisfy both the participatory engagement and research components of this thesis is Photovoice, a strategy that has been developed by Carolyn Wang and her colleagues, and that is based on Paulo Freire's (1970) popular education techniques. In this chapter, I will describe the participatory approach that guided my research design, the recruitment process and the Photovoice procedures that served as a methodological framework for this project.

My research design and methods were guided by the following research questions, which aim to explore and deconstruct the participants' views on health, explore their realities and open up critical dialogue on issues pertaining to health and identity amongst racialized and Indigenous young women living in Victoria:

- 1) *How does social exclusion act as a social determinant of health amongst racialized and Indigenous women living in Victoria?*
- 2) *How do the intersections of race, gender, class and other social variables impact the daily experiences of health and well-being amongst racialized and indigenous young women in Victoria?*

### *Research Design*

In the attempt to understand the complex, intersecting realities of the women in this study, while engaging with them in a social change project, I utilize a modified participatory approach throughout my research design that parallels Anti-dote approach to feminist participatory action research.

Participatory Action Research (PAR) is about “personal and social transformation for liberation,” and is characterized by “justice, freedom and ecological balance” (Smith, 1997, p. 173). Participatory action research involves action for social change, in which participants develop critical awareness of the circumstances that influence their lives (de Koning & Martin, 1996). PAR arose in the early 1980’s from work done with marginalized people in Brazil, India and Tanzania, as an alternative method of stimulating social and economic changes (Smith, 1997). According to Smith (1997), PAR is characterized by the following principles:

- 1) PAR intends on achieving liberation, or the eventual achievement of equitable communities and societies.
- 2) PAR develops a compassionate culture, which involves commitment to a shared struggle, building community, person and place, and creating dialogue for evolving partnership.
- 3) PAR involves dynamic processes of action-reflection (praxis), which is organic, ever-changing, non-linear, interactive and unique to each group.
- 4) PAR values what people know and believe by using their present reality as a starting point and building on it. It relates historical contexts to present circumstances and structures, and believes that personal experiences, feelings and belief are vital ways of knowing.
- 5) PAR promotes collective investigation and action on needs that people have strong feelings about.

- 6) PAR aims to consciously produce new knowledge. The group makes decisions and takes on activities that are grounded in members' experiences.

In addition, PAR is a research framework that links research to social action and social change by including research participants in all aspects of the research process (Martin, 1996). Through participation, education and collective action, participatory research aims to create a research environment that moves away from the subjects being passive objects, and towards participants being active researchers of issues that are important to them (Martin, 1996).

Although my research approach reflects these descriptions and principles, I initially avoided using the term, PAR, to describe my research because I conceptualized the "action" segment of PAR to be beyond the scope of a Master's thesis. I felt more comfortable introducing the project as "PR" – participatory research, in which case we would follow the principles of PAR, but not be indebted to an integrated action piece involving "long-term process and commitment," which PAR "purists" often specify as a distinguishing feature of this methodology (Israel, et al., 2003, p.58).

I realize, now, that there are several dimensions of the "A" in PAR. For example, it is nine months post-data collection (as defined by the ethical confines of my study) and the network of Sistahs who participated in my study has not only expanded in size, but in capacity. We have since established a structure that allows a sharing of leadership throughout our meetings and events. Important topics that emerged throughout the study were addressed at a Sistahs Silkscreening workshop held in September, 2007. We also dedicated our November meeting to the themes of sexual health and relationships,

relevant topics that are not often discussed openly in a safe, shared environment. This sense of “authentic commitment” is what drives Anti-Dote, and should be considered “action” in that it shows persistence over the long term “toward the shared goal of social transformation” (Fals-Borda, 1991, p.4). Paulo Freire (1970) believed that social transformation is achievable through the process of critical awareness and action. This thesis is an action piece in of itself, as it embodies the energy, passion and soul that the racialized and Indigenous women in this study have consciously chosen to put forth towards social change.

#### *Feminist participatory action research framework*

Despite its democratic ideals, earlier PAR studies have been criticized for their male-centered focus, and their paucity in considering gender and diversity within women’s experiences (Maguire, 1987; Frisby et al., 2005). According to Frisby and colleagues (2005), feminist participatory action research (FPAR) attempts to incorporate the view that gender, which intersects with race, class, sexual orientation and other forms of oppression, is embedded into power structures, institutions and interpersonal relations (Frisby et al., 2005). My research approach, which parallels Anti-Dote’s approach to FPAR, also embodies this lens.

#### *Anti-Dote’s FPAR framework*

The methodologies that I used are in line with Anti-Dote’s member-focused, bottom-up approach, as I attempted to provide a platform for the voices of Sistahs (and participants recruited from outside of Anti-Dote) to be heard, and contribute to our ongoing capacity and solidarity as a group. Anti-dote works to build community networks and self-advocacy among girls and women, uncover unspoken experiences,

help bring about social justice and equality, and foster respect for diversity (Anti-Dote website, 2007).

My approach parallels Anti-Dote's approach to feminist participatory action research (FPAR), which promotes the translation of feminist, anti-racist theories into meaningful, sustainable, grassroots community initiatives, with the understanding that racialized and Indigenous women and girls can be excluded from modes of knowledge and policy production. Furthermore, this approach attempts to give voice to Indigenous and minority girls and women through the use of creative and expressive methods, such as digital media, art and theatre. The premise behind Anti-Dote's framework is that regardless of our background, age, sexuality, class or ability, we, as racialized women and girls, often have difficulties negotiating our multiple identities as minorities in this predominantly white, Anglo-European city. Drawing upon our individual lived experiences, Anti-Dote provides a supportive space where we can exert our political agency and collectively act against social injustices.

#### Data Collection

My primary data collection method was Photovoice. I chose to use Photovoice methodologies, which are grounded in participatory action research (PAR), because of my prior experience with this method and because of its emphasis on critical reflection and participatory engagement.

“Photovoice is an innovative participatory action research method based on health promotion principles and the theoretical literature on education for critical consciousness, feminist theory, and nontraditional approaches to documentary photography” (Wang, 1999, p. 185). It allows people to listen to and learn from the participants' own portrayal

of their lives (Wang, 1999). The Photovoice concept was initially developed and applied by Carolyn Wang and Mary Ann Burris, in 1992, to enable Chinese village women to photograph their everyday health and work realities (Wu et al., 1995). It has since been used in several situations involving marginalized populations all over the world (Dixon & Hadjialexiou, 2005; Killion & Wang, 2000; Miller, 2006; Moss, 1999; Vanucci, 1999).

The following goals and key concepts about Photovoice are derived from Wang's (1999) experiences using Photovoice and PAR to address issues in women's health.

#### *Goals of Photovoice*

- 1) to record and reflect personal and community strengths and concerns
- 2) to promote critical dialogue and knowledge about personal and community issues through group discussions of photographs
- 3) to reach policymakers

#### *Key concepts*

The key premises behind Photovoice are that images “contribute to how we see ourselves, how we define and relate to the world, and what we perceive as significant or different” (Wang, 1999, p. 185). Pictures can speak a thousand words, and photos that are taken with intent and purpose can convey meaningful messages that might otherwise not be expressed because of the systemic and structural barriers that prevent many underprivileged and marginalized people from having a voice in society (Wang, 1999). Furthermore, the immediacy of visual image provokes the sharing of experiences and knowledge in a participatory way amongst group members (Wang, 2003). Images can also serve as analytical tools for understanding how messages and meanings associated

with them are produced, interpreted and reinforced, and how they can influence our world view (Freire, 1970).

Freire's (1970) educational praxis emphasized the importance of identifying historical and social patterns governing individuals' lives, and analyzing their situations in terms of their "root causes" in order to foster change. Photovoice methodologies also draw upon feminist theories by attempting to disrupt and deconstruct oppressive representations of gender, class, race and ethnicity (Wang, 2003). According to Wang (2003), "the Photovoice concept is designed to enable people to produce and discuss photographs as a means of catalyzing personal and community change" (p. 181).

Photovoice entails a process that begins with people coming together to define both group and individual goals and objectives and ends with people being able to use their Photovoice pieces as a platform for speaking to policymakers, creating change, and laying ground for further action (Wang, 1999). Participants are encouraged to think critically about the factors and forces that influence their lives (Freire, 1970). In the stages leading up to photo taking, participants are deconstructing their lives, becoming critically conscious of the issues that affect them, and validating their experiences with the support of group members (Wang, 2003). Once participants have taken the photos and assigned personal meaning to them, the participatory debriefing element of Photovoice allows them to further analyze and reflect upon their photos while receiving feedback through group discussions (Wang et al., 1998). This feedback serves to trigger further conversation on issues of importance (Wang, 2003).

Finally, Photovoice images can influence policy by helping to set the public agenda (Wang, 1999). The potential for using Photovoice as a tool to influence policy

resides in the exchanges among community people, health workers, and policymakers over the images of interest (Wang, 1999). Photovoice is grounded in the understanding that policies derived from the integration of local knowledge, skills and resources within affected populations will more effectively contribute to healthful public policy (Wang, 1999).

### *Participants and Recruitment*

Once I received ethical approval and permission from Anti-Dote (my partnering organization) (See Appendix J) to conduct this project, I began the recruitment process.

Eight participants were selected for this study, using a purposive sampling process (Patton, 1990). Self-identified racialized or Indigenous women between the ages of 18-30 living in Victoria were eligible to participate in the study. The reason for using the terms “racialized” and “Indigenous” in the inclusion criteria instead of “racial minority,” “visible minority” or “woman of color” is because the term “racialized” implies that the individual acknowledges that she is a part of a system in which her racial classification has been socially constructed, and that she has already begun to question her formation of and/or resistance to racial identification. A further criterion for participation in this study was that the respondent must be willing to share her experiences and be actively seeking social change (whether through personal transformation or political action).

The eight participants who fit the inclusion criteria for this study ranged in age from 21 to 28. Six out of the eight participants had prior affiliation with Anti-Dote. These women were recruited by word of mouth through the Anti-Dote network or had responded to an e-mail that was sent out to the Anti-Dote list serve (See appendix D). I also saw this recruitment process as an opportunity to perform outreach for Anti-Dote by

extending the invitation to participate to community members who were not already involved in Anti-Dote. Two participants from outside of Anti-Dote were recruited through snowball referral (Patton, 1990).

The participants' relevant background information is presented in Table 1. In addition to the information provided, no participants indicated that they had any disabilities and all participants identified as heterosexual. Participation was on a voluntary basis, and no honorarium was offered. However, transportation costs and food at the workshops were provided by the researcher. All names used are pseudonyms that were either chosen by the participant or assigned by the researcher.

Table 1  
*Participant Background Information*

<b>Name (Pseudo-nym)</b>	<b>Occupation</b>	<b>Citizenship</b>	<b>Years in Canada</b>	<b>Languages (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>)</b>	<b>Highest level of education</b>	<b>Cultural/Ethnic background</b>	<b>Nationality</b>	<b>Class background</b>	<b>Age</b>
Dawn	Writer/analyst	Canadian	12	1) Hokkien 2) Tagalog 3) English	Bachelor's Degree	Chinese, Filipino	Canadian	Middle	24
Jenna	Student	Canadian	11 total	English	Some post-secondary	Filipina-Canadian (mixed)	Canadian	Upper-middle	21
Rebecca	Student	Canadian	27	1) English 2) French	Some post-secondary	Métis	Canadian	Lower-middle	27
Jessica	Student	Canadian	15	1) Cantonese 2) English 3) Korean	Bachelor's Degree	Chinese	Usually Hong Kong	Middle	28
Sushma	Intern/Student	Indian and Canadian	6	1) Pahadi 2) English 3) Dutch	Bachelor's Degree	Kashmiri	Indian	Upper-middle	26
PP	Coordinator	Canadian	12	1) Farsi 2) German 3) English	Graduate degree		Iranian	Upper-middle	28
Susan	University ESL staff	Thai	4	1) English 2) Thai 3) Mandarin	Bachelor's degree	Asian	Thai	Upper-middle	24
Monica	Student	Canadian	7	1) English 2) Spanish 3) French	Some post-secondary	East Indian	South African	Middle	23

Table 2

*Outline of Procedures*

<b>Procedures</b>	<b>Summary</b>
Step 1 – Pilot testing	Met with one participant to pilot test discussions questions and activities
Step 2 – Photovoice Workshop	<ul style="list-style-type: none"> <li>• Check-in</li> <li>• Goal-setting</li> <li>• Explaining Photovoice assignment</li> <li>• Discussing Photography techniques</li> <li>• Use of digital cameras</li> </ul>
Step 3 – Week of Reflection	<ul style="list-style-type: none"> <li>• Participants took photos, reflected, wrote in journals</li> <li>• Check-ins</li> </ul>
Step 4 – Selecting and transferring photos	Participants selected top 3-6 photos and sent them to me via email at the end of the week of reflection
Step 5 – Debriefing Workshop	<ul style="list-style-type: none"> <li>• Check-in</li> <li>• Critical reflection <ul style="list-style-type: none"> <li>○ Selection</li> <li>○ Contextualization/Storytelling</li> <li>○ Codification</li> </ul> </li> </ul>
Step 6 – Follow up	Met with participants to confirm accuracy of statements

*Overview of Procedures*

I have broken down the procedures of this thesis into six major steps, which are outlined in Table 2. This rest of this chapter describes each of these steps in further detail.

**Step 1: Pilot Testing**

Once recruitment was completed, I met with one of the participants who said she was unavailable to attend the first half of the first scheduled workshop to pilot the questions and activities that I devised based on principles of community-based participatory research. Based on this pilot test, I modified the questions and activities slightly because I recognized that some of the questions assumed that the participants were all there for the same reasons. I realized that my initial activities had to allow room for the participants to situate themselves and develop their own understandings of why they were participating in this study.

**Step 2: Photovoice Workshop**

Participants signed an informed consent form and image release forms, and filled out an optional background information questionnaire before beginning this session. The workshop took place in the women's centre, which is located in the university's Student Union Building (SUB). Once participants settled with their food, I introduced myself and the purpose of this project as it related to my thesis requirements. We then went around the circle introducing ourselves by doing a group "check-in." This is a method that is commonly used in Anti-Dote meetings and events to enter and get to know the group, and might be referred to by Smith (1997) as a "bridge activity" (p.237).

I explained the research aim, issues of confidentiality and anonymity, and discussed the idea of Photovoice and participatory research. I wanted to set up an understanding that the objectives and research questions would be left open for the group to define and modify throughout the course of the project. The entire workshop, including introductions, was audio-recorded.

*Goal-setting.* We then moved into a group discussion of our goals, objectives and reasons for participating in this study. I facilitated the discussion while one of the participants wrote our ideas on flip chart paper. The questions that were asked were: 1) Why are we here? 2) What do we have in common (if anything)? and 3) What goals do we want to reach (individually)? The purpose of this activity was to allow participants to become conscious of the role they wanted to play as an individual and group member in this project. I thought this activity would be a good way to carry on with discussions held at Sistahs meetings surrounding the need for a project centered on our realities.

What I was not prepared for, however, was the fact that not all participants were “Anti-Dote Sistahs” and many were unfamiliar with the language and approach that we use. After backtracking and explaining the background and purpose of this project, we continued with the activity of writing down our goals, and the young women who were not familiar with Anti-Dote were guided through the process by clarifications along the way. I realize now that the mixing of participants from within and outside of Anti-Dote provided inherent challenges that I did not foresee. I was limited by the multiple purposes I attempted to fulfill, which included building Sistahs capacity *and* performing outreach. As a result, I set up a situation in which those who did not fit in with the dominant group (Anti-Dote members), were potentially marginalized and placed at a disadvantage in terms of being fully included in conversations and activities that tended to reflect Anti-Dote’s approach.

Despite this limitation, the participants were able to set four goals, which could be used as a point of reference for the remainder of the project. The goals they came up with were: a) to establish a common language, b) to engage in critical self-reflection, c) to identify “issues” that are meaningful to us, and d) to create a safe space to share experiences and thoughts.

*Brainstorming activity.* To initiate a discussion on health and well-being, I asked the participants to brainstorm on what health and well-being resembled and felt like to them at different points in their lives. I gave the participants a few minutes to write on small sticky notes words (e.g., nouns, adjectives, verbs) or phrases that described concepts or instances in their lives that related to feeling “healthy.” Next, I asked the participants to write down words or phrases that described concepts or instances in their

lives relating to when they felt “unhealthy.” The purpose behind exploring notions of healthiness and unhealthiness at different temporal locations in their lives was to encourage a broad range of understandings that went beyond their present conceptualizations of health.

I then gave participants some time to place their sticky notes on a wide sheet of paper on the wall, which represented a “map” of their lives from the past to present to future. Since they each wrote with a different coloured marker, this mapping exercise painted a visual picture of when and how participants experienced different feelings associated with varying conceptualizations of health. As we stood around the “map of health” we discussed what we observed and noted patterns of similarity and difference between group members. I then asked participants to pick out three words they used to describe “feeling healthy” and three words they used to describe “feeling unhealthy” and explain to the group why they chose those descriptions. After we went around the circle, I asked if anyone had any thoughts about the outcomes of this activity or comments to make. The aim of this discussion was to allow participants to reflect upon their lives and open up avenues for critical consciousness. According to Smith’s (1997) Framework for Praxiology, this brainstorming activity was an initial step in “grounding in context,” which is a process of recognizing common concerns or questions and getting to know the context by consciously exploring the setting (p.202).

*Probing.* After a short break, we returned to the topic of health and well-being, but shifted the focus to race and gender. I posed the following questions in regards to the words and concepts they wrote to represent their own understandings of health and well-being: “Do you feel that these words relate to all women in the world?” and “Do you feel

that these words are unique to you?” “How do you think these words relate to the experiences of other racialized and Indigenous women living in Victoria?” The reason I asked these questions was to probe participants to look deeper into how their outlooks on health might relate to the intersectional dimensions of their lives. At the time, I felt that by talking directly about race and gender, I would be able to provoke insights on issues pertaining to the concept of intersectionality. But in reality, it was presumptuous to assume that there was a shared reality amongst the group. I realized I had to provide an opportunity for participants to talk about their lives before delving into an analysis. The focus group ended up flowing naturally into the next activity - story telling.

*Story Telling.* Story telling was an integral piece in setting the context for the remainder of the study. The women told stories and anecdotes that were prompted by the previous activity. It allowed them to talk about experiences that had an impact on their lives and to expose what they may have been previously internalizing. Another purpose was to encourage the women to build a sense of solidarity and connectedness with one another by hearing each other’s similar experiences and feelings. According to Freire (1970), stories often act as “codes,” which pose problems and provoke further questions.

*Explaining the Photovoice Assignment.* To set the stage for the week-long Photovoice assignment, we referred back to the goals that we had originally drawn out as a group. This allowed a transition into my introduction of the goals and key concepts of the *Photovoice* methodology (Wang, 1999). We talked about the use of photography as a “code” for opening up discussion and action on issues that are not often talked about amongst racialized women. We also discussed the concept of visual imagery as a powerful form of communication.

The participants' assignment was to take pictures of places, people, objects, scenes, symbols, etc. that tell stories about issues that affect their health and well-being. They were asked to take approximately five photos each day over the course of the week and to keep a journal of their thoughts and feelings while taking the photos. They were given a task sheet consisting of five questions aimed at guiding them through the photo taking process:

- 1) How can my background and identity be represented?
- 2) What does my optimal level of health and well-being look like?
- 3) What does my current state of health and well-being look like?
- 4) What does it look like when I am feeling unhealthy or unwell?
- 5) How can some of the issues that affect my health and well-being be represented (e.g., What does exclusion look like? What does feeling "silenced" look like?)

I mentioned that they could either focus on the themes and issues that surfaced throughout the workshop, or simply take pictures of their everyday realities, and let themes emerge afterwards. I encouraged creativity and critical reflection as key components of the explorative process. I handed out blank booklets that the participants could use as journals throughout the week. The purposes of the journals were to provide a means for participants to reflect on the photos while they were being taken, make any notes about them, and provide an alternative outlet for critical reflection. I advised the participants to keep their cameras, journals and folders (containing participant and subject consent forms and image release forms and task sheet) on hand whenever possible.

*Discussing Photography Techniques.* After going over the assignment with participants, we discussed some techniques that would increase the effectiveness and

aesthetics of their photos. For example, we went over basic photo-taking tips, such as leaving the sun behind the photographer and making sure fingers were away from the lens. I also warned the participants against always trying to place the subject at the centre of the photo. I showed examples of how placing the subject at different angles and positions in the frame could purposefully change the effect that the photographer was trying to create. I handed out a sheet containing tips and information on techniques that would maximize the effectiveness of the message that the image is intended to convey (see Appendix E).

*The Use of Digital Cameras.* I had inquired beforehand about whether or not the participants had their own digital cameras to use throughout this project. Five out of the eight participants had their own digital cameras, which they said they preferred to use. For the other three participants, I arranged to borrow digital cameras that they could use throughout the week. I chose to use digital cameras for three reasons:

1) *Cost-efficiency.* The cost of buying disposable cameras for everyone, then developing an entire roll of film exceeded my personal budget.

2) *Time-efficiency.* Digital cameras allow the photographer to see their photo right away. Using digital cameras eliminates the time-consuming step of sorting through prints that have not yet been viewed during the debriefing session.

3) *Methodological consistency.* Whether or not they are digital or disposable, I felt it was important for everyone to use the same type of camera because it is easier to collect and analyze the photos as a group if it is all done the same way.

**Step 3:** Week of reflection

The participants took photographs throughout their homes and communities, while journaling their thought processes for one week. Wang (1999) suggests that one week is a suitable amount of time for participants to undertake a Photovoice task.

*Check-ins.* During this week, I phoned and emailed the participants to find out how they were doing with their Photovoice tasks. For organizational and systematic purposes, I kept a log of which participants were reached by phone or by e-mail and kept track of our interactions. Checking in with participants not only held them accountable, but also provided them with guidance and support throughout this critical reflection process. I found that many participants welcomed the opportunity to talk to me on an individual basis, rather than expressing their thoughts and feelings in group format.

#### **Step 4:** Selecting and transferring the photos

On day 5 of reflection week (August 19), I reminded the participants that they would be selecting their top 3-6 photos to send to me via e-mail by August 20. I asked them not to erase the remainder of their photos in case they wished to use them in the future. I asked them to upload their selected photos onto a computer and e-mail them to a Gmail account that I created specifically for this project. By the morning of the debriefing workshop (August 21), I had received digital copies of 7 out of 8 participants' photos via e-mail. I printed all of the photos using a color printer, and brought them to the debriefing meeting. The one participant who had not sent me her photos had uploaded them onto her laptop computer, which she had brought with her to the workshop.

#### **Step 5:** Debriefing workshop

The three-hour debriefing workshop was held in the University of Victoria Women's Studies Department Reading Room. The purpose of this workshop was to

discuss the events and thought processes that occurred over the past week and use the photos that were taken to open up critical dialogue about issues that impact the health and well-being of the participants. I provided food once again to establish a comfortable and welcoming environment. One participant was absent from this workshop, but I met up with her two days later to do a one-on-one debriefing. Both sessions were audio-recorded.

*Check-in.* We started off with a group check-in. Because I did not have the chance to connect individually with each participant throughout the week, I wanted to give people an opportunity to follow up on any continuing thoughts from the first workshop.

*Critical Reflection.* I used Wang's (1999) three-stage process of critical reflection to open up dialogue about important issues in the participants' lives, using photos as "codes" for discussion. Wang's (1999) model includes: 1) Selection, 2) Contextualization and 3) Codification.

### Stage 1: Selection

The selection process was an important stage in generating questions that the participants, themselves, wished to explore in addition (or complement) to the research questions that were initially posed by the researcher. When Photovoice is done with non-digital cameras, the selection process normally takes some time because it involves sorting through a stack of photos and thinking back to why each photo was taken. But since the participants used digital cameras, this process was bypassed and the selection of their photos was done throughout their week of reflection.

In my past experiences facilitating Photovoice workshops with film-loaded cameras, participants have been excited to view their developed photos for the first time. During the process of comparing their photos with others and choosing the ones that they

liked the best from the entire roll, they could generate ideas about why they took the photos and what they could say about them. Digital cameras, on the other hand, allow participants the opportunity to erase photos, view their photos immediately after they take them and select their favorite ones on their own. To make up for the lack of a collective selection process, I asked participants to tell the group about what went through their minds as they captured and selected their favorite images and what their selections were based on. This verbal debriefing allowed the participants to justify their personal standpoints and speak about the challenges, themes and revelations that emerged over the course of the week.

### Stage 2: Contextualizing and Storytelling

It is evident that health and well-being can mean different things to different people. This stage of the reflection process was meant to establish a common ground upon which we could contextualize our photos. I asked the participants to think about the following questions regarding the photographs they selected: 1) How do these images make us feel? 2) What issues could they possibly raise? 3) Can we use an intersectional lens to reflect upon these images? This last question was meant provoke critical thinking on issues of gender, class and race, as they may have pertained to each participant's lived realities.

I also described Wang's (1999) **SHOWeD** acronym, which is meant to help participants obtain a critical stance on each of the selected photographs:

What do you **S**ee here?

What is really **H**appening?

How does this relate to **O**ur lives?

Why does this situation, concern, or strength exist?

What can we Do about it?

I invited participants to use this acronym if they felt it could be applied to any of their photos. The SHOWeD acronym is used as a method of “root-cause questioning” that helps “identify the problem or the asset, critically discuss the roots of the situation, and develop strategies for changing the situation” (Wang, et al., 1998, p.80). This stage is referred to by Freire (1970) as “naming reality,” and can bring participants to a level of awareness about the structures, ideas and practices that place them into positions of inequality (de Koning & Martin, 1996).

I next asked participants to provide written descriptions of their photos or of the symbolic meanings behind the photos they chose. Many had already written about their photos in their journals. I asked those who had already written to refine and add to their pieces after thinking about how their work might eventually speak to policy makers or act as catalysts for social change. I gave participants about 15 minutes to write about one or more of the photos they selected. One participant, who I had not been able to connect with throughout the week, had finished her writing early, so I conducted an individual interview with her in another room. Because she was not a member of Anti-Dote at the time, I wanted to ask her how she was feeling about this process, and if there was anything she wanted to express.

When the writing period was over, everyone gathered around the table to present their Photovoice pieces to the group and discuss them. Due to time constraints, each participant chose only one or two pieces to present to the group. There was a brief group discussion after each of the presentations. This stage of self-expression and group

discussion was an important component of “praxis,” which is a back and forth dialectic of action and reflection that develops increased critical consciousness among group members (Smith, 1997). Critical consciousness, or conscientization, is a term used by Freire (1970) to describe the “learning and perception of social, political and economic contradictions, and to take action against the oppressive elements” (p.19). According to Ira Shor (1993), critical consciousness consists of four qualities: 1) being aware of power, 2) critical literacy (analyzing and understanding social contexts, processes, texts and situations beyond surface-level impressions), 3) desocialization (recognizing, critically examining and challenging values, language and myths that operate in society), and 4) self-organization and self-education. The process of doing individual reflection through written and verbal forms was an important method of linking the processes of knowing and learning through ongoing cycles of action and reflection (de Koning & Martin, 1996).

### Stage 3: Codifying

The third stage of the critical reflection process involved codifying issues, themes or theories that arose from their photographs (Wang, 1999). The Photovoice concept of codification is derived from Paulo Freire’s use of “codes” that often took the form of visual images, line drawings or photographs representing significant realities (Wang & Burris, 1997). These “codes” are then used to cultivate discussions and group dialogue on how people contribute to culture (Maguire, 1987). Photovoice takes Freire’s concept one step further by allowing participants to create the images themselves (Wang & Burris, 1997).

In this study, the process of codification occurred throughout the discussions following the storytelling and contextualization stage. I asked the participants to think

about the photos and discussions that were held in the workshops and relate them to health, well-being, gender, class, age, sexuality, intersectionality and identity. I asked if they noticed any common themes or predominating feelings throughout the week. The themes will be presented and discussed in Chapters 4, 5 and 6 of this thesis.

Towards the end of this discussion, I brought out the original piece of flip chart paper on which we had written our goals at the previous workshop. I asked if anyone thought we had achieved our goals and if we had accomplished anything that we did not expect. There was a unanimous agreement that we achieved all of our original goals. I concluded the workshop by presenting the participants with small gifts as a token of my appreciation for participating in the study.

#### **Step 6: Follow Up**

This final procedure occurred while I was analyzing and writing up the findings. Even though some participants moved away after the main data collection phase of the project, I kept in contact with most of the participants on a regular basis. Although the majority of my data was collected during the initial two-week period of the project, the follow-up consultations that I had with participants guided the theoretical analyses of this thesis and confirmed the accuracy of some of the statements and ideas that I was formulating. Once a draft of the thesis was complete, it was circulated to all interested project members for an official “member check” of the data, procedures, interpretations and findings.

## Other Data Collection Instruments

### *Field Notes*

Keeping field notes, or a “field diary” is a necessary counterpart to other qualitative data gathering methods, such as interviews and focus group discussions (Bell, 1998). It is a record of my observations, activities and thoughts (Bell, 1998). I kept field notes during every stage of the study, including recruitment, data collection and data analysis. The field notes were both observational and theoretical, and were meant for drawing inferences in the future (Hughes, 1994).

### *Interviews*

Interviews are one of the key data collection methods used in qualitative research, and are used to gather informants’ reports and stories, learn about their perspectives, and give them voice (DeVault & Gross, 2007). I had not originally planned on conducting individual interviews with participants because I thought that the collaborative process of Photovoice would sufficiently allow themes and research questions to emerge. But as the study progressed, I felt it was necessary to connect with certain individuals who wanted to share their stories with me individually, or who had to miss parts of the study for personal reasons. Aside from the pilot study, I collected data from interviews with four of the women (Sushma, Dawn, PP and Jessica), which occurred within two weeks of the study period. All of the interviews were unstructured, and revolved around the particular feelings and concerns of the participant during that time.

### Data Analysis

There were five main sources from which my data were collected: 1) focus groups (during Photovoice and debriefing workshops), 2) interviews, 3) Photovoice pieces, 4)

participants' journals and 5) field notes. The themes that were generated through participants' personal reflections were refined through processes of action and reflection that occurred in our group discussions of the data. Wang's (1999) three-stage process of selection, contextualization and codification provided a guiding framework for group data analysis. Each individual, including myself, had the opportunity to analyze our thoughts, which translated into data, during and between the two workshops.

Once the group data collection and analysis period ended, my individual analysis of the data became a cyclical process of going back and forth between my field notes, memos, transcripts and the literature. I started off by transcribing the audio tapes of the workshops and interviews, and the participants' written journals. I then selected the information that I wanted to include in the analysis. I did an initial review of the transcripts, while inserting theoretical memos, which served as reminders for me to read about certain topics in the literature (Hughes, 1994). Next, I inputted my transcripts into a computer software program called NVivo, which helped me organize and manage the data. I applied codes throughout the data to summarize, synthesize and sort the observations that I made from the raw data (Bryman & Burgess, 1994). This initial process of breaking down and categorizing the data is known as "open coding" (Strauss, 1987). Next, I grouped together the small clusters of codes and represented them under broader themes. This process is known as "axial coding" and serves to make connections between categories (Strauss & Corbin, 1990, p. 96). The connections and themes became starting points for theoretical analysis. I went back into the literature, read about certain themes with the guidance of my committee members, and went back into the data to re-

organize my themes. This is often considered the first step in the emergence of theory (Bryman & Burgess, 1994).

Once I derived the major themes, I used them to generate further discussion with the participants whenever necessary. Such discussions occurred informally on a number of occasions, mainly while I was drafting the discussion of the analysis. Data analysis was an iterative, reflexive process, which involved several cycles of reviewing the transcripts and field notes, referring to different bodies of literature, conversing with participants, with whom I have developed sustained relationships outside of the project, and consulting my committee members on numerous occasions. Finally, I have drawn upon my own lived experiences as a key data source and analytic tool in this process.

#### Ethical Considerations

I addressed ethical considerations both at the start of the study and at the end of the Photovoice workshop. Before the project began, participants were issued a consent form and image release forms, which are located in Appendices F, G, H and I. The project proceeded once these forms were explained and signed. Ongoing consent was obtained by all participants, which allowed me to proceed with subsequent interviews and study-related procedures over the course of the project without participants having to sign a consent form each time.

Towards the end of the Photovoice workshop, I addressed ethical issues concerning photo taking. I explained that participants (as researchers) should use sound judgment when taking photos. I briefly outlined the following ethical concerns, as suggested by Wang and Redwood-Jones (2001):

- Invasion of personal privacy

- The need to obtain prior consent by using the consent form provided
- Avoiding the false construal of a situation that may consequently become a public concern
- Avoiding potentially “incriminating” photos
- Avoiding the creation of false impressions of one’s character, intentions or actions
- Avoiding making a profit at someone else’s expense
- Considering whether or not the participant/researcher would like to have their photo taken in a particular circumstance
- Avoiding putting themselves into physically or emotionally dangerous or hazardous situations

I explained to participants that they needed to explain the purpose of the project to the subjects of their photos and have them sign the consent/release form that I provided to them. In addition, I briefed the participants on the purpose of the subject consent/release forms, which contained the following information:

- The photographer-participant’s responsibilities as a member of a research team and as a research participant
- A space for subjects to sign, thereby giving permission to have their picture taken and used in future communications
- If the subject of the photo is under the age of 18, they need to have a parent/guardian sign the consent/release form

Furthermore, I explained that the digital images that the participants took were theirs. Since most of the participants used their own digital cameras, there were no ethical issues to address concerning the disposal of images. I advised the participants who

borrowed digital cameras to burn their photos onto a CD for their own safe-keeping, because the photos would be erased upon returning the cameras to their owners. I assured participants that the photos they sent electronically to me would be transferred onto a portable USB flash drive and not used in any way other than what was agreed upon and outlined in the participant consent form. I let participants keep the hard copies of the photos that I printed.

### Trustworthiness

In feminist research, the notions of reliability, authenticity, generalizability and consistency of results are not as applicable as establishing credibility through strategies such as audit trails and member “validation” (Greendorfer & Hasbrook, 1991; Olesen, 2000). According to Bray, Lee, Smith & Yorks (2000), relevance and trustworthiness of data in participatory research rests on the commitment to improve the human condition and the active involvement of research participants in the production of knowledge. Feminist participatory action research uses critical approaches that attempt to maintain a democratic research process, acknowledge lived experiences, promote social justice and challenge the highly racialized, classed and gendered power relations that inform dominant ideologies (Reid & Frisby, 2007). While Frisby and colleagues (2005) suggest that it is impossible to remove all power imbalances in participatory research, they maintain that the researcher must be reflexive and conscious of her subject positions and take measures to level out power imbalances in whatever ways possible.

To establish trustworthiness and ethical responsibility in this project, I attempted to maintain a high level of integrity and commitment towards uncovering the silenced voices of the participants, while providing honest, caring and representative

interpretations of the participants' stories. I kept an audit trail of my interactions with participants, and connected with five out of the eight participants at various times throughout the writing process to check for accuracy, meaning, and relevance of the data. Rather than taking an unbiased, objective stance, as is often done in positivistic research, I use a subjective, ethnographic present, first-person voice whenever possible throughout this thesis to acknowledge my personal standpoint and self-reflexivity (Harding, 2007). My shifting and emerging identities, subject locations and knowledge are shaped by my gender, race, class, sexuality, history, age, geography, physical ability and other intersecting variables; therefore, I try to acknowledge these socially constructed influences throughout my interpretations and findings. I provide detailed accounts of my thought processes, oversights, challenges and observations throughout this thesis because I feel that the lessons I have learned are equally as important as other research findings. In addition, I used triangulation, or "multiple methods and theoretical schemes" to cross-check information and gain trustworthiness in this study (Lather, 1991, p. 69). The multiple methods I used were Photovoice methods, group discussions, individual interviews and field notes, which allowed data to emerge under different circumstances and through various thought processes and perspectives.

## RESULTS AND DISCUSSION

### Introduction to Chapters 4, 5 and 6

The results and discussion are separated into three chapters based on primary themes and topics; however, each topic is influenced and intertwined with the other. Such is true with intersectional research. It is difficult to analyze our race, gender and class separately, as if they are unitary factors, unassociated with one other. Multiplicity and ambiguity make us who we are. Many of us live with the everyday struggles of finding out who we are and where we fit in. We are here to explore possibilities for ending these struggles and finding health and wellness within this state of multiplicity. The more we unravel the threads that add to our complexities, the better equipped we will be towards finding a space that is defined *by* us, rather than *for* us.

The next three chapters speak to our realities, which are not all the same, but are grounded in a common desire to seek personal transformation and social justice. The participants have entered this study not only as Sistahs and activists, but as researchers of their own lives. They have embarked on a journey to discover what health and well-being mean to them. Their stories and experiences set the context for an in-depth exploration of the multiple and interrelating constructs that have shaped their identities and their personal sense of health and well-being.

## CHAPTER FOUR

### Race, Racialization and Everyday Racism: Impacts on health and well-being

#### *Introduction*

In this chapter, I draw on the argument that I made (in Chapters 1 and 2) about the need to examine in further detail the concept of social exclusion as a social determinant of health. Rather than accepting this term as simple and given, explained primarily by socio-economic factors and the racialization of poverty, I examine social exclusion as a multi-layered concept, manifested by several exclusionary practices. I present stories and narratives that highlight the complexity of the participants' lives and attempt to understand processes that occur at the intersections of race, gender, class and other social relations amongst participants, on a day-to-day basis. In this chapter, I also aim to contribute to a deeper understanding of the mechanisms of racialization, racism and other forms of oppression as they pertain to the lived realities of the young women in this study and expand upon the existing knowledge that has been generated on social exclusion as a social determinant of various dimensions of health.

#### *Black or White? The Politics of Skin Color*

*“Daily, we feel the pull and tug of having to choose between which parts of our mothers’ heritages we want to claim and wear and which parts have served to cloak us from the knowledge of ourselves” (Moraga, 1983, p.23).*

The above passage by Cherrie Moraga (1983) highlights the daily struggles that racialized women often face in terms of choosing between fitting into, outside of, or resisting the categories that have been set in place by patriarchal, imperialist discourses.

Jenna, a 21-year-old participant who self-identifies as Filipina-Canadian, but was raised in the Southern United States for most of her life, claims that her struggles as a mixed race individual with darker skin began in grade one, when she was forced to identify her ethnicity as either Black, White or “other” on a standardized school test. She states:

It was the first standardized test I’d ever really took and I asked my teacher... ‘what do I do because my mom is Filipina and my dad is white?’ I said something like, ‘I’m both.’ She was like, ‘oh, just do whatever your dad is’...So from grade 1 through maybe grade 7 or 8, I checked White for every single standardized test that I did and like, look at me! I’m not even White!

This passage exemplifies the dangers of accepting pre-defined categories as natural and objective. Several critical race theorists have examined *race* as a construct that has been created through social and historical processes of racialization (Miles, 1989). Through these processes, certain characteristics (whether real or imagined) were assigned specific meanings of superiority or inferiority. These representations have become so normalized that Jenna, who does not even look White, did not question her teacher’s justification for placing her into the White category. Moreover, her teacher’s instruction to choose Jenna’s father’s racial background over her mother’s instils an assumption that male genes take precedence over female genes.

As far as Jenna was concerned, if the state considered her White, she could accept it, especially because being White is more desirable than being considered an “Other.” Had Jenna not been given permission to check off “White,” the five-race framework (Black, White, Asian/Pacific Islander, Native American, Hispanic, Other), which was

adopted by the Federal Office of Management and Budget in the United States, would leave room for Jenna only to fit into the “Other” category (Root, 2002). Jenna learned at a young age that it was more acceptable to fit into one of the pre-determined categories, while ignoring a whole side of herself, than to identify as an “Other.” This sheds light on the system of racialization that forms the basis of power relations in our society. Miles and Brown (2003) define racialization as a “dialectical process by which meaning is attributed to particular biological features of human beings, as a result of which individuals may be assigned to a general category of persons that reproduced itself biologically” (p. 102).

The nation-state’s placement of people into rigidly defined racial categories is a method of social control and racialization, which sets up a social hierarchy that places the creators or enforcers of the system (Whites) in a superior position over racialized “others” (Root, 2002). The state’s ideas on racial categorization are embedded into the dominant values, ideals and attitudes of society, normalizing Whiteness and differentiating non-Whites as “Others” (Essed, 2002). For, Jenna, this had many consequences. Because she identified as “white” on paper for so many years, she claims that she “ignored the fact that [she] was different” up until recently. She gives an example of the sacrifices she has made in the past to fit into a framework of White hegemonic “normality”:

I found that I would do anything to be considered, like normal...I really tried, I like curled my hair and I always wished that I could get blue contacts, I wouldn’t get out in the sun because my mom told me I’d get so much darker, and I have all these other stories. But now that I look back on it, I ignored it so much that I tried to create my own identity for myself that wasn’t true. Like I basically dismissed

the idea that I was even Filipina. You know, I didn't speak the language, I never would tell anybody that I was Filipina. I'd always say like, 'What do you think I am?' and I was like, 'Ok, I'll be that'. I'll be Puerto Rican, I'll be Mexican, I'll be any type of Latina that you want me to be because J-Lo was cool at that point, but I was never Filipino.

Although almost all teenagers struggle with trying to "fit in" and appear "normal," not all are made to feel inherently "different" because of their skin color, ethnicity or race. Racialized youth cannot simply buy a pair of brand name jeans to be seen as "normal." They must contend with the dominant hegemonic norms that brand them as "different" or exotic simply because they are not white. Furthermore, individuals who identify as "mixed race," "bi-racial" or "multi-racial" might find it more difficult to navigate their way through the classification systems, which attempt to establish clean lines between groups (Root, 2002). Root's (2002) *Bill of Rights for Racially Mixed People* asserts that multiracial people must refuse to fragment and marginalize themselves; that they "have a place and a purpose at this point in history to cross the borders built and maintained by delusion by creating emotional/psychic earthquakes in the social system" (p.360). The act of resistance entails declaring multiple racial affiliations and/or ethnic identities (Root, 2002).

This Photovoice project gave Jenna an opportunity to re-define her ethnic identity and share her experiences with others. Her Photovoice piece, shown following, challenges the notion that race can be explained by a simple racial classification framework, and acknowledges her realities of living with multiple identities.



*Figure 1.* Photovoice piece by Jenna, entitled “Trifle.”

This picture represents my favourite foods. It has chocolate chips, strawberries, whipped cream and brownie mix. I find that this somehow reaches me due to my ethnicity as a mixed race young woman. I feel that my multiple identity as both “white” and “racialized or brown” makes it impossible to mix both models or both cultures, even though I try to. I find that I end up layering each identity on top of each other.

Jenna’s analysis of her ethnic ambiguities unpacks the mechanics of racism, oppression and racial categorizations that have forced people to “prove their ethnic legitimacy in order to have an identity in an ethnically diverse society” (Root, 2002, p. 357). In reference to this piece, Jenna talks about the inability to find her “own space:”

I just found it really complex, just like skin politics, how people categorize you, it’s like there’s no grey area, there’s no area where I felt like I could fit cuz it’s like I can’t be Filipina because I have all these other features, but yet I can’t be white...It’s like well I can’t be white, I can’t be other, per se, or racialized cuz I’m

somewhere in between and it's like there wasn't an area left, there's no little space for me.

The pressures that Jenna faces to fit into one category or another, while feeling like there is nowhere that she actually belongs can be considered a mechanism of social exclusion, which can have various impacts on her mental, social and emotional health and well-being (Reid, Frisby, & Ponc, 2002). The next section further highlights some of the ways in which daily forms of racialization, racism and oppression impact the health and well-being of participants in this study.

### *Everyday Racism*

According to Philomena Essed (2002), "everyday racism" is embedded into familiar practices, socialized attitudes and behaviours, and is defined not only by "acts" but also by complex relations of acts and attitudes that are prevalent in a given system. She explains that everyday racism permeates throughout "systematic, recurrent, familiar practices" and that it "connects structural forces of racism with routine situations in everyday life" (p.177).

Sometimes it is easier to passively accept, ignore or internalize the mechanics of racism, discrimination and oppression than to resist and challenge them. Whether it may be because we lack the energy, confidence, support or language to battle against injustices, the repercussions of internalizing racism can gravely affect our health and well-being. For example, Edmonds (2001) states that amongst members of the Black community in Nova Scotia, the effects of ingrained racist judgments and behaviours are one of the most severe obstacles to achieving optimal health. She contends that internalized racism has the potential to interfere with self-confidence, personal

relationships and a person's ability to get an education (Edmonds, 2001). Furthermore, the fears and difficulties of speaking up against racism, combined with the repeated experiences of being personally devalued, can contribute to an accumulated stress that may lead to physical health issues such as diabetes, thyroid problems and other chronic diseases (Edmonds, 2001).

Several participants in this study mentioned feeling frustrated and upset with themselves and at others when they were unable to explain, justify or name the racist or discriminatory mechanisms that caused them to feel angry or indignant. For example, Jenna spoke about an experience she had speaking about anti-racism at a conference sponsored by an international development agency. When a well-intentioned White, middle-aged Canadian man raised his hand and claimed that he could relate to being racialized because when he went to Britain, everyone commented on how his accent was different, she found it difficult to respond because she did not feel that his experience was at all similar to the racism and oppression that women of color face on a daily basis. At the time, however, she could not find the words to effectively express these feelings in front of an audience without either embarrassing the man or herself. She decided that instead of speaking back to his comment, she would let it go, thereby internalizing a sense of frustration and disempowerment. She comments: "It's really hard to get over that lump and it's frustrating as a racialized individual to sit there and go, [sigh], is it even worth talking about sometimes? And I left there and I felt very despaired."

Incidents like these, which may occur on a daily basis, can ultimately affect our mental and emotional health, making us feel silenced and hopeless. On a similar note,

Jessica, a 28-year-old participant, talks about her lack of confidence in expressing her concerns effectively about a comment that made her feel indignant:

A comment like that can really make you go crazy. You know, like my problem is when I just regret so much that how come I couldn't come up with a better response?...Either something bad would come out of my mouth or I would get overly, like I would overact, and then blame myself for overreacting or something. Or just like, how come I didn't think of a better way to respond or a smarter way to defend myself?

As young, racialized women, we often doubt our own intuition and tell ourselves that we are being overly sensitive because there are very few people, especially in Victoria, who experience similar realities to our own. As a result, we may internalize our negative feelings and become isolated. According to Reid, Frisby and Ponc (2002), social exclusion and feeling socially isolated can lead to excessive psychosocial stress and the adoption of health threatening behaviours.

In this study, I found that social isolation and exclusion can arise from feeling unsupported or tokenized amongst a group of people. Twenty-four-year-old Susan told a story about how she recently felt indignant when somebody at her office made a racist comment during a meeting: "I felt indignant because, I think, there wasn't any reaction from the group. Nobody supported it, but nobody came to my defence at the time."

It is not uncommon for people, both racialized and non-racialized, to clam up in awkward silence when they sense that a racist remark has hurt someone. For a white person to defend a racialized person who has been discriminated against, it might require them to recognize their privilege and risk surrendering power. As Cherrie Moraga (1983)

writes in *This Bridge Called My Back*, “I have come to believe that the only reason women of a privileged class will dare to look at *how* it is that *they* oppress, is when they’ve come to know the meaning of their own oppression. And understand that the oppression of others hurts them personally” (p. 33). By choosing not to act against discrimination, Susan’s coworkers were not only contributing to her marginalization and internalization of the racist remark, but also hurting themselves. Moraga (1983) further explains that racism stems from the oppressor’s fear of similarity; that he, too, will discover in himself the pains and longings of the people he has hurt. She also highlights the need for White women, and not only White men, to become conscious of their privilege and their oppressive power. Moraga (1983) writes: “As third world women, we clearly have a different relationship with racism than white women, but all of us are born into an environment where racism exists. Racism affects all of our lives, but it is only white women who can “afford” to remain oblivious to these effects. The rest of us have had it breathing or bleeding down our necks” (p. 62).

### *Cultural Essentialization*

Susan’s complex identity is further layered by the ways in which people essentialize her cultural identity. For example, at Susan’s job, where she worked amongst international students, her ethnicity was often called into question:

The Chinese students or the Korean students or whatever will say or assume that I must be from, that I must be Chinese or Korean, or even Japanese sometimes. But nobody will ever think, oh, she’s from Thailand. And fair enough, because I don’t look like that, but even when I do tell them that, it’s like, oh but you must speak some Chinese... then I think, well maybe I should be able to?

Susan also spoke about feeling essentialized by people of her own ancestral background in Vancouver's Chinatown.

I'd be like afraid to go into Chinatown...in Vancouver and walk around and buy things because they'll automatically try and speak Cantonese to me and you know, I can't speak Cantonese, really, and I didn't really get a good vibe...and that's when I thought, you know, this is a really weird situation.

I, too, can familiarize with being essentialized based on my physical appearance and ethnic origins. I found understanding from Anita Sheth and Amita Handa's (1993) essay which unpacks the invention of the term "Indian." They state: "I don't understand the contestation over the category India/n, I understand it to be purely ideological...It was invented in the course of people living in a racist environment..." (p. 77). Sheth and Handa's analysis of the essentialized "Indian" identity demonstrates that there are so many contradictions within the concept of India/nness that fracture and fragment the commonalities that are associated with this essentialized category. Their analysis can be applied to Susan's multiply layered "culture" and "ethnicity" which can be seen as contradictory to her physical appearance, transnational upbringing and educational background, among many other aspects of her life.

Uma Narayan (1998) uses the term "cultural essentialism" to denote the construction of sharp binaries between "Western" and "non-Western" cultures. She maintains that cultural essentialism often equates "the values, worldviews, and practices of some socially dominant groups with those of 'all members of the culture'" (p. 88).

PP, a 28-year-old participant who has an Iranian background, also experiences cultural essentialization in dealing with Islamophobic racism at the everyday level. She

notes that racial profiling and discrimination were particularly problematic surrounding the time of September 11, 2001:

When everything happened with September 11, people would talk, judge, you know, ask you your religion, you know, your brothers, or just judge that you are terrorists...at my work...my boss said, 'So did you hear about the 19 terrorists that got arrested in Toronto yesterday?' I was like, 'Yeah, that sucks.' 'Were they your cousins?' In front of everyone, you know, and I'm like, wow...that's the time that I was getting so many comments about terrorists and bombing and my brothers had problems, or my brother, he has an American girlfriend, so going over the border, they were really mean to him all the time and almost made him cry and things like this.

The fact that PP's boss probably did not intend on embarrassing or hurting PP by his comments and assumptions is what makes this type of racism even more frustrating to contend with. Edward Said's (1978) theories on Orientalism have often been used to analyze Westerners' fears and assumptions about the Middle East and the "Orient." His work suggests that the "Orient" is a fictitious invention of the European imagination, whereby experts – usually scholars, professors and artists in the era of European imperialism, imitated or depicted aspects of Eastern cultures and peoples, essentializing them as mysterious and exoticized "Others." Said also argues that current discourses on culture, which should be understood as ideological, have created a divide between East and West, situating the West as a superior culture to the East. The assumptions that people in the West often have about Islamic countries, particularly post-September 11<sup>th</sup>, are unwarranted and harmful to society.

PP describes how her experiences of being the target of racial discrimination, labelled and stigmatized as an “Other” have had major impacts on her health:

It always made me so angry, and you feel very alone, you feel like it’s a war actually, you know, like you are part of this country, you belong, you work, you want to make it better, but you’re still not the same. So it made me very, very skinny, it made me very sick, just because I was angry all the time.

Said’s (1978) theories of Orientalism can also apply to the everyday forms of racism that have attempted to exoticify and ostracize Dawn, aged 24, who talks about the experiences she has had in the lunch room at her workplace in Victoria:

I would bring my lunches and they would be like you know, rice or like noodles or you know vegetables and maybe a little bit different from everybody else’s lunch, and there’s this guy who constantly makes interesting comments about my lunch...he would come up to me...and say, oh [Dawn], you always have these exotic lunches...I sometimes feel like, ‘k maybe I should try having a sandwich because everyone else is having it. And you know, when I do have a sandwich, I feel like a small, small part of me is like, ok I finally feel like I’m fitting in with everyone else who’s eating a sandwich.

Dawn’s story highlights ways that culture, which can be represented by food, is essentialized by dominant discourses and conceptualizations of belonging (explored further in chapter 5). Her story also shows how the attitudes and beliefs stemming from these discourses govern the ways in which racialized women must often bend and twist in order to “fit in,” for a reluctance of being questioned or depicted as “different” or inherently inferior. In turn, the sacrifices we make can affect our health and well-being,

not only through the foods that we eat, but by how we view and value ourselves in relation to how we are ranked in the social hierarchy.

*Contending with Stereotypes*

The next Photovoice piece by Rebecca, a 27-year-old participant who identifies as Métis, elaborates on the feelings of frustration and confusion that she faces when contending with the stereotypes surrounding her authenticity as an Indigenous woman.



*Figure 2.* Photovoice piece by Rebecca, entitled “My Reflection.”

This photo of myself deals with ‘Indian’ stereotypes. When I look at my own reflection I ask myself, ‘who am I?’ ‘Am I healthy? What is that to me?’ Right now I feel that being healthy is about accepting who I am and getting rid of the shame. Sometimes I do wonder if I have native physical characteristics. Do I look native enough? Then I stop myself and ask why should that matter? Blood quantum seems to always come up in conversations with people about my Métis ancestry. I have to deal with questions like, “So how much native blood do you have in you?” When people see my tattoo they then ask if I am native. Once I tell them that my father is Métis, they respond with “Oh, yeah, I see the native in you!” This drives me crazy! Why should it matter if I look native or not? We have

been bombarded with a specific stereotype of aboriginal peoples – long black, braided hair, dark eyes, high cheekbones, dark skin. We see these images on the television and at tourist gift shops. My skin color should not matter nor should my blood quantum. I am Métis, a half-breed.

The questions that Rebecca raises in this piece, “Do I look native enough?” and “Why should that matter?” highlight the struggles that many racialized people face, whether mixed race or not, in regards to their identity. In Maria Root’s (2002) *Bill of Rights for Racially Mixed People*, she writes:

Countless number of times I have fragmented and fractionalized myself in order to make the *other* more comfortable in deciphering my behaviour, my words, my loyalties, my choice of friends, my appearance, my parents, and so on....fragmenting myself seldom served a purpose other than to preserve the delusions this country has created around race. (p. 355)

Rebecca expresses frustration over people’s need to identify her race or ethnicity and the lack of choice she has in responding to their questions. When we are being probed about “what we are” or “what nationality our parents are,” we are being asked to confirm the enquirer’s stereotypes and “buying into the mechanics of racism” (Root, 2002, p. 355). Root proposes an affirmation of “rights” that people of mixed race should remember in order to “break the spell of the delusion that creates race to the detriment of us all” (p. 358). The frustration that Rebecca feels is addressed in Root’s proposition: *I have a right not to justify my ethnic legitimacy*. Root claims that “tests of ethnic legitimacy are always power struggles” and that “those who initiate such struggles usually win, because they create the rules – or change the rules to suit themselves” (p.

361). She draws upon the work of Paulo Freire (1970) in her assertion that “anyone who unquestioningly accepts these tests, begging for acceptance, remains a prisoner of the system” (Root, 2002, p. 361).

Rebecca also expresses annoyance with stereotypes that people often use to affirm their understandings of her Nativeness:

People expect, you know, if you have the dark hair, the dark eyes, dark skin, that oh, ok, you are a Native. I even have some friends who have like blue eyes and blonde hair and they’re Cree and stuff like that...but I was talking to somebody a little ago about it and then he looks at me and he says, yeah, I can see that you’re native. And I was like, what? It’s not, like, about that, you know? Like I don’t know, I’m hearing that more and more...and yeah, I find it really frustrating.

*Taking on the tools of the oppressor*

It is not always easy to resist stereotypes and name the reasons why we feel frustrated, confused and ashamed because of our “race.” The denial of our ancestry, cultural roots, ethnicity and history was an important theme in this study. For Rebecca, her feelings of shame over her Aboriginal ancestry were confounded by the privilege of being able to “pass as White.” She explains how her light skin color helped her deny her Native ancestry and gain power over her sister:

I never wanted to associate with being, you know, an Aboriginal person because I saw how they were, and I was like, I’m not that at all, and so I was quite lucky that I had the lighter colored skin, whereas my middle sister, she’s got the long dark hair, the dark eyes, and the very dark skin and I remember as a child, saying, and I still feel horrible, but telling her her skin was dirty...And she still, like I

know, I scarred her, she went to the bathroom when she was maybe like 5 years old and had one of those scrubby things and was like scrubbing her skin...I still feel horrible doing that, but yeah, that's kinda what that picture brings out is yeah, dealing with my ancestry, the denial of that.

The above narrative shows how we often mimic the dominant discourses that oppress us and how we may become as harmful as our oppressors. As A. Tijerina (1990) writes in *Making Face, Making Soul*, "We take from the oppressor the instruments of hatred and sharpen them on our bodies and our souls" (p. 172). This quote refers to the ease at which we internalize the strategies that our oppressors use to gain power over us. When we try to adhere to the dominant hegemonic norms, we often sever parts of our identity and become self-hating individuals (Tijerina, 1990). When we submit ourselves to the power of the system instead of resisting it, we can become as dangerous as our oppressors (Tijerina, 1990).

#### *Chapter Summary*

The main finding in this chapter is that processes of racialization, racism and racial discrimination affect the health and well-being of racialized and Indigenous women on multiple levels. The first theme in this chapter indicates a structural mechanism of racialization, whereby the placement of people into rigidly defined racial categories sets up inherent contradictions and confusions for "mixed race" people. Jenna shared stories about her feelings of exclusion, as she has tried to negotiate her multiple locations inside and outside of the racial categories that do not accommodate her realities. The next theme presents examples of ways in which everyday forms of racism socially exclude and affect the health and well-being of participants in this study. Jenna, Jessica and Susan tell about

instances where they have not been able to find the words, energy or support to rationally defend themselves against the perceived injustices. PP describes how she felt during the time of September 11, 2001, when she and her family felt the heightened effects of islamophobic racism. Dawn explains how she felt exoticized and “othered” when she brought non-Western lunches into her workplace. And finally, Rebecca’s Photovoice piece expresses her frustration over having to justify her ethnic authenticity and to contend with stereotypes surrounding her Aboriginal identity. She shares a heart-felt story of her past, and how she translated the shame she felt about her native ancestry into oppression over her darker-skinned sister. These instances stem from overarching racist attitudes and beliefs that are embedded into state policies and systems, and underlie what the social determinants of health literature terms “social exclusion.” Some of the effects of everyday racism, as reported by the participants in this study, can include desperation, low confidence and self-esteem, physical sickness, depression and social discomfort, all of which are valid health concerns that are often overlooked by mainstream health models. The next chapter explores social exclusion as it relates to the notions of living “in-between” worlds.

## CHAPTER FIVE

### Living Between Worlds: Exploring Health, Identity and Belonging

#### *Introduction*

In this chapter, I further explore the daily experience of participants, but focus more on the notion of living “between worlds” as another dimension of social exclusion. Most of the participants express in some way that being in a constant state of limbo has varying effects on their health and well-being. Although many young women struggle with finding their own identity and space, especially during the years leading up to adulthood, the young women in this study not only contend with the intersections of age, gender, race and class, but their identity formation processes are also intertwined with issues of migration, language and transnationalism, among many other factors. This chapter speaks to the realities of participants who often feel the ongoing tensions and contradictions of negotiating between more than one cultural, ethnic or national identity. It also challenges mainstream understandings of the “immigrant experience” and draws links between their unique searches for belonging and social exclusion as a social determinant of health.

#### *The social construction of the “immigrant woman”*

For most participants in this study, migration between countries and transnational experiences are integrated into their everyday realities, identities and concepts of health and well-being. Most participants who speak of migration express a variety of feelings and impacts, including disappointment, shock, uprootedness, family hardship, transition and acculturation. However, the health literature tends to overlook the diversity in the experience of migration, in part, by inserting all women who migrate to Canada into the

category, “immigrant” women. By drawing on the narratives and photos of study participants, I want to challenge the homogenizing effects of this term. Within the group of participants that can be considered “immigrants” to Canada, there is significant variation in history, experience, religion, class, transnational movement and ethnic status within the countries from which they emigrated. This counters mainstream beliefs that immigrants are a unitarily defined group of people who have emigrated from a fixed country of origin to Canada, which becomes their permanent new home.

Immigrants, especially those who are women, are often essentialized as “others” and are assumed to face similar problems of adjustment and settlement (Lee, 1993). This myth of otherness that is associated with immigrant women can become internalized and often prevents researchers from recognizing “immigrant women” as a socially constructed category (Lee, 1993). Ng (1989) argues that until a woman immigrates to Canada, she does not see herself represented as an “immigrant woman” in the way that this social category is perceived by Canadians. This category is “materially reinforced through laws and state administrative policy,” thereby causing her to depend on this “immigrant” identity as a means of survival (Lee, 1993, p. 34). The consequences of labelling women as “immigrants” are similar to the outcomes of racialization. Women are positioned unequally according to their physical characteristics, language skills, country of origin, length of time in Canada, educational background and professional qualifications (Lee, 1993).

By hearing the stories of the women in this study, I learned that only one participant (Jessica) who immigrated to Canada was a member of the dominant ethnicity in the country in which she last resided. The other six participants who immigrated to

Canada experienced being members of minority cultures in the countries in which they last resided. This observation points to the emergence of diasporic and hybrid identities as new technologies and communications that are congruent with the rise in globalization facilitate the mobility and transient nature of migrating individuals and communities.

In this chapter, I attempt to draw on aspects of transnational and post-structural theories to understand the ever-changing identities of female migrant subjects and analyze the issues they face in terms of health and identity. These analyses attempt to dispel the myth that all immigrant women face similar health issues and concerns when settling or adapting into a new environment. The stories that participants share draw attention to the uniqueness of their intersecting realities and validate the need to bring an intersectional lens into the study of health amongst racialized, Indigenous and immigrant women in Canada.

#### *Living a “double life”*

The notion of living a “double life” was brought forth by Dawn, a participant who is familiar with the complexities of transnational migration, cultural adaptation, being a part of a second generation diasporic community, and having more than one ethnic/cultural influence. Her experiences with migration differ from dominant immigrant health perspectives that view immigrant youth as being caught at the crossroads between assimilating to the dominant societal norms and retaining the cultural values of the home country (Handa, 2003). Several immigrant health studies embody a “cultural orientation” perspective, placing Asian “collectivist” and North American “individualist” cultures in binary opposition to one another. Dawn’s description of living a “double life” must be carefully nuanced from the cultural orientation model’s dichotomous views of culture.

The following piece by Dawn explains how her notion of “living a double life” is linked to the idea of liminality, or living in an “in-between” space:



*Figure 3.* Photovoice piece by Dawn, entitled “Compass in the Sky.”

I love the fact that the compass is situated in between the two tall buildings. This, in my mind, is the perfect symbolism for my journey – living in the liminal. The liminal space is where I sit, speak, thrive, trash, ponder, explode and sometimes just breathe. What I mean by liminal is that it is basically the in-between, the just-there-but-not-quite, the “this and that.” It is where uncertainty dwells. In the liminal space, one is inclined to be lost because the boundaries are not well-defined. Such is true for my life, where the path is not so certain. It can be, but it also can’t. My identity is divided, and so are my decisions, inclinations, relationships.

The “liminal” space that Dawn refers to is described by postcolonial theorists and feminists of color as the “third space” (Anthias, 2002; Bhabha, 1994; Runyan, 2003). This is a space of ambiguity and hybridity, where the boundaries between “same” and “different” are not so clear (Runyan, 2003). Bhabha (1994) notes that by exploring the

space of liminality, “we may elude the politics of polarity and emerge as the others of our selves” (p. 66). In the Third Space, common binaries, such as universal and particular or local and global become melded together, and there is no longer a simplistic way of categorizing someone as one thing or the other (Runyan, 2003).

Gloria Anzaldua (1987) calls this space the *Borderlands/La Frontera*, signifying the space where “two or more cultures edge each other, where people of different races occupy the same territory, where under, lower, middle and upper classes touch, where the space between two individuals shrinks with intimacy” (p. 1 of preface). This narrative is mixed in genre, language and nationality; it is complex and contradictory (Anzaldua, 1987). Anzaldua (1987) describes her borderland as “a vague and undetermined place created by the emotional residue of an unnatural boundary” in “a constant state of transition” (p.3). Although the Borderlands represent a place of discomfort and contradiction to Anzaldua, she asserts that there are also numerous compensations and joys for the *mestiza* (her hybridized identity). She describes that “there is an exhilaration in being a participant in the further evolution of humankind, in being ‘worked’ on” (Anzaldua, 1987, p. 1 of preface).

For many people, however, this pride and exhilaration that Anzaldua expresses is not easily attained. Rather than struggling to achieve a middle ground as Anzaldua has proposed, it is often easier to “fit in” or gain approval within these dominant discourses. We only become conscious that we are selling ourselves short when they try to erase the “difference” that exists between us, rendering us protective of the parts of our identities that distinguish us from the dominant society. Runyan (2003) states, “the difficulty lies in how to actuate a third space, how to conduct a politics that neither suppresses difference

nor reduces it to ‘the liberal emphasis on equality’ that fails to recognize injustice, oppression, and power imbalances among women” (p. 69). This third or “liminal” space is constantly changing; it is neither universal nor easily defined.

### *Liminality and Health*

Dawn explains how the notion of leading a “double life” and living in a “liminal space” involves psychological division, which can lead to negative effects on her health:

The whole sense of being between two worlds...I find for myself that it’s something that I deal with every single day...I think that for me that’s probably the single most important thing that I have to deal with and it affects a number of areas in my life that you know ultimately affect my health...just being psychologically divided, and how do we negotiate that...by virtue of being racialized you’re going to experience that psychologically and it has implications on our health. Like most obviously mental health, but there’s also social health, and then and in some senses, like, our relationships as well.

Dawn elaborates on the notion that her health is tied to the quality of her relationship with her mother: “If say, you know, my mom and I are not doing so good I tend to feel down and like confused and sad and kind of helpless as to what to do and I tend to not feel very good about myself.”

Young racialized women often have difficulties finding comfort in the “liminal space” because it may be a space that is largely unexplored and hidden by discourses that force us to choose one identity or another. We not only face pressures from our parents to make the right choices and be “good daughters,” but we may also struggle with trying to break free from the stereotypes and expectations that society has of us. Residing in this

in-between space brings discomfort and contradiction, but it is often necessary to remain in it until we can transform it into our own space. The search for this space of belonging and comfort usually coincides with a search for health, wellness and a positive sense of self.

*Multiple Identities, Finding Balance and Self-Acceptance*

Negotiating between multiple identities is not unique to transnational migrant subjects. The notion of living a “double life” is also experienced by Rebecca, a self-identified Métis participant, who claims that her health and well-being are dependent on the acceptance of her whole self. In the following piece, Rebecca describes the feeling of not being fully accepted as a Métis and an artist by her ex-partner, and how this took a toll on her health and well-being.



*Figure 4.* Photovoice piece by Rebecca, entitled “Love Me If You Dare.”

The photo of the videos, to me, represent taking time for self care. The stresses of academic life tend to throw my life out of balance as a result I forget about me. A very important part of my life is my involvement with the aboriginal community, on-campus and off campus. I want to assist with change, but sometimes I give too

much. This year, I have made the choice to take time to watch movies, on my own. The majority of the films that I rent are rather artistic. A year ago, I struggled with ‘that part’ of me – the artist. The creative self was hiding and now I am finally exploring my creativity. There are times when I still struggle with myself. I must remember to love – self. I also have the yearning for someone to love me for who I am. I had a previous relationship where my partner did not want to accept that I was Métis and an artist. This had a negative impact on my health. I internalized everything and forgot to take care of myself. My life was out of balance and now I’m trying to find that balance. The image is blurred because sometimes I feel like I am living a dream. I am finally waking up from a deep sleep.

Not only does this piece refer to the awakening and acceptance of different parts of Rebecca’s identity, but it also points to the fact that productivity and the constant need to prove our worth as minority women in Canadian society can be overwhelming at times. Rebecca reflects further on this past relationship and the Photovoice piece:

I was thinking about our relationship and how we really struggled because it’s only been in the last few years that I’ve started to identify as, or I, yeah, identify as being, uh Aboriginal. And he just couldn’t get it, he didn’t understand it and he was part of my life...when I was going through this process, and it was almost like, you were talking about a double life, and like, I was living that double life. I was really involved with the Métis community, I was involved here on campus, but my boyfriend never came to any of those things and we’d have our own friends, but then I’d also have my other life that was going on and they never

intersected, and then there was one time that it that's when I knew him and I just couldn't be together anymore.

Rebecca's comments point to the inherent difficulties that are involved in joining separate parts of our lives and identities. These difficulties may have been intermingled with gendered power struggles, whereby her ex-partner's refusal to accept Rebecca's multiple identities was a form of control over her. The notion of living a "double life" in Rebecca's case refers to the restrictedness, disintegration and unnaturalness that came from trying to separate her life into silos. This type of lifestyle can only go on for so long before feeling stressed and unbalanced.

The stories that Rebecca and Dawn share indicate that as women, we often seek approval from our parents, our partners and others around us. Our difficulties are compounded by the intersecting dynamics of race, class and age, among other social constructs. In addition, the challenges that Rebecca and Dawn face with trying to separate parts of their identities are somewhat metaphorical to the difficulties that intersectional research presents. While an intersectional approach provides a more realistic and comprehensive understanding of the whole self, it may be more difficult and complicated to adopt than simply viewing gender, class and race as separate entities.

### *Multi-National Upbringing*

The experiences of living between worlds can be further complicated by growing up in several different countries around the world. The problematic nature of "immigrant health" paradigms, which focuses primarily on the settlement and adaptation experiences of "newcomers" who have moved permanently from a country that is linked to their "ethnic" origin to a new country, is evidenced by Sushma's experiences of having lived

in five different countries prior to moving to Canada six years ago. Sushma highlights incidences where she experienced racism growing up and claims that she “was always the outsider.” She elaborates on the feelings of exclusion and discrimination that she faced in her childhood:

Children are cruel. Very obviously and they’re honestly cruel. So in Yemen, I was in a Dutch school...where at some point, there was no disintegration between us, but then there was one family that came where the children were very racist, and not even aware of racism. They would exclude me. In Holland, I was teased for being brown...then when I went to Ethiopia I was a tougher person but there it was really hard because there suddenly I was too white and I wasn’t brown enough and I was targeted...and they would talk about me, making it obvious, too, they were talking about me, but not, and it was really really hard.

Sushma was educated in an international school system, where she claims that there were “very stringent rules” against racism and exclusion. She says that the school took great care in dealing with matters of racism, and the support and protection she received from the teachers and the school system made her feel very empowered. She explains that because of this empowerment in her youth, she has learned to become stronger and more defensive: “So I’m on the defensive and I’m always aware and I’m always critical, so I don’t think they can even get the chance to hurt me that way.”

Upon moving to Victoria, Sushma says that she encountered less overt racism here than elsewhere in the world:

And here is the one place I haven’t felt active racism against me. I know there’s racism against my peers and I notice and am critically aware of systemic and

systematic racism, but I was never targeted...Because I'm older here the racism that I might encounter, I don't, because it's more hidden. And people are polite here.

Here, Sushma is comparing her experiences of "overt racism" abroad to more concealed versions of racism in Victoria that she does not necessarily associate with being racist. I extrapolate this idea from the contradiction she makes in the next statement, which reveals that she does, in fact, struggle with certain stereotypes that exist in Victoria: "But I do find here that I get bunched in with east Indians, and I don't like that, because I'm not East Indian, I'm Indian. They're different..."

She also writes in her journal: "I struggle with being grouped as an East Indian, Sikh, Punjabi, oppressed woman from a hot country. I am none of the above."

Sushma's stories indicate that even she, as a racialized woman with multi-national experiences, is socialized to focus on the type of racism that is targeted and ill-intended. Her contradicting statements emphasize the fact that it is the more subtle forms of racism that are the most difficult to comprehend because they are often masked by politeness.

Next, Sushma distinguishes her experiences as a transnational migrant subject as different from those of others who may identify more with the dominant Canadian culture:

And you know, I'm not, I don't have the dilemma of being born and brought up in Canada and feeling Canadian and being told I'm not. That's a completely different ball game. That's, you know, they're taking your identity away from you. And nobody can take mine away. It's been formed by my family and by my friends...

Sushma explains that although she can relate to the experiences of racialized young women living in Victoria, she feels that her racialization is imposed upon her by people of her own ethnic culture: “So I found that I didn’t really feel that I was being put in a race by quote unquote white people, the mainstream, but I felt that I was being racialized by my very own people and by quote unquote east Indians.” Sushma’s Photovoice piece, “the Romantic Associate” further describes this feeling of being racialized by her “own people:”



*Figure 5.* Photovoice piece by Sushma, entitled “The Romantic Associate.”

My [boyfriend] and a cat. Both utterly disapproved of by my parents. The former more than the latter. My health is taken away from me because that, which I believe heals me, is considered wrong. I am negatively racialized by my own culture. Having lied about [my boyfriend] for 2 years left me an emotional and physical wreck. I am now better because my parents know, disapprove, but accept. This beautiful young man is still classified information from the rest of my family. The hypocrisy and narrow-mindedness is revolting. The worst of it is: I

cannot share my life with my own people; they push me away to where I do not belong.

The contempt that Sushma seemingly holds towards the “narrow-mindedness” and “hypocrisy” of her culture causes her to distance herself from it in much the same way that Western ideologies promote the “cultural conflict” theory. This theory portrays second-generation South Asian young women as being inherently in conflict with their parents, who are perceived as being overly protective, strict and unreasonable. To provide an alternative perspective, I turn to Amita Handa (2003), who unpacks this “cultural conflict” theory:

Keeping in mind that the centrality of whiteness and the West relies on the construction of the ‘other,’ it is possible to see that discourses about immigrant culture conflict in Canada help to position and protect the fiction of white/Western superiority. (p. 164).

She argues that the “culture clash is not an ethnic phenomenon” but that it is instead a “clash between the cultures of traditional and modern” (p.36-37). Handa (2003) further explains that “the ways in which we understand the concepts of youth and women in relation to East and West are very much a product of the modern era” (p. 36) in that White, middle-class parents in the 1950s also feared that their children would be corrupted by modern social progress and its possible “dark” side. She compares these anxieties surrounding white youth in the 1950’s to how non-white immigrants are positioned today; being seen as potentially volatile and in need of protection and guidance. She suggests that South Asian women, in particular, “are seen as in need of protection not only because of their age, but because their culture is seen as threatened by

erosion,” and this often justifies various forms of social control and restrictions placed on women (p. 37). Furthermore, ideas of womanhood in India have become “inseparable from a politics of cultural authenticity, preservation and Indian identity itself” (Handa, 2003, p. 38).

Sushma’s Photovoice piece, *The Romantic Associate*, depicts complex feelings and emotions that are associated with the negotiation between multiple values, traditions and identities. The turmoil and contestation that affect Sushma’s health and well-being are highly gendered, ethnicized, cultured and classed. The sense that her relationships and lifestyle are not supported by her parents or her culture, are exacerbated by the dominant discourses, which support the notion that her parents’ ethnic values surrounding gender roles, dating and lifestyle, are backwards and archaic.

#### *Assimilation Anxiety*

During a follow-up interview with Dawn, she offered the term “assimilation anxiety” to refer to the feelings that are often falsely construed by the “cultural conflict” or “cultural dissonance” theories that Handa (2003) has criticized. She says that she uses the former term because it focuses on the internal processes that affect her health and well-being, whereas the latter implies that there is a dichotomous, oppositional relationship between the two cultures.

In reference to Sushma’s Photovoice piece, *The Romantic Associate*, Dawn comments on the pressures that she, too, has felt from her parents:

My parents brought the family here I guess so that we could learn to speak English, not that we didn’t [already know how to speak English], but, I guess, learn how to be white and you know get a white education and be in the white

culture, but when we embraced some aspects of whiteness, they were baffled and shocked. They were like, ‘what happened to you?’

Dawn continues to explain that the disappointment her parents felt with the family’s migration to Canada are related to being misled by the notion of the “American Dream,” which promotes the idea that anybody who possesses the initiative and work ethic to get ahead will have an equal opportunity to succeed in American society (Zhou & Lee, 2004). This ideal, which has transcended into Canadian society, gave way to major shock and regret on her parents’ part when they realized that discrimination was rampant in Canada and “equal opportunity” was a myth. She states:

It’s interesting how the dominant perception that the West is better, the West is cooler, worship the West, you know, inform my parents’ thinking. They thought the West was better, the West was cooler, and to come here and be disappointed and to find out it’s not really what it’s cracked up to be, or it did not meet their expectations...Right now, the transition my family’s going through is actually coming to terms with the fact that we’ve migrated. And it took my parents maybe like 12 years...

Dawn also discusses her family’s lack of preparation for the transformation that took place once they moved to Canada:

[My parents] actually regret the fact that we immigrated and my dad thinks it’s like the biggest mistake ever and because they’ve lost us...My sister and I were not really prepared for the transformation that took place as well, and it’s a constant process of negotiating and really doing the double life thing, which

sometimes you can do skilfully and not others and sometimes you just want to break out of it.

I find it interesting that in thinking of her own health and well-being, Dawn provides examples of her parents' shock when they discovered that she and her sister had embraced elements of Whiteness, her parents' disappointment with the migration to Canada, her parents' continual "transitions" and her parents' lack of preparation for the move. I find that each of these examples points to her parents' assimilation anxieties as much as her own. The difficulty for Dawn, however, lies in trying to separate herself from her parents' anxieties while negotiating an in-between space, where she can retain both a healthy relationship with herself and with her family.

#### *Ambivalence*

Susan has lived in Thailand, Hong Kong, Indonesia and Communist China before moving to Victoria, where she has resided for four years, apart from her parents. She, too, dealt with parental anxieties surrounding her espousal of Western cultural aspects. She states: "I remember when I was growing up my mom saying, 'We put you in a British school because we wanted you to speak English, but we didn't want you to be White. We didn't want you to be *Farang*.'" [*Farang* means "foreigner" in Thai].

The photo she entitles, "Mum and Dad in a Frame," represents the distance she now feels from her family and upbringing. The subjects of this photo were not available to sign the image release form; therefore, I have blacked out their faces to protect their anonymity.



*Figure 6.* Photovoice piece by Susan, entitled “Mum and Dad in a Frame.”

This photo of my parents was taken during their first trip to Victoria and to Canada after I had lived here for 2 years. It had been a momentous trip as I think it was then that they realized that I had established a life and identity that was very different and removed from what they had built for me. I grew up moving around and living in different countries. Home to me is not a physical place as it is the people and atmosphere. I remember thinking how remarkable it was that shortly after my parents had arrived and settled into the house that I felt that I was home again. Mum was tidying and arranging things again while Dad was checking stocks and the news on my computer and cutting up fruit. This photo is framed and sits on my desk as a reminder of what home is to me. Familiar and comforting but something I wanted to be neatly packaged and at an arm’s length. At least for now while I sort myself out.

This piece sheds light on the notion of family, home and identity in relation to health and well-being. Susan’s lived realities demonstrate that there are no fixed

meanings or concepts of home. Just as the geographical boundaries that control what we typically perceive as “home” can fluctuate, so can the borders we place around our definitions of health and identity. The familiarity and comfort that Susan feels when she is in the presence of her parents are juxtaposed against her wishes to keep them “at an arm’s length.” Although Susan does not critically analyze this ambivalence, I feel that it relates to her experiences living in a “liminal space,” similarly described by Dawn. She mentions on more than one occasion feeling uncomfortable with the idea that her transnational upbringing was not conducive to a “neatly packaged” culture, ethnicity and identity. For example, she writes in her journal: “After a life of instability, I think I crave routine and normalcy in my day-to-day life.”

So far, the themes of liminality, multi-nationality, assimilation anxiety and ambivalence have woven into a central theme of identity, characterized by uncertainty, hybridity, multiplicity and contradiction. Health and wellness amongst participants in this study are influenced by the awareness and negotiation of various discourses. The next theme describes a participant’s search for a more stable identity, one which represents certainty and belonging despite her negotiations between differing ideals of nationalism, language and citizenship.

#### *A search for certainty*

This theme surrounds Jessica’s shifting locations as she searches for belonging, identity, health and wellness. In contrast to the common assumptions linked to “immigrants” in Canada, most of the participants in my study who migrated from countries where English was not the first language, were fluent in English before arriving. During the focus groups, nobody brought up *language* as a contributing factor to their

health and well-being. It was not until after the debriefing session that Jessica approached me and asked if we could meet to continue our discussions from the project. During our interview, she told me that she was unable to express herself fully in the group sessions because she is and always has been self-conscious about her English language abilities. She revealed to me that she felt that this barrier set her apart from the rest of participants, who all seemed extremely articulate and well-spoken. Although Jessica's English is far from poor, she said she felt more comfortable talking one on one, rather than in a group setting. In the interview, she went into more detail about her background and told me things that she could not capture through her photos.

When Jessica emigrated from Hong Kong to Canada, she considered it "a trend" because many of her friends' families were moving to the West prior to the 1997 handover of Hong Kong back to China. In Hong Kong, knowing how to speak English was a status symbol, but in Canada, it was a means of survival for Jessica. She talked about the issues she has had with language and communication throughout her migration experiences and the impacts they have had on her health and well-being.

I've always been very very...conscious of my linguistic ability...I know I'm not good at expressing myself very well, and I struggle with the English language a lot...When I first came to Canada, my primary way of sort of wanting to fit in to the dominant cultural group was mainly polishing my English...It is such a huge thing to be able to communicate myself and my thoughts clearly. Communication is so important! And so it is totally relevant to health...I've gone through major depressions because every time usually after, say, like a meeting or a presentation

when I didn't do well because of my inability to express myself, it actually causes depression.

Jessica's explanations for her feelings of depression are likely more complex than simply struggling with the English language. These feelings might also stem from the fears of not belonging, not feeling smart enough, competent enough, or up to Canadian standards of citizenship.

Throughout the interview, I got the chance to reflect upon my own identity as a "Chinese-Canadian" and the idea of "Chineseness" as a concept that cannot be understood as one-dimensional and fixed. I learned that Jessica and I embody different types of Chineseness, and have had different lifestyles, even though our ancestors are descendents from China, we lived within 50 kilometres of each other in Vancouver's lower mainland, and we are around the same age. When comparing our upbringings throughout our interview, we became aware of the main factor that prevented us from crossing paths while growing up – Jessica immigrated at the age of 13 and I was Canadian-born. Whereas my social networks were largely white, Jessica's social groups were primarily Chinese, classifying us into different social categories.

Jessica says in her interview, "I could almost say 99% of my friends in high school were Chinese. Either Taiwanese or from Hong Kong."

I found it interesting that although Jessica expressed the yearning to "fit in" to the mainstream society and to not be perceived as Chinese, she retained a sense of pride and comfort in being Chinese and hanging out with Chinese friends. Because of my own fears of being treated like someone who does not belong in Canada due to my race and ethnicity, I asked Jessica if her reasons for wanting to improve her English had anything

to do with feeling “mistreated” as an immigrant. She stated, “...My goal at that time was to be good at English, and so it might not have had to do with the anxiety of being treated differently...that could be it too, but also, I wanted to prove to myself, you know? That I was good at English. It was more personal satisfaction.”

Whereas I always perceived large groups of Asians in high school to be worse off than their Canadian-born co-ethnic peers in terms of being socially excluded, Jessica revealed that her experiences growing up amongst a large Chinese community was empowering, rather than marginalizing. I discovered that Jessica’s interpretation of Chinese identity was not relative to Whiteness like mine was. Whereas my conceptualization of Chineseness was compared to growing up middle-classed in a predominantly White middle-classed space where Chinese was considered “different” and inherently inferior to Whites, Jessica’s conceptualization of Chineseness was relative to her class privilege and pride in being from Hong Kong, rather than from mainland China. Having immigrated to Canada at the age of 13 to an area of Vancouver that housed a large diasporic community of first-generation Chinese-Canadians, she expressed that she made a conscious choice to befriend Chinese-speaking friends.

Because I had a choice. I could, you know, choose who I wanted to make friends with and also somehow I always ended up hanging out with my high school friends who were mostly Chinese and so when we got together, we were mostly speaking in Chinese, and there was that intimacy. You know when you can just...

Reflecting on her statement, I sense that Jessica’s “choice” to hang out with mainly Chinese speaking friends was motivated by the need for a sense of belonging, and could have been used as a protective strategy for “resisting the racisms around her”

(Sheth & Handa, 1993, p. 63). I gather this from another statement that she makes, claiming that even though she so badly wanted to improve her English when she first arrived, she “felt comfortable hanging out with [her] Chinese friends, because [she] knew that [she] was still limited in [her] English vocabulary.” I interpret this statement as a feeling that until her English was up to par, Jessica could find belonging and inclusion primarily within her Chinese networks, and to a lesser extent within the broader networks of Canadian society.

This finding demonstrates how social exclusion can be manifested through systems and structures that do not provide immigrants, refugees and other minorities with equal access to social, economic, political or cultural resources (National Collaborating Centre for the Social Determinants of Health [NCC-SDH], 2006). While Jessica was fortunate to have a group of friends with whom she could find a sense of belonging, the lack of access to social inclusivity amongst broader Canadian networks could have been potentially harmful to her social and psychological health (NCC-SDH, 2006).

After immigrating to Canada, Jessica experienced several shifts in identity, which were often related to her linguistic challenges. She says, “Two to three years after I came here, I really started to lose my Chinese language skills. I think partially it was on purpose, because I wanted to improve my English so badly that I thought, ok, if I stop speaking Chinese, then perhaps my English will get better.”

She identifies her first major shift in cultural identity at the time when she got a job as a coordinator of a program in Vancouver’s Chinatown, which required her to communicate with Chinese merchants in Cantonese:

That was when I really made an effort to regain that Chinese language skill and I had to for my work because I was forced to. I had to speak Chinese, I had to be able to read Chinese, as well...I really felt that pressure to learn and it was good for me. It was really good for me. And I felt really good when I realized that I could see some improvement in my Chinese and that I was almost slowly realizing and having a better understanding of my identity. Yeah, because to me, language ability defines my identity a lot. So being able to speak Chinese to me is very important.

The next shift in her identity occurred when she was in Korea for two and a half years teaching English.

In Korea, again that question of identity it became a part of my life every single day because I was not the typical, you know, white north American, blue eyes blonde hair that most parents would expect their kids to be taught by...Never have I once said I was from Canada. I was very strong in saying I was from Hong Kong...

For Jessica, the increased certainty of her Chinese identity was linked to her gained confidence in the Chinese language. She states, "I was feeling more confident that I didn't have to be questioned by other Chinese saying 'I don't think you're Chinese enough.'"

Jessica reflects on the shifts in her identity throughout her lifetime: "I have transitioned to the stage where now I see myself more Chinese and that when now at least when people say I have a Chinese accent, I'm proud, I'm happy, actually. I'm like, yes, I still have remnants of my Chineseness! It's a huge shift..."

Even though Jessica can recognize the shifts she has made in her ethnic identity and has found more confidence in identifying with being Chinese, this does not imply that her identity will remain stable and fixed forever. Jessica's pride and happiness in confirming her Chineseness can be linked to the idea that choosing one culture over another is more acceptable than identifying with multiple and overlapping aspects of more than one culture or ethnicity. Jessica's identification with Hong Kong may be coupled with the factor of convenience and simplicity that comes with not having to explain the details of her transnational, trans-cultural and trans-ethnic background.

#### *Citizenship, Social Exclusion and Health*

A key question that is raised amongst participants through their narratives is "what is citizenship?" Stasiulis and Bakan (1997) argue that while 'citizenship' is commonly understood as "an ideal type, presuming a largely legal relationship between an individual and a single nation-state," it is actually a "negotiated relationship" that is acted upon within "social, political, and economic relations of collective conflict, which are shaped by gendered, racial, class and internationally based state hierarchies" ( p.113).

The link between citizenship and health can be associated with the mechanisms of social exclusion and inclusion. According to Grace Edward Galabuzi (2002), the exclusion from civil society, social goods, social production and economy are social determinants of health. Social exclusion is linked to the experience of racism and discrimination, which puts racialized group members and immigrants at higher risk for mental health concerns (Beiser, 1988; Noh et al, 1999). According to Renato Rosaldo (1997), dominant norms discriminate against the cultural differences of new immigrants. This discrimination becomes a "part of the everyday experience of minorities and

immigrants as they learn to negotiate the rules of belonging that are taken for granted by the mainstream” (Ong, 2003, p.5). The stories of participants in this study bring these statements to reality and demonstrate some of the mechanisms that lead to their social exclusion.

For example, PP, who was brought up both in Iran and in Germany, and is now a Canadian citizen, feels like she is not legitimately accepted as a “Canadian.” Signifiers of non-acceptance, exclusion and difference are often shown through people’s assumptions regarding her accent and skin color. She states: “When they see you and you have a little bit of accent or you’re coloured, they’re like, right away, ‘Where are from?’ right away! So therefore, you’re not the same.”

I asked PP how it made her feel to be questioned about her race, and she replied: It makes me feel that I am a minority. That I am not Canadian, that I don’t, that I’m not being seen as a Canadian. Like, yes I am, on the passport, it says that I am Canadian, but when you look at me, you wouldn’t say, oh, she’s Canadian...right now I know I am Canadian, which is weird because I don’t really feel it in my heart.

The feeling of being minoritized in Canada is compounded by the fact that there is nowhere else she feels she can claim “citizenship” to:

I go back to Germany, where I was raised, and I thought that was my home, but I don’t belong there. If I go back to Iran, I have an accent, I am very Westernized. I don’t belong there. Here, I am brown, but I am Western, I still don’t belong. So those things are very, very different, very hard.

Her expression of frustration over not feeling “Canadian” even though she is a Canadian “citizen” highlights the power and deception of the underlying Anglo-Canadian nationalism that has “achieved a more or less stable hegemonic status that encircles and subsumes power relations among other contending bases for Canadian nationalism” (Lee & Cardinal, 1998, p. 215). Lee and Cardinal (1998) draw on the work of Gramsci (1971), in stating that hegemony is achieved “when ideas and beliefs are no longer questioned but are taken for granted and assumed as natural” (p. 216). Hegemonic nationalism reinforces the pervading assumptions of true “Canadianness,” which is imagined as naturally white, male, Christian, English-speaking, British, middle-upper class and Northern European in cultural heritage (Lee & Cardinal, 1998).

The following Photovoice piece by Jessica presents an alternative outlook on Canadian citizenship. In the discussion that follows, she highlights the lack of congruence between her nation of residence and her self-defined nation of belonging.



Figure 7. Photovoice piece by Jessica, entitled “Privileges.”

“Privileges” – wrote in Chinese, “clothes,” “food,” “shelter.” House keys = “mobility.” Passport - All of which I have! I won’t need a cell phone if I have no

friends/families/co-workers who would call me! Passport is something that people must not take for granted. To be a legitimate citizen of country means a lot. And the fact that I can travel to places is a huge privilege.

To Jessica, the passport and other identifiers of her life in Canada, symbolize the privileges with which Canadian citizenship provides her in Hong Kong, her self-identified nation of belonging. She elaborates further on how the privilege associated with Canadian citizenship is linked to her health:

I think it's only been recently that I have really thought about the privileges that I have and this one picture this is the one showing...Like the fact that I have house keys means that I have a home to go to, that I have shelter...and a cell phone, a cell phone means that I've got friends and I've got family who would call me up and care about me, and the passport, the passport means a lot. The passport is something that we should not take for granted. Because it means a lot when you actually are a legitimate citizen of a country...The basic human needs, so you have clothing, a home, food and mobility. And I think the passport definitely represents that. You know that you can cross borders.

The privileges that Jessica associates with having Canadian citizenship are often taken for granted by White Canadians, whose personal identities are more readily implicated into the ideals of the nation. Jessica recognizes that because of her class position and status that the Canadian passport brings to her, she is equipped to lead a healthy lifestyle. Upon reflecting on her migration experiences and family background, Jessica realizes that her ethnic identity and citizenship do not correspond. She sees her Canadian citizenship, rather, as a privilege which acts in her benefit transnationally:

I realized right away that I'm only Canadian because I have the citizenship. I don't feel Canadian in any other way. Just the passport. The passport is privilege, really. I can't imagine how different it would be to carry a Hong Kong passport as opposed to a Canadian passport, right? So it's a privilege, I see that, the fact that my family came to Canada, you know...It's a status thing, also, I think. Yeah. It's ridiculous though, right? Totally ridiculous how having a citizenship of one country would put you up on that social hierarchy, cuz when I go back to Hong Kong, people are very likely to hire someone who has a Canadian education experience.

The idea that citizenship in Canada has traditionally been used as a marker of belonging seems irrelevant to Jessica. According to CRIAW (2003), access to citizenship means having the rights and ability to participate fully in a democratic society. Even though immigrant women of color may hold passports, they are only granted partial citizenship rights because of the systemic racism that characterizes them as "outsiders" or "foreigners" (Nadeau, 2003; Parrenas, 2001). Most Canadians take for granted that passport holders are truly "Canadian" and afforded the status and dignity that white Canadian citizens hold. Most are not aware of the ways in which the socially constructed notions of citizenship exclude immigrants from certain countries, religious, racial and ethnic minorities, and indigenous peoples from full and meaningful participation in civil society (Stasiulis & Bakan, 1997).

The feelings that PP and Jessica both express about being "othered" and excluded from the ideal image of Canadianness are not coincidental. As Lee and Cardinal (1998) suggest, "the myth of a universal citizenship equally available to all citizens has been

contradicted by the reality that citizenship categories are used to regulate the boundaries between “us” and “them” (p. 223). Indicators such as race, gender, ethnicity, class, language and culture are used to hierarchically organize people into categories of citizenship, thereby “justifying and allowing for differential treatment of groups seen as ‘non-national’” (Lee & Cardinal, 1998, p. 223). Both of their stories indicate that while citizenship acts as a marker of inclusion and belonging for some, it may just as easily be used as a mechanism of social exclusion for those who display aspects of non-nationality.

### *Chapter Summary*

This chapter highlighted the impacts of living “in between worlds” on the health and well-being of participants in this study. Almost all of the participants were affected by experiences of migration; however, the variation in their experiences demonstrates the problems with reducing “immigrant women” to a unitary group that shares common needs, vulnerabilities and concerns, which is often depicted by mainstream “immigrant health” literature. Participants express that it is the internal process of negotiating between more than one cultural, ethnic or national influence that impacts their health and well-being, not the clash or conflict between two oppositional cultures. Dawn uses the terms, “living a double life” and “living in the liminal space” to describe the psychological division that affects aspects of her emotional, social and mental well-being. Sushma feels that it is the hypocrisy and narrow-mindedness of her ethnic culture that impacts her personal health and well-being. Susan’s health and well-being are affected by the uncertainty of her identity, which is linked to the lack of structure and conventionality in her transnational upbringing. Jessica identifies several shifts in her identity, which is influenced by her sense of belonging and competence in her cultural environment. Both

Jessica and PP recognize that they do not necessarily feel “Canadian” even though they hold Canadian passports.

The main finding in this chapter is that the participants’ transnational and unfixed identities, which do not often fit neatly into the “immigrant” or Canadian citizenship categories, are potential mechanisms by which the health impacts of social exclusion could occur. There are various ways in which living in an “undefined” space can be riddled with tensions, contradictions, confusions, all of which contribute to the mental, social, emotional, intellectual, spiritual and oftentimes physical health and well-being of racialized young women.

## CHAPTER SIX

### Breaking down barriers: Strategies for achieving health and wellness

#### *Introduction*

Paulo Freire's (1970) ideas on "liberation" and "conscientization" and Linda Tuhiwai Smith's (1999) thoughts on self-determination, decolonization and deconstruction are a backdrop to the analysis of participants' discourse in this chapter. Paulo Freire (1970) asserts that "it is only when the oppressed find the oppressor out and become involved in the organized struggle for their liberation that they begin to believe in themselves" (p. 52). He believes that achieving liberation is linked to conscientization, or becoming critically aware, and involves both activism and serious reflection. He also argues that "the content of critical and liberating dialogue should be in accordance with historical conditions and the level at which the oppressed perceive reality" (p. 52). The point at which his work intersects with the work of Linda Tuhiwai Smith is their common focus on acknowledging history. Smith (1999) posits that the critical pedagogy of decolonization involves knowing the colonizer, recovering ourselves, analyzing colonialism, and seeking self-determination.

This chapter presents some of the strategies that participants use to achieve personal measures of health and wellness. Telling stories, revisiting the past and decolonizing their identities are just some of the ways in which participants work towards becoming liberated, critically aware and self-determined. The participants often use a postcolonial lens to tell about how their histories have affected their health and well-being.

*Revisiting the past*

The work of both Paulo Freire (1970) and Linda Tuhiwai Smith (1999) suggest that becoming healthier requires “speaking back” to the history of colonialism, which has had many impacts on the present states of health and well-being of women in this study. Smith (1999) states that “the need to tell our stories remains the powerful imperative of a powerful form of resistance” (p.35). The following Photovoice piece, entitled “Empty Bottle,” indeed tells a story about Rebecca’s past. In this piece, Rebecca revisits the history of alcoholism on the paternal side of her family and reveals her silenced shame.



*Figure 8.* Photovoice piece by Rebecca, entitled “Empty Bottle.”

This photo is a reflection of my mother and I. We are in my mother’s space – the kitchen. When I was taking the photo I thought of the beer bottle as my father. The beer bottle represents a lot about my past and who I am today. I have been silenced for many years regarding my Métis ancestry, which is from my paternal side of the family. Growing up I remember all the empty beer bottles lying around the house when my father was in town. He would spend weeks up north working and then come home and party. As a child I remember feeling shameful for myself and my family. Alcoholism had a negative impact on my family. I did not

want to be an ‘Indian.’ Years later I have come to understand the intergenerational behaviours within my father’s family. I finally feel healthy – mentally, spiritually and physically.

Rebecca’s shift from denial and shame about her Native ancestry to feeling healthier on various dimensions is aided by talking about her past and understanding the intergenerational impacts of alcoholism in her family. By understanding the colonial and imperial discourses that play such a large part in her history and struggles with her native identity, Rebecca is moving away from blaming herself, her family and her “Indian” culture for the negative impacts that alcoholism has had on her life. Her identity is formed by more than just the current influences in her life. Although she does not go into much detail, Rebecca also mentions the abuse that was associated with alcoholism in her family. She links her health in the past, present and future to the effects of this abuse, alcoholism, struggle and shame, which are inseparable from the ongoing effects of Canada’s colonial history (Varcoe et al., 2007).

As mentioned in chapter two, recognizing and understanding the racism, sexism and classism in the imperial history of Canada is important in deconstructing the colonizing frameworks that have impacted the health and well-being of Indigenous and racialized women in Canada (Smith, 1999). Smith (1999) describes the process of decolonization as “a process which engages with imperialism and colonialism at multiple levels” (p. 20). Rebecca’s willingness to share personal stories about her past inspired the women in the group to also seek self-determination and reclaim identities that were lost throughout processes of colonization (Smith, 1999).

### *Reclaiming Lost Identities*

The loss of culture and tradition does not only occur to those whose lands have been conquered by colonizers. Those who migrate and are displaced by forces of colonization and oppression may also struggle to reclaim their identity and regain their health and well-being. For Monica, empowerment comes from looking back to her roots and reclaiming an identity that was lost on numerous occasions. In her two Photovoice pieces, Monica discusses how her health and well-being are affected by her identity, and how the uncertainty of her culture, ethnicity and “home” contributes to her feelings of being lost and displaced through migration and colonization. The reclaiming of her identity and the reconnection to her ancestry are both forms of resistance and strategies that Monica uses to seek wellness.



*Figure 9.* Photovoice piece by Monica, entitled “Longing.”

My feet remain grounded but still unsteady. I am calmed and connected to the passing tide, my love of the ocean and my longing for it comes from my longing of my homeland. Also there is my ancestral ties to the ocean – it symbolically represents where I’m from. My forefathers come from coastal towns in India

swept to coastal towns in Africa. Twice removed we find ourselves drawn to similar places in Canada. The ocean conveys a collective memory of past and community. The image of my feet being touched by the waves can also represent cleansing, washing away of the old, a rejuvenation. Health, to me, is formed by who I am and how I feel – my identity is reflected by my connection to the sea, which I associate with where I come from.

Monica draws important links between her health, which is formed by who she is and where she comes from, and the uncertainty of her ancestry due to a colonial history. During the debriefing workshop, she discusses this feeling of uncertainty in greater detail:

We don't exactly know where we're from because a lot of documents were destroyed, and a lot of things to do with our identity were destroyed as well. Like my inability to speak Indian languages; [speaking Indian languages] was suppressed growing up in Africa.

The suppression of language, culture and Indigenous forms of knowledge by colonizers was a common form of “discipline” that was used to ensure control and domination over the colonized (Smith, 1999). Its effects are still apparent today, as many of us now feel disconnected from our pasts, and are resentful that our ancestors were systematically “de-humanized,” while those who conquered us maintain the privilege of tracing back their roots for multiple generations (Smith, 1999).

Monica continues to describe her family's loss of identity: “We just have this longing of our past because it's lost, like it seems lost. Like we've tried to trace back family to where we're from, and it's come to dead ends, just because of I don't know, bureaucracy, colonialism...”

Her family's longing to search back to their roots is a method of reclaiming a voice, "reconnecting and reordering those ways of knowing which were submerged, hidden or driven underground" (Smith, 1999, p.69).

Monica's next statement expresses how the bond her family has tried to maintain with their original homeland does not sufficiently provide her with a sense of belonging:

I guess immigrant family from Africa, like we hold strong cultural ties to India because that's where our forefathers were taken from as indentured labourers to South Africa and growing up in South Africa, you're constantly aware of who you are and your identity because of our past with racial exclusion, and I don't know, I just have trouble ever finding home, I think, because I don't have one set place.

Without a strong sense of ancestral identity, Monica struggles to find balance in her life. Her expressions of longing for her "homeland" after being displaced by the forces of colonization and migration can be linked to theories of diasporic hybridity. The terms, hybridity and diaspora are considered coterminous because they "both denote an important reconfiguration of 'ethnic' boundaries and bonds and posit the growth of transnationalism" (Anthias, 2002, p.35). The term, diaspora, indicates the dispersal of people from a center, locus or home, the putting down of roots elsewhere, and the image of multiple journeys (Brah, 1996). The dispersal of Monica's ancestors from their home was invoked by European conquest and colonization, resulting in the removal of Indian people from their lands through a system of indentured labour (Brah, 1996). Drawing on Paul Gilroy's book, *The Black Atlantic* (1993), Anthias (2002) suggests that "diasporic positionality produces a form of consciousness that crosses the borders of given national, or ethnic, tunnel visions" (Anthias, 2002, p. 35).

Monica's consciousness indeed crosses borders and generations, and is brought to life by feelings of instability and homelessness, which, in turn, manifest her health and well-being. The notion of "home" is an important theme for Monica, as demonstrated by the following Photovoice piece.



*Figure 10.* Photovoice piece by Monica, entitled "Home."

The importance of good, home-cooked food and the connection to my family and culture. Roasting spices, sorting through the lentils for stones – my mum using her hands to mix the ingredients together – this is comforting, this is nourishment and also nostalgic. Food brings us together and reminds us of home. Home is many different places but still entirely South Africa. Home is here in Vancouver, home is the imagined memory of India. We have never lived in India, nor have we visited but we are connected culturally and spiritually as our motherland.

Home, for Monica, is related to food, cooked and prepared by her mother; food that brings her comfort and nourishment. Home is also linked to geographical location. Monica's health and well-being are associated with home and her identification with the locations in which she has resided and the places from which her family members were physically removed.

The experience of diaspora is marked by themes of alienation, national longing and transnationalism (Loomba, 1998). Some critics of postcolonial theory (Hall, 1994) term this longing for the past “romantic nativism,” and suggest that there is no turning back to the idea of a collective pre-colonial culture, which once found, will bring security to our sense of selves (Loomba, 1998, p. 182). Hall (1994), instead, suggests that these histories “have their real, material and symbolic effects” and that “the past continues to speak to us” (p.395) (as cited in Loomba, p. 182). Therefore, it cannot “simply be erased or shrugged off as a kind of false consciousness” (Loomba, 1998, p. 182).

This is true for Monica, who talks about her urge to re-connect with her family members, who share a spiritual bond with the places they come from:

My grandparents are not with us, but every time I’ve spoken to them, I’ve just been taking notes about their lives and trying to document their lives. I think it’s this urge that I have because information has been lost. And so it’s like trying to reclaim this history and get it back.

Monica’s expression and acknowledgement of her feelings of displacement and longings for a connection with her past are ways of locating her intersectional realities in the “multiple histories of colonialism and postcoloniality” (Loomba, 1998, p. 183).

### *Identifying Loss*

An important part of decolonization is to identify points in time where our traditional knowledge and culture has been lost or severed. The following narratives by Rebecca and Jessica bring up questions that help to identify these critical points in history and understand how colonizers attempted and still attempt to retain control over “Others.”

Similarly to Monica, Rebecca also expresses feelings of loss and longing for a recovery of her past. She resents the fact that the traditional language and knowledge of her Aboriginal ancestry were not passed on to her because they had been filtered throughout generations of colonial manipulation:

My dad went to a catholic day school in northern Saskatchewan. It was taught by nuns, and he didn't even finish, I think, elementary school. It was the same thing with my Cocum, which is my grandmother. And um, yeah, then that makes me think about language and stuff like that, that was lost, like she speaks Cree and I don't have that knowledge, but I have other knowledge from textbooks, but is that knowledge?

Rebecca's question, "Is that knowledge?" is central to poststructuralist thought, which assumes that words and texts have no fixed or intrinsic meanings (Scott, 2003). Poststructuralists ask questions such as: 'By what textual and social processes has meaning been acquired?' 'How do meanings change?' 'How have some meanings emerged as normative and others disappeared?' and 'What do these processes reveal about how power is constituted and operates?' (Scott, 2003, p.379). By asking ourselves these questions, we are better positioned to understand why we hold certain beliefs and perform behaviours that affect our health and well-being.

Jessica addresses these questions by drawing links between mechanisms of power and the loss of culture in a colonial society. Loomba (1998) states that "the experience of diaspora is also marked by class, and by the histories that shape each group that moves" (p. 180-181). By reflecting upon the colonial governance of Hong Kong while she was

growing up, Jessica reveals the interplay of class, culture and value systems that informed her upbringing and beliefs:

Many people in Hong Kong worship the West and even up 'til high school, 'the West is best' is a very common mentality in Hong Kong and in many British colonies, especially if your family is sort of middle, high class, you want to be associated with those who have an English or British background or associations.

This "West is best" mentality and her family's social status reinforced the belief, when Jessica was young, that learning English was more important than learning Chinese. She continues:

I was brought up in an environment where knowing English was a very important asset. Being a British colony...schools with sort of an English centered curriculum were considered a higher quality school, because in Hong Kong...there is a huge hierarchy...There are certain schools that are called Band 1. And there are schools in that category that usually the elite, you know, children of either government officials, lawyers, doctors, dentists, they go to those schools. And those schools are the ones that, just the same as in India, are the ones that are more have a better reputation, and I went to one of those schools. And so I always thought in my head that if I could speak English well, it's a good thing. It will put me up at a higher social status. And so that was also the reason I didn't care about Chinese...I thought Chinese was not a priority, you know?

Jessica's story demonstrates the power of class status and hegemonic values in influencing her beliefs about which "culture" should be a "priority." In her interview and in the focus groups, Jessica reveals that she suffered from depression, anxiety and even

suicidal thoughts at a very young age, due to the intense academic pressures of the colonial Hong Kong Band 1 education system. She said in her interview that when she began to fall below the academic standards of the school in the subjects that were taught in Chinese, she reverted to focusing on doing well in her English subjects. Jessica's pre-occupation with improving her English, as mentioned in chapter five, was a major source of stress once she arrived to Canada. She was able to identify several points in her life where she attempted to distance herself from her Chinese culture in favour of perfecting her English. The intersecting variables of class, race, gender, colonialism and immigrant status, among other social relations in Canada, have shaped Jessica's self-esteem, self-concept, identity, health and well-being. In naming these socially constructed variables, Jessica is empowering herself to decolonize and self-determine her multiple and shifting identities.

### *Naming Privileges*

The naming of privileges by participants occurred at various points throughout the study. Perhaps in recognizing their privileges, participants are justifying their demands for members of the mainstream society to name theirs. The naming of privilege may also be indicative of a higher level of consciousness; one which is synonymous with critical awareness, personal transformation and growth. The following examples demonstrate the participants' awareness and recognition of their own privileged positions in certain situations. They also show how critical awareness and transcendence from the past can lead to a heightened sense of health and well-being.



*Figure 11.* Photovoice piece by Rebecca, entitled “In My Bed.”

This black and white image is of me sleeping in my bed. The bed is a safe place where you sleep, dream, have sex and rest. An important part of being healthy is making time for my bed. I tend to sleep alone in my bed which is my own private space. I have my back to the camera because I want to be left alone. I am not ready to face the truth or reveal that to the viewers of this photo. My eyes have seen a lot of pain. My body has also felt the pain of being abused. Sometimes ignoring the past makes things easier. Deep down inside I know this affects my health, in a negative way. The darkness in the background is my mysterious past. Yet in the foreground the white sheets are almost glowing. The white makes me think about purity. Why is it that these Eurocentric views of whiteness still exist? White skin = purity. I think not. My mind then starts to wonder about how different my life would have been if I looked “more native.”

Rebecca’s Photovoice piece, entitled “In My Bed,” is about coming to consciousness about the health effects that stem from issues of the past. In the discussion

of this piece, Rebecca talks about the struggles she overcame with identifying as Métis, and finally feeling comfortable in her own skin: “I feel more myself, and you know, more comfortable identifying with who I am as a woman and um, being aboriginal.” Rebecca also expresses that she still struggles to even identify as being Indigenous or racialized, given the shame that was passed on throughout the generations. She explains, “It’s very empowering for me now as having carried that shame for many, many years and finally being able to identify and it feels good.”

“In My Bed” not only brings about a feeling of empowerment by uncovering her past, but it also sheds light onto the privileges she has had in relation to her family members. She refers to this photo in the following explanation:

And I was thinking about the white sheets, um, again, privileged life that I’ve had based on my white skin, and I wonder how different things would have been if I was the one who had the darker skin, you know, and had those, you know, typical native features and stuff like that, growing up? Or even now, as an adult. And then another thing that made me think about bedding too, was like my family, and social status. Because I have money to buy things like that. But my mom, she doesn’t. Like I think some of her stuff is like used. And then same thing with my dad. His bedding is from like, I don’t know, probably 30 years old, type thing, you know? So I just, I’ve lived a really privileged life. At times I’m grateful for it, other times I’m not.

Monica also reflects on the privileges that she had because of the color of her skin in South Africa:

And then me growing up in Africa I was very privileged to be East Indian because I wasn't black, and because we were in between this White privilege and Black under privilege, I guess, and so yeah, that's just something I've been reflecting on a lot lately. Of just who I am and being aware of my privileges and my identity and yeah...

Rebecca and Monica's reflections demonstrate a deeper level of consciousness that is both reflective and critical. This level of consciousness can be explained by Du Bois's (1989) concept of double consciousness. According to Du Bois (1989), Black people are simultaneously aware of the stereotypes that misrepresent them and equipped with the knowledge of their reflexive truths. Double consciousness is achieved through the awareness of being excluded from white American society and through the consciousness of being both African and American (Du Bois, 1989).

I feel that most of the participants in this study are somewhat doubly conscious, in that they are simultaneously aware of the ways in which they are perceived, and aware of the ways in which they act according to how people perceive them, oftentimes perpetuating their own oppression. The possession of a critical and reflexive level of awareness is also a privilege, in that racialized women who have the knowledge to look into others as well as themselves have the power to create great changes in society.

### *Chapter Summary*

Although participants use different outlets and strategies to overcome their individual struggles, they share a common desire to become healthier individuals, search deeper into their lives and find spaces where they feel like they can be themselves and belong at this point in time. Both Rebecca and Monica cope with having severed ties to

their ancestral roots, language and culture by asking critical questions that help them reclaim their identities. They also tell stories that revisit the past and analyze how their histories of colonization have impacted their current states of health and well-being. This chapter also sheds light on the different mechanisms through which identity and culture can be lost or displaced. For example, Jessica considers the mechanisms of class status and hegemonic power as she makes conscious decisions about her national and ethnic identity. As Rebecca and Monica consider their circumstances, they become conscious of naming their privileges. This chapter emphasizes the fact that the racialized women in this study are not helpless victims, but rather, active agents striving for social justice. Their stories demonstrate a level of critical reflection that acts as an important strategy for achieving health and well-being.

## CHAPTER SEVEN - CONCLUSION

The words and images that the women in this study have used to represent their feelings of ambiguity and “in-between-ness” can be used to describe the state of discomfort and uncertainty that I have experienced throughout the production of this thesis. Throughout every phase of this process, I asked myself why I was bothering to go against the grain and explore a topic that was somewhat controversial or unconventional in my field of study. I have caught myself on a number of occasions intuitively reverting to more simplistic models and frameworks of analysis, because in using these, I could be assured that my findings would not shock people or cause adverse reactions. Still, I cannot say that I have entirely broken out of this desire to please, to fit in, and to maintain congruency with mainstream paradigms. However, when I read through these women’s stories or see them around town, or sit down and have a coffee with them, I find the strength to believe in myself and to know that my own experiences and knowledge are just as real as anything I have read or have been conditioned to believe.

As I reflect on the stories that the women share in this study, I remember why I embarked on such a project in the first place. To me, this thesis represents much more than a piece of writing that fills gaps in the health literature. It embodies the hearts and souls of racialized women who, like me, have been taught not to see differences in people, and thus, to ignore the actual feelings of difference that we know to be true and pertinent to our identities, to our health, and to the ways in which we live our lives. The women in this study have been brave enough to creatively share their stories and explore aspects of their lives that they might not normally talk about. It is not easy to think critically about issues that affect our health and well-being because we have traditionally

been conditioned to conceptualize health as solely physical. It is difficult to name realities that counter mainstream beliefs because we do not want to be seen as victims, hypersensitive or unconfident. Issues of race and gender are always laced with tension because most people find it awkward or uncomfortable to think about their privileges in relation to others. We are given the message that talking about race is inherently conflictive and that we must not offend people or raise our voices too loudly.

We all have friends and loved ones who are white, who are male and whom we trust. It is difficult to explain to them that we are not trying to further separate the divide between “races” and that we are not trying to use reverse racism to gain power over Whites. Instead, we are rightfully trying to name the forces that serve to marginalize us and become allies with those who are willing to take responsibility and work towards achieving social justice. Our actions and purposes are often difficult to explain because the language and discourses that are helpful to us are not embedded in the everyday vocabulary of society. Our attempts to apply these discourses to our lives often come off as rash, harsh and radical. Oftentimes, there is emotion involved, especially when we are beginning to “de-center” ourselves and come to a critical level of consciousness about the forces that have influenced our lives. I see these attempts as being far from radical. They are completely necessary if we are to achieve a more liveable and healthy environment for all.

Changing the ways I see the world and myself was a long process that I am still enduring. I am slowly unpacking years of internalized pain and struggle, which is a conscious attempt at becoming a more well and whole person. The stories and photos that

the participants in this study share represent their attempts at understanding how some of their daily realities influence their health and well-being.

The question now is: how do we translate these realities into knowledge that is usable and comprehensible to the public? My current contribution to this translation of knowledge resides in the linking of my own lived experiences, the experiences and knowledge provided by the research participants, and the theoretical knowledge that others have produced, which speaks to our lived realities. This final chapter summarizes the ways in which these links have been made throughout this thesis. To begin, I will provide a summary of the key findings that relate to the research questions that I initially posed. Next, I reflect on some of the assumptions that I had upon entering the study, the challenges I faced and the lessons I learned throughout this process, all of which I consider to be important findings. Finally, I will provide some recommendations and directions for future critical health research.

### Summary of Key Findings

*Research Question #1: How does social exclusion act as a social determinant of health amongst racialized and Indigenous women living in Victoria?*

One of the main purposes of this study was to gain insights into the individual and everyday processes and mechanisms through which social exclusion can affect the health and well-being of racialized and Indigenous young women living in Victoria. Drawing upon the experiences of the women in this study, I found several key findings that help explain the concept of social exclusion on an everyday level.

Firstly, processes of racialization and everyday racism are major contributors to

social, emotional, psychological, and physical dimensions of health and well-being amongst racialized women living in Victoria. These processes can include dealing with stereotypes based on our physical appearance or ethnic ancestry and learning how to navigate through the politics of skin color and food, which distinguish us as “different,” exotic, foreign or inferior.

Secondly, the state’s use of pre-defined racial categories serves as a structural mechanism of racism, whereby those who are not accommodated by the classification systems may internalize feelings of “otherness” and social exclusion. Furthermore, those who do happen to fit into one of the pre-defined racial groupings may feel essentialized into a category that does not represent their shifting, changing and hybridized identities.

Thirdly, the women in this study share many personal stories that demonstrate how social exclusion can manifest pain, despair, isolation, marginalization, helplessness, loneliness, frustration, shame, indignation, low self-esteem and confidence, depression and a variety of other mental and physical health issues. These findings also indicate that health and well-being extend far beyond physical and biomedical parameters. The mechanisms of social exclusion are deeply rooted in larger political, economic, historical and social systems and structures, and must be seen in accordance with physical manifestations of health.

Finally, social exclusion can be manifested through hegemonic discourses of nationality. The terms, “immigrant” and “Canadian” are entrenched in socially constructed ideals and stereotypes that tend to dichotomize these two terms. These discourses can serve to marginalize transnational migrant subjects who are supposedly given the rights to full participation in Canadian society, but who are simultaneously

labelled as “immigrant women.” Some of the participants in this study who hold Canadian passports report not feeling Canadian because they are not included in the ideal image of the White, male, Christian, heterosexual, middle-classed and unaccented English-speaking Canadian citizen.

Furthermore, the immigrant health literature tends to view migration as a uni-directional movement pattern from a place of origin that matches the migrant’s ethnic/cultural background to a new, permanent place of settlement. Popular immigrant health discourses analyze the adaptation and settlement processes of newcomers, usually identifying cultural insensitivity and language barriers as factors preventing full access to health care services. Moreover, “culture clash” theories are over-utilized and often misused in the analysis of the experiences of immigrant youth. They often portray young immigrant women as “torn” between assimilating to the dominant norms of the new culture and abiding by the traditional cultures of their family. These types of explanations often give rise to cultural essentializations or models that place cultures in binary opposition to one another. The reality and nuances of migratory experiences are often difficult to explain without the use of theories that incorporate concepts of transnationalism, globalization, diaspora, hybridity and intersectionality.

*Research Question #2: How do the intersections of race, gender, class and other social variables impact the daily experiences of health and well-being amongst racialized and Indigenous young women in Victoria?*

A key finding in this study was that notions of identity are woven into our daily experiences of health and well-being. Identity is often viewed as fixed and unchanging, but this study found it to be emergent from participants’ historical backgrounds,

migration experiences, nationality, age, gender and race, among many other factors. To help explain the concept of intersectionality as I have come to understand it, I will draw upon an example from the study. One participant stated that her identity was influenced by her connection to her ancestors, who were twice removed from coastal towns in India and South Africa due to systems of indentured labour, colonization and socio-economic factors. Her history, womanhood, skin color, race, ethnicity, language, financial status and many other influences contribute to her whole self, her lived experiences and her health and well-being. Attempting to analyze any one of these variables separately would not provide a comprehensive or realistic understanding of the multiplicity of factors affecting her health and well-being. Each participant had unique experiences that were influenced by a number of interconnected and intersecting factors. To gain a fuller understanding of race, gender, class and health, we must view health as an experience, rather than simply a status; identity as malleable, rather than static; and race, gender and class as complexly intersecting social relations rather than inherently separable traits.

### Reflections and Other key findings

#### *Abandoning assumptions*

In addition to the key findings that address the above research questions, there were several important findings that emerged throughout the participatory engagement processes of this project. There were several occasions throughout this study where I had to re-frame the methods that I was using because of the underlying assumptions that had previously informed my planning. The first assumption that I found myself abandoning was that *all racialized women have similar levels of consciousness about race, class and gender, and that we are informed by critical theories, perspectives and discourses.*

Some of the questions and issues that were raised throughout the focus groups indicate that not all participants had an understanding of alternative theories that challenged mainstream paradigms. It became apparent during the Photovoice workshop that two different discourses underscored the initial discussions and activities. One was framed through an anti-racist, feminist critical lens, and the other was influenced by liberal discourses on equality and multiculturalism. These discourses emerged from the story telling activity that occurred in the initial Photovoice workshop. A participant was telling a story that provoked anger and frustration in her. Another participant interrupted the story and advised her to keep her anger to a minimum because she believed that the goal of this project was for us to learn how to more effectively communicate inter-culturally and eventually integrate better into society. She was concerned about the use of “angry” tones because she wanted to resist stereotypes that label all racialized women as being angry and opposed to white people. Another participant interjected and stated her opinion that this space was a safe space where racialized women could come together and express feelings and emotions that they would likely internalize otherwise. Although these broad paradigms are very much interrelated, it became apparent early on that we needed to carve out a space that both allowed these conversations to happen while trying to keep a focus on the research objectives. There were many thoughts going through my head while this was happening. My main concern was trying to stay focused on the research questions, while keeping in line with PAR principles, which promote shared decision making, valuing what people know and believe and dynamic processes of action and reflection (Smith, 1997). At the same time, I was concerned about my role as a facilitator and my sense of obligation to moderate discussions and keep a linear focus

within the group. My previous experience in facilitating focus groups followed a more systematic format of asking a question and having participants say their answers one at a time. I was trained not to let discussions get out of hand and off topic, both of which seemed to be happening in this focus group. I found myself debating whether I should intervene in the conversations and try to get everyone on the same wavelength or let these differing discourses emerge. Although I was uncomfortable in this state of ambiguity, I tried to think of myself as a Sistah and a co-researcher, not an expert facilitator who had a personal agenda to follow. As the conversation moved forward, various participants stepped up to clarify their understandings of others' opinions and acknowledge that each of our opinions were valid. This long and tedious process somehow fostered a sense of trust and solidarity within the group, whereby participants were willing to recognize and accept each other's differing backgrounds, opinions and experiences in favour of working together and supporting one another.

This finding led me to abandon another underlying assumption that *by virtue of being racialized women, we share a common political struggle*. I have heard this "common political struggle" phrase being used by several feminist authors, and also entered this study with the assumption that these common political struggles would be uncovered. In actuality, there was little direct evidence of shared struggles. There was, however, evidence of a shared willingness to deconstruct our lives and explore health and well-being in the contexts of our unique everyday realities. This shared desire to learn and discover contributed to the formation of an unspoken alliance – one which offers support and compassion, but which does not necessitate the commonality of struggle.

In addition, I could not assume that *health and wellness could be generalized in terms of common experiences or concerns*. I entered this study with the expectation that there would be several health issues that most, if not all participants could relate to in some way, thus, allowing me to identify major themes that represented different aspects of health and well-being. In reality, each participant presented themes, topics and issues that were unique to their own conceptualization of health and well-being, making the analysis of data extremely difficult. I learned that in order to gain a fuller understanding of the intersectional dynamics of our lives, I had to honour each individual's complexity and uniqueness.

The results from this study do not represent the experiences of all racialized and Indigenous women living in Victoria. I have found that health is subjectively defined and experienced, which makes it difficult to generalize from person to person. Moreover, it cannot be assumed that *all racialized and Indigenous women feel socially excluded* or feel that *social exclusion leads to poor health*, nor can it be assumed that *social exclusion only affects women of color*. It was not until the data were collected and analyzed that I was able to link the findings to processes of social exclusion.

#### *Battling against positivistic tendencies*

One of my biggest challenges was to conduct the workshops and activities without knowing what themes, topics and issues would emerge. I had to trust that the participants were there because they wanted to explore their health and identity (in a very broad sense). But I did not tell them explicitly what aspects of health and identity to focus on because I could not assume that my ideas and experiences were the same as theirs. This put me in a difficult position, considering that the findings from the study were to be

used for the writing of this thesis. While I certainly did not want the participants to feel like they were being “used” for research data, I could not deny that I had my own intentions in mind for these data. This is a point where I consciously battled against my positivistic tendencies, which plotted “the use of data for my thesis” in binary opposition to “the participants feeling used.” I had to bring myself to an in-between mentality, whereby trust, communication, theory and personal reflection grounded my decisions and actions. I soon discovered that to doubt the participants’ ability to grasp the multiple purposes behind this study was to inadvertently suggest that they do not have the power, agency or free will to make their own informed decisions. I realized that the participants also benefited from this project and each had their own purposes for partaking in it. These realizations allow me to now reflect on the findings from this thesis and understand how personally meaningful they are to me and everyone who contributed.

#### *Wearing multiple hats*

Another challenge for me was to negotiate and manage multiple roles. I was a researcher-facilitator, a peer, a Sistah, an Anti-Dote board member, a graduate student and a previous classmate to some of the participants. What helped me find comfort in having these multiple roles was the knowledge that the participants also had multiple roles, which were relative to mine. It is as if we were working as a team to sort out how we could each contribute to making this project a success to each of us individually. I do not think I could have come to these understandings had I not been involved in Anti-Dote prior to this study. Likewise, I do not think this thesis would have been possible had I not found the inspiration and motivation within the group of Anti-Dote Gurlz, Sistahs and Aunties to create this project.

On a different dimension, the participatory process also involved several communications between the board of Anti-Dote, my two graduate supervisors and my participants at every crucial point along the way. This took a lot of thought, focus and attention to detail, which was difficult at times because I often lacked clarity. I found, however, that the more I communicated with the multiple stakeholders involved in this project, the more clarity and confidence I gained.

#### *Working against time*

Finally, time was a minor challenge that I faced. I had a very short time period to work within because I anticipated that many of my potential participants would be students, and that they would be too busy to participate in this project once school resumed in September. Despite recruiting the eight participants at the end of summer, many of them commented that they did not have enough time to create the Photovoice pieces with as much depth and thought as they would have liked. Some participants were working full-time, had family members visiting or had to leave town for a few days during the week of reflection. At the same time, had I prolonged the time period to take their photos, they might have lost interest, focus, or become even busier.

Time was also an issue during the debriefing workshop. Although I had allotted three hours to the workshop, it was challenging to accommodate the participants' presentations of their work (seven people were present), while leaving room for discussions afterwards. I would recommend having fewer participants or lengthening the debriefing session to four hours with a break in between for writing.

### Directions for future research

In light of the findings, challenges and lessons that I have reflected on, I recommend the following directions for future research in fields that seek to critically examine health and wellness in relation to race, gender, class and other social, political and economic variables:

- 1) Additive approaches that examine one factor at a time, such as race or gender, are inadequate at understanding the multiple and complexly intertwining factors that contribute to inequalities in health. Health researchers should attempt to consider gender, race, class and other socially constructed variables, as inseparable from one another.
- 2) Binary models that dichotomize men/women, Whites/others, West/East, etc. should be critiqued when trying to understand the intersectional experiences of racialized women.
- 3) Further studies on intersectionality and health should incorporate women who are also minoritized by sexuality, religion, disability and other intersecting factors.
- 4) Social determinants of health research needs to build upon a bottom-up approach, whereby participatory models are used to engage targeted populations and investigate their everyday realities.
- 5) The perspectives of racialized and Indigenous young women in Canada need to be more widely represented in health and wellness literature.
- 6) Transnational feminist, anti-racist, postcolonial and intersectional frameworks need to be applied to the social determinants of health discourse in order to gain a

more in-depth understanding of the multiple facets of social exclusion and its effects on the various dimensions of health.

- 7) Population health and health promotion frameworks need to view health more holistically, incorporating conceptualizations of wellness that include not only physical dimensions, but also emotional, social, intellectual, psychological and historical dimensions, among many others.
- 8) Photovoice is a highly modifiable and adaptable tool and method for performing community-based participatory health research. It allows participants to engage in both individual and group reflection, while generating concrete images that can be used to open up critical dialogue for the purposes of inducing social change and personal transformation.

### Conclusion

In conclusion, I feel that the findings from this study filled several gaps. In terms of research, this thesis helped bring racialized and gendered perspectives to the health literature. It helped expand the limits of the social determinants of health literature, which examines social exclusion on a primarily socio-economic level. It also contributed to the growing body of intersectional health literature, which has been acknowledged by many Canadian health researchers as being in its beginning stages.

On a personal level, this thesis represents the completion of one segment of a long journey that will continue throughout my life. I encountered Anti-Dote at a time when I was ready to gain a deeper understanding of issues of race, health and identity, which I had previously kept internalized. The events that took place thereafter unfolded so organically that it seemed natural to propose a thesis topic that explored the health and

identity of Anti-Dote Sistahs, a group that I found a sense of connection with. As I worked with the Sistahs, I was simultaneously putting the theories, language and knowledge that I was learning in academia into practice, while trying to make sense of them through the deconstruction of their/our experiences. Throughout this simultaneous process of action and reflection, I was becoming more comfortable living in “in-between” spaces. I have come to own these spaces and realize that I do not need to have one fixed identity. I have realized that my health and well-being are not simply determined by my race, gender and class, but that the experiences I have had over my lifetime are largely influenced by the intersections of these relations and how I have positioned myself accordingly.

In creating a space for the Sistahs of Anti-dote to come together and open up a critical dialogue on health and well-being, I also made room for me, as a researcher, to legitimize the feelings of marginalization and discrimination that I faced in my career as a graduate student in the field of health promotion. The process of writing this thesis permitted me representation in a field where my own realities relating to health and wellness had not previously been included.

This project amplified the voices of women like me, who were also interested in exploring their identities in the contexts of health and wellness. I cannot speak for the participants in terms of the impacts that this project has made on their lives, but I do feel that this project solidified our alliances and support for one another, and established a safe space that can always be found again.

## REFERENCES

- Anthias, F. (2002). Diasporic hybridity and transcending racisms: Problems and potential. In F. Anthias & C. Lloyd's (Eds.), *Rethinking anti-racisms: From theory to practice* (pp. 22-43). London and New York: Routledge.
- Anti-Dote* Web site. (2008, April 7). Retrieved May 22, 2008, from [www.anti-dote.org](http://www.anti-dote.org)
- Anzaldua, G. (1990). En rapport, in opposition: Cobrando cuentas a las nuestras. In G. Anzaldua's (Ed.), *Making face, making soul: Creative and critical perspectives by feminists of color* (pp. 142-148). San Francisco: Aunt Lute Foundation.
- Anzaldua, G. (1987). *Borderlands/La frontera: The new mestiza*. San Francisco: Spinsters/Aunt Lute Book Company.
- Armstead, C.A., Lawler, K.A., Gorden, G., Cross, J., & Gibbons, J. (1989). Relationship of racial stressors to blood pressure and anger expression in black college students. *Health Psychology, 8*, 541-556.
- Ash, M.C.T. (2004). But where are you really from? Reflections on immigration, multiculturalism, and Canadian identity. In C.A. Nelson & C.A. Nelson's (Eds.), *Racism, eh? A critical inter-disciplinary anthology of race and racism in Canada* (pp. 398-409). Concord, ON: Captus Press.
- Bannerji, H. (2005). Introducing racism: Notes towards an anti-racist feminism. In B.A. Crow & L. Gotell's (Eds.), *Open boundaries: A Canadian women's studies reader* (pp. 53-59). Toronto, ON: Pearson Education Inc.

- Barnett, R., White, S., & Horne, T. (2002). *Voices from the front lines: Models of women-centred care in Manitoba and Saskatchewan*. Winnipeg, MB: Prairie Women's Health Centre of Excellence.
- Bell, L. (1998). Public and private meanings in diaries: Researching family and childcare. In J. Ribbens & R. Edwards' (Eds.), *Feminist dilemmas in qualitative research: Public knowledge and private lives* (pp. 72-86). London: Sage Publications.
- Benhabib, S. (1999). Sexual difference and collective identities: The new global constellation. *Signs*, 24(2), 335-361.
- Beiser, M. (1988). Influences of time, ethnicity and attachment on depression in Southeast Asian refugees. *American Journal of Psychiatry*, 145, 46-51.
- Bennett, G.G., Merritt, M.M., Sollers, J.J., Edwards, C.L., Whitfield, K.E., Brandon, D.T., & Tucker, R.D. (2004). Stress, coping, and health outcomes among African-Americans: A review of the John Henryism Hypothesis. *Psychology and Health*, 19(3), 369-383.
- Benoit, C., & Nuernberger, K. (2006). Draft discussion paper on health determinants and women's health. Michael Smith Foundation for Health Research (MSFHR) Women's Health Research Network (WHRN). Retrieved May 22, 2008, from [http://www.whrn.ca/documents/WHRNdeterminantspaperbenoitandnuernbergerfeb062006\\_2\\_.pdf](http://www.whrn.ca/documents/WHRNdeterminantspaperbenoitandnuernbergerfeb062006_2_.pdf).
- Bhabha, H.K. (1994). *The Location of Culture*. London and New York: Routledge.
- Bolaria B.S., & Bolaria R. (Eds.) (1994). *Racial minorities, medicine and health*. Halifax: Fernwood Press.

- Bottomore, T. (ed.). (1983). *A dictionary of Marxist thought*. Oxford and New York: Oxford University Press.
- Bowen-Reid, T.L., & Harrell, J.P. (2002). Racist experiences and health outcomes: An examination of spirituality as a buffer. *Journal of Black Psychology*, 28, 18-36.
- Brah, A. (1996). *Cartographies of diaspora: Contesting identities*. London and New York: Routledge.
- Bray, J.N., Lee, J., Smith, L.L., & Yorks, L. (2000). *Collaborative inquiry in practice: Action, reflection and making meaning*. London: Sage.
- Browne, A.J., Smye, V.L., & Varcoe, C. (2007). Postcolonial-feminist theoretical perspectives and women's health. In M. Morrow, O. Hankivsky, & C. Varcoe's (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 124-142). Toronto: University of Toronto Press.
- Bryan, S.N., Tremblay, M.S., Perez, C.E., Ardern, C.I., & Katzmarzyk, P.T. (2006). Physical activity and ethnicity: Evidence from the Canadian Community Health Survey. *Canadian Journal of Public Health*, 97(4), 271-276.
- Bryman, A., & Burgess, R.G. (Eds.). (1994). *Analyzing qualitative data*. London: Routledge.
- Canadian Research Institute for the Advancement of Women [CRIAW]. (2001). Fact sheet: Women, health and action. *Canadian research for the institute for the advancement of women*, July, 2001. Retrieved May 7, 2005 from [http://www.criaw-icref.ca/indexFrame\\_e.htm](http://www.criaw-icref.ca/indexFrame_e.htm).
- Canadian Research Institute for the Advancement of Women [CRIAW]. (2002). Women's experience of racism: How race and gender interact. *Canadian research*

for the institute for the advancement of women, July, 2002. Retrieved May 7, 2005 from <http://www.criaw-icref.ca/factSheets/racegendere.htm>.

Canadian Research Institute for the Advancement of Women [CRIAW]. (2003). Fact Sheet: Immigrant refugee women. *Canadian research for the institute for the advancement of women*, July, 2002. Retrieved May 7, 2005 from [http://www.criaw-icref.ca/factSheets/Immigrant\\_fact\\_sheet\\_e.htm](http://www.criaw-icref.ca/factSheets/Immigrant_fact_sheet_e.htm).

Citizenship and Immigration Canada (2007). Canada – Female Permanent Residents by Category, 1980 to 2006. *Facts and Figures 2006, Immigration Overview: Permanent Residents*. Retrieved May 27, 2008, from <http://www.cic.gc.ca/english/resources/statistics/facts2006/permanent/01.asp>

Comeau, T.D., & McMullin, J.A. (2004). CAGE(s) and health. In J. McMullin's (ed.) *Understanding Social Inequality: Intersections of Class, Age, Gender, Ethnicity, and Race in Canada* (pp. 236-277). Don Mills, ON: Oxford University Press.

Crow, B.A., & Gotell, L. (2005). *Open boundaries: A Canadian women's studies reader*. Toronto, ON: Pearson Education Inc.

Currie, J.C. (2001). *Best practices: Treatment and rehabilitation for women with substance use problems*. Ottawa, ON: Her Majesty the Queen in Right of Canada, represented by the Minister of Public Works and Government Services, Canada.

Cutrifelli, M.R. (1983). *Women of Africa: Roots of oppression*. London: Zed Press.

de Koning, K. & Martin, M. (1996). Participatory research in health: Setting the context. In K. de Koning, & M. Martin's (Eds.), *Participatory research in health: Issues and experiences* (pp. 1-18). New Jersey: Zed Books.

- DeVault, M.L., & Gross, G. (2007). Feminist interviewing: Experiences, talk and knowledge. In S.N. Hesse-Biber's (Ed.), *Handbook of feminist research: Theory and praxis* (pp. 173-198). Thousand Oaks, CA: Sage.
- Dion Stout, M., Kipling, G.D., & Stout, R. (2001). Aboriginal women's health research: Synthesis project. Final report prepared for the Centres of Excellence for Women's Health Research Synthesis Group. Ottawa, ON: Centres of Excellence for Women's Health.
- Dixon, M., & Hadjialexiou, M. (2005). Photovoice: Promising practice in engaging young people who are homeless. *Youth Studies Australia*, 24(2), 52 -57.
- Dua, E. (1999). Canadian anti-racist feminist thought: Scratching the surface of racism. In E. Dua, & A. Robertson's (Eds.), *Scratching the surface: Canadian, anti-racist, feminist thought* (pp. 7-31). Toronto, ON: Women's Press.
- Du Bois, W.E.B. (1989). *The souls of black folk*. New York: Bantam.
- Dunn, J., & Dyck, I. (2000). Social determinants of health in Canada's immigrant population: Results from the National Population Health Survey. *Social Science and Medicine*, 51(11), 1573-1593.
- Dyer, R. (2002). The matter of whiteness. In P.S. Rothenberg's (Ed.), *White privilege: Essential readings on the other side of racism* (pp. 9-14). New York: Worth Publishers.
- Edgington, D.W., Goldberg, M.A., & Hutton, T. (2003). The Hong Kong Chinese in Vancouver. Vancouver Centre of Excellence, Research on Immigration and Integration in the Metropolis. Working Paper Series No. 03-12. Retrieved on May 22, 2008 from <http://riim.metropolis.net/Virtual%20Library/2003/wp03-12.pdf>

- Edmonds, S. (2001). Racism as a determinant of women's health. Racism as a Determinant of Women's Health: A Workshop by Susan Edmonds. Presented in two locations on September 17, 2001. Retrieved May 21, 2008, from <http://www.cwhn.ca/resources/racism/racism.pdf>
- Essed, P. (1991). *Understanding everyday racism: An interdisciplinary theory*. Newbury Park: Sage.
- Essed, P. (2002). Everyday racism: A new approach to the study of racism. In P. Essed & D.T. Goldberg's (Eds.), *Race critical theories* (pp. 176-194). Malden, MA: Blackwell.
- Fals-Borda, O., & Rahman, M.A. (Eds.). (1991). *Action and knowledge: Breaking the monopoly with participatory action-research*. New York: The Apex Press.
- Fang, C.Y., & Myers, H.F. (2001). The effects of racial stressors and hostility on cardiovascular reactivity in African America and Caucasian men. *Health Psychology, 20*, 64-70.
- Fanon, F. (1990). *The Wretched of the Earth*, London: Penguin.
- Fleras, A. (2004). Racializing culture/culturalizing race: Multicultural racism in a multicultural Canada. In C.A. Nelson, & C.A. Nelson's (Eds.), *Racism, eh? A critical interdisciplinary anthology of race and racism in Canada* (pp. 430-443). Concord, ON: Captus Press.
- Frisby, W., Reid, C., Millar, S., & Hoerber, L. (2005). Putting "participatory" into participatory forms of action research. *Journal of Sport Management, 19*, 367-386.

- Freire, P. (1970). *Pedagogy of the oppressed*. (M.B. Ramos, Trans.). New York: Continuum Publishing Co.
- Galabuzi G.-E. (2002). Social Exclusion. A paper and presentation given at The Social Determinants of Health Across the Life-Span Conference, Toronto, November 2002.
- Galabuzi, G.-E. (2004). Social exclusion. In D. Raphael's (ed.) *Social determinants of health: Canadian perspectives* (pp. 235-252). Toronto, ON: Canadian Scholars' Press.
- Gee, G.C. (2002). A multilevel analysis of the relationship between institutional and individual racial discrimination and health status. *American Journal of Public Health*, 92(4), 615-623.
- Gilroy, P. (1993). *The black Atlantic: Modernity and double consciousness*. Cambridge, MA: Harvard University Press.
- Gramsci, A. (1971). *Selections from the prison notebooks*. (Q. Hoare, & G. Nowell Smith, Eds. and Trans.). London: Lawrence and Wishart.
- Greendorfer, S.J., & Hasbrook, C.A. (1991). *Learning experiences in sociology of sport*. Champaign, IL: Human Kinetics Books.
- Grewal, I., & Kaplan, C. (1994). Introduction: Transnational feminist practices and questions of postmodernity. In I. Grewal & C. Kaplan's (Eds.), *Scattered hegemonies: Postmodernity and transnational feminist practices* (pp. 1-33). Minneapolis: University of Minnesota Press.
- Hall, S. (1990). Cultural identity and diaspora. In J. Rutherford's (Ed.), *Identity: Community, culture, difference* (pp. 222-237). London: Lawrence & Wishart.

- Hall, S. (1994). Cultural identity and diaspora. In P. Williams & L. Chrisman's (Eds.), *Colonial discourse and postcolonial theory* (pp. 392-403). New York: Columbia University Press.
- Handa, A. (2003). *Of silk saris and mini-skirts: South Asian girls walk the tightrope of culture*. Toronto, ON: Women's Press.
- Hankivsky, O. (2007) Gender based analysis and health policy: The need rethink outdated strategies. In M. Morrow, O. Hankivsky, & C. Varcoe's (Eds.), *Women's health in Canada: Critical theory, policy and practice* (pp. 143-168). Toronto: University of Toronto Press.
- Hankivsky, O., Cormier, R., DeMerich, D., & Chou, J. (2008). *Intersectionality: Moving women's health research & policy forward*. Draft primer for Women's Health Research Network Intersectionality Workshop (April 17-18, 2008). Vancouver, BC: Institute for Critical Studies in Gender and Health.
- Harding, S. (2007). Feminist standpoints. In S.N. Hesse-Biber's (Ed.), *Handbook of feminist research: Theory and praxis* (pp. 45-70). Thousand Oaks, CA: Sage.
- Harrell, J.P., Hall, S., & Taliaferro, J. (2003). Physiological responses to racism and discrimination: An assessment of the evidence. *American Journal of Public Health, 93*(2), 243-248.
- Health Canada. (2007). *Mental health and wellness*. First Nations and Inuit Health. Retrieved May 22, 2008, from [http://www.hc-sc.gc.ca/fnih-spni/promotion/mental/index\\_e.html](http://www.hc-sc.gc.ca/fnih-spni/promotion/mental/index_e.html).

- hooks, b. (2002). Representations of whiteness in the black imagination. In P.S. Rothenberg's (Ed.), *White privilege: Essential readings on the other side of racism* (pp. 19 – 23). New York: Worth Publishers.
- Hosken, F. (1981). Female genital mutilation and human rights. *Feminist Issues*, 1(3), 3-24.
- House, J.S. (2002). Understanding social factors and inequalities in health: 20<sup>th</sup> century progress and 21<sup>st</sup> century prospects. *Journal of Health and Social Behavior*, 43(2), 125-142.
- Hughes, C. (1994). From field notes to dissertation: Analyzing the stepfamily. In A. Bryman and R.G. Burgess' (Eds.), *Analyzing qualitative data* (pp. 35-46). London: Routledge.
- Hyman (2001, September). *Immigration and Health*. Working Paper 01-05. Ottawa: Health Canada Health Policy Working Paper Series.
- Israel, B.A., Schulz, A.J., Parker, E.A., Becker, A.B., Allen III, A.J., & Guzman, J.R. (2003). Critical issues in developing and following community based participatory research principles. In M. Minkler & N. Wallerstein's (Eds.), *Community based participatory research for health* (pp. 53-76). San Fransisco, CA: John Wiley & Sons, Inc.
- James, S.A. (1994). John Henryism and the health of African-Americans. *Culture, Medicine, and Psychiatry*, 18, 163–182.
- Jones, D.R., Harrell, J.P., Morris-Prather, C.E., Thomas, J., & Omowale, N. (1996). Affective and physiological responses to racism: The roles of Afrocentrism and mode of presentation. *Ethnicity and Disease*, 6, 109-123.

- Kaplan, J.B., & Bennett, R. (2003). Use of race and ethnicity in biomedical publication. *Journal of the American Medical Association, 289*(20), 2709-2716.
- Karlsen, S., & Nazroo, J.Y. (2002). Relations between racial discrimination, social class, and health among ethnic minority groups. *American Journal of Public Health, 92*(4), 624-631.
- Kessler, R.C. (1997). The effects of stressful life events on depression. *Annual Review of Psychology, 48*, 191-214.
- Killion, C., & Wang, C.C. (2000). Linking African American mothers across life stage and station through Photovoice. *Journal of Health Care for the Poor and Underserved, 11*, 310-325.
- Krieger, N. (1990). Racial and gender discrimination: Risk factors for high blood pressure? *Social Science & Medicine, 30*(12), 1273-1281.
- Krieger, N. (2003). Does racism harm health? Did child abuse exist before 1962? On explicit questions, critical science, and current controversies: An ecosocial perspective. *American Journal of Public Health, 93*(2), 194-199.
- Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. New York: Routledge.
- Lawrence, B. (2003). Gender, race, and the regulation of native identity in Canada and the United States: An overview. *Hypatia, 18*(2), 3-31.
- Lee, J.A. (1993). Organizing with immigrant women: A critique of community development in adult education. *The Canadian Journal for the Study of Adult Education, 7*(2), 19-42.

- Lee, J.A. (1999). *Immigrant settlement and multiculturalism programs for immigrant, refugee and visible minority women: A study of outcomes, best practices and issues*. A report submitted to the British Columbia Ministry Responsible for Multiculturalism and Immigration. Victoria, BC: University of Victoria Department of Women's Studies.
- Lee, J.A. (2007). Identity, Belonging and Community Solidarity Among Indigenous and Racialised Girls and Young Women. *Research Proposal*. Submitted to the University of Victoria Human Research Ethics Board.
- Lee, J.A., & Cardinal, L. (1998). Hegemonic nationalism and the politics of feminism and multiculturalism in Canada. *The University of British Columbia Centre for Research in Women's Studies and Gender Relations, Conference Proceedings in Women's Studies and Gender Relations, 5(1)*.
- Lin, S.S., & Kelsey, J.L. (2000). Use of race and ethnicity in epidemiologic research: Concepts, methodological issues, and suggestions for research. *Epidemiological Reviews, 22(2)*, 187-202.
- Lindsay, B. (Ed.) (1983). *Comparative perspectives of third world women: The impact of race, sex, and class*. New York: Praeger.
- Loomba, A. (1998). *Colonialism/postcolonialism*. London and New York: Routledge.
- Maguire, P. (1987). *Doing Participatory Research: A Feminist Approach*. Amherst, MA: Center for International Education.
- Marmot, M., & Wilkinson, R.G. (2006). *Social determinants of health*. New York: Oxford University Press.

- Martin, M. (1996). Issues of power in the participatory research process. In K. de Koning and M. Martin's (Eds.), *Participatory research in health: Issues and experiences* (pp. 82-93). New Jersey: Zed Books Ltd.
- McCall, L. (2005). The complexity of intersectionality. *Signs: A Journal of Women in Culture and Society*, 30(3), 1771-1800.
- McDonald, J.T., & Kennedy, S. (2005). Is migration to Canada associated with unhealthy weight gain? Overweight and obesity among Canada's immigrants. *Social Science & Medicine*, 61, 2469-2481.
- McNeilly, M.D., Robinson, E.L., Anderson, N.B., Pieper, C.F., Shah, A., Toth, P.S., Martin, P., Jackson, D., Saulter, T.D, White, C., Kuchibatla, M., Collado, S.M., & Gerin, W. (1995). Effects of racist provocation and social support on cardiovascular reactivity in African American women. *International Journal of Behavioral Medicine*, 2, 321-338.
- Miles, R. (1989). *Racism*. London and New York: Routledge.
- Miles, R., & Brown, M. (2003). *Racism* (2<sup>nd</sup> ed.). London and New York: Routledge.
- Miller, C.J. (2006). Images from the streets: Art for social change from the Homelessness Photography Project. *Social Justice*, 33(2), 122-135.
- Mohanty, C.T. (2003). *Feminism without borders: Decolonizing theory, practicing solidarity*. Durham & London: Duke University Press.
- Mohanty, C.T., Russo, A., & Torres, L. (Eds.) (1991). *Third world women and the politics of feminism*. Bloomington: Indiana University Press.
- Moraga, C., & Anzaldúa, G. (1983). *This bridge called my back: Writings by women of color*. Watertown, MA: Kitchen Table Press.

- Moraga, C. (1983). La guerra. In C. Moraga & G. Anzaldúa's (Eds.), *This bridge called my back: Writings by women of color* (pp. 27-34). Watertown, MA: Kitchen Table Press.
- Morris-Prather, C.E., Harrell, J.P., Collins, R., Jeffries Leonard, J.L., Boss, M., & Lee, J.W. (1996). Gender differences in mood and cardiovascular responses to socially stressful stimuli. *Ethnicity and Disease*, 6, 123-131.
- Morrow, M. (2007). 'Our bodies our selves' in context: Reflections on the women's health movement in Canada. In M. Morrow, O. Hankivsky & C. Varcoe's (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 33-63). Toronto, ON: University of Toronto Press.
- Morrow, M., & Hankivsky, O. (2007). Feminist methodology and health research: Bridging trends and debates. In M. Morrow, O. Hankivsky, & C. Varcoe's (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 93-123). Toronto: University of Toronto Press.
- Moss, T. (1999). Photovoice: Youth put their world on view. *Children First*, 3(27), 32-35.
- Mullings, L., & Schulz, A.J. (2006). Intersectionality and health: An introduction. In A.J. Schulz & L. Mullings' (Eds.), *Gender, race, class & health: Intersectional approaches* (pp. 3-17). San Francisco: Jossey-Bass.
- Nadeau, M.-J. (2002). "Who is Canadian now?: Feminism and the politics of nationalism after September 11. *Atlantis*, 27(1), 19.
- Nandy, A. (1989). *The intimate enemy: Loss and recovery of self under colonialism*. Delhi: Oxford University Press.

- Narayan, U. (1998). Essence of culture and a sense of history: A feminist critique of cultural essentialism. *Hypatia*, 13(2), 87-106.
- The National Collaborating Centre for the Social Determinants of Health (2006). Foundations for the future: A backgrounder on the social determinants of health and health inequities. Pyra Management Consulting Services Inc.
- Ng, R. (1989). Sexism, racism and Canadian nationalism. In J. Vorst, et al. (Eds.), *Race, class, gender: Bonds and barriers* (pp. 10-25). Toronto, ON: Between the Lines & Winnipeg: Society for Socialist Studies.
- Ng, R. (1993). Sexism, racism, Canadian nationalism. In H. Bannerji's (Ed.), *Returning the gaze: Essays on racism, feminism and politics* (pp. 182-197). Toronto, ON: Sister Vision Press.
- Noh S., Beiser M., Kaspar V., Hou F., & Rummens J. (1999). Perceived racial discrimination, discrimination, and coping: A study of South East Asian refugees in Canada. *Journal of Health and Social Behaviour*, 40, 193-207.
- Noh, S., & Kaspar, V. (2003). Perceived discrimination and depression: Moderating effects of coping, acculturation, and ethnic support. *American Journal of Public Health*, 93(2), 232-238.
- Olesen, V.L. (2000). Feminisms and qualitative research at and into the millennium. In N.K. Denzin & Y.S. Lincoln's (Eds.), *Handbook of Qualitative Research (2<sup>nd</sup> ed.)* (pp. 215-256). Thousand Oaks, CA: Sage.
- Ong, A. (2003). *Buddha is hiding: Refugees, citizenship, the new America*. Los Angeles: University of California Press.

- Parken, A., & Young, H. (2007). Integrating the promotion of equality and human rights for all. Cardiff, Wales: Towards the Commission of Equality and Human Rights. Copy in possession of the authors. (See Hankivsky, Cormier, DeMerich & Chou, 2008).
- Parrenas, R.S. (2001). Transgressing the nation-state: The partial citizenship and 'imagined community' of migrant Filipina domestic workers. *Signs*, 26(4), 1130.
- Patton, M.Q. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.
- Pederson, A., & Raphael, D. (2006). Gender, race, and health inequalities. In D. Raphael, T. Bryant and M. Rioux's (Eds.), *Staying alive: Critical perspectives on health, illness and health care* (pp. 159-191). Toronto, ON: Canadian Scholars Press.
- Raphael, D. (2004). *Social determinants of health: Canadian perspectives*. Toronto: Canadian Scholars' Press Inc.
- Reid, C. (2002). A full measure: Towards a comprehensive model for the measurement of women's health. Vancouver, BC: British Columbia Centre of Excellence for Women's Health.
- Reid, C., & Frisby, W. (2007). Continuing the journey: Articulating dimensions of feminist participatory action research (FPAR). In P. Reason & H. Bradbury's (Eds.), *Handbook of action research: Participative inquiry & practice* (2<sup>nd</sup> ed.) (pp. 93-105). London: Sage Publications.

Reid, C., Frisby, W., & Ponio, P. (2002). Confronting two-tiered community recreation and poor women's exclusion: Promoting inclusion, health and social justice.

*Canadian Woman Studies*, 21(3), 88-94.

Promoting women's health, equity, and inclusion: The role of accessible community recreation in reducing social isolation. Paper presented at the Tenth Canadian Congress on Leisure Research, May 22-25, 2002. Edmonton, AB: Canadian Association for Leisure Studies.

Reimer Kirkham, S. (2003). The politics of belonging and intercultural health care.

*Western Journal of Nursing Research*, 25(7), 762-780.

Ro, M. (2002). Moving forward: Addressing the health of Asian American and Pacific Islander women. *American Journal of Public Health*, 92(4), 516-519.

Root, M.P.P. (2002). A bill of rights for racially mixed people. In P. Essed & D.T.

Goldberg's (Eds.), *Race critical theories* (pp. 355-368). Malden, MA: Blackwell.

Rosaldo, R. (1997). Cultural citizenship, inequality, and multiculturalism. In W.V. Flores & R. Benmayor's (Eds.) *Latino cultural citizenship: Claiming identity, space and politics* (pp. 27-38). Boston: Beacon Press.

Runyan, A.S. (2003). World-traveling feminisms in an era of global restructuring. In M.A. Tetreault & R.L. Teske's (Eds.), *Feminist approaches to social movements, community and power: Vol. II. Partial truths and the politics of community* (pp. 67- 85). University of South Carolina Press.

Said, E. (1978). *Orientalism*. New York: Pantheon Books.

Scott, J. (2003). Deconstructing equality-versus-difference: Or, the uses of

poststructuralist theory for feminism. In C. McCann & S.-K. Kim's (Eds.),

- Feminist theory reader: Local and global perspectives* (pp. 378 – 390). New York and London: Routledge.
- Sheth, A., & Handa, A. (1993). A jewel in the frown: Striking accord between India/n feminists. In H. Bannerji's (Ed.), *Returning the gaze: Essays on racism, feminism and politics* (pp. 38-82). Toronto, ON: Sister Vision Press.
- Shor, I. (1993). Education is politics: Paulo Freire's critical pedagogy. In P. McLaren & P. Leonard's (Eds.), *Paulo Freire: A critical encounter* (pp. 25-35). Routledge, London.
- Singh, J. (2004). Re-articulating multiculturalism: Transcending the difference-blind liberal approach. . In C.A. Nelson & C.A. Nelson's (Eds.), *Racism, eh? A critical interdisciplinary anthology of race and racism in Canada* (pp. 444-455). Concord, ON: Captus Press.
- Smith, L.T. (1999). *Decolonizing Methodologies*. Dunedin, New Zealand: University of Otago Press.
- Smith, S.E. (1997). Deepening participatory action-research. In S.E. Smith, D.G. Williams & N.A. Johnson's (Eds.), *Nurtured by knowledge: Learning to do participatory action-research* (pp. 173-263). New York: The Apex Press.
- Snowden, L.R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health*, 93(2), 239-248.
- Stasiulis, D., & Bakan, A.B. (1997). Negotiating citizenship: The case of foreign domestic workers in Canada. *Feminist Review*, 57, 112-139.
- Statistics Canada (2008a). Ethnic origins, 2006 counts, for census metropolitan areas and census agglomerations – 20% sample data (table). *Ethnocultural portrait of*

*Canada Highlight Tables, 2006 Census*. Statistics Canada Catalogue no. 97-562-XWE 2006002. Ottawa. April 2, 2008. Retrieved May 22, 2008, from [http://www12.statcan.ca/english/census06/data/highlights/ethnic/pages/Page.cfm?Lang=E&Geo=CMA&Code=935\\_&Data=Count&Table=2&StartRec=1&Sort=3&Display=All&CSDFilter=5000](http://www12.statcan.ca/english/census06/data/highlights/ethnic/pages/Page.cfm?Lang=E&Geo=CMA&Code=935_&Data=Count&Table=2&StartRec=1&Sort=3&Display=All&CSDFilter=5000)

Statistics Canada. (2008b). Visible minority groups, 2006 counts, for Canada and census metropolitan areas and census agglomerations - 20% sample data (table).

*Ethnocultural portrait of Canada Highlight Tables, 2006 Census*. Statistics Canada Catalogue no. 97-562-XWE 2006002. Ottawa. April 2, 2008. Retrieved May 22, 2008, from <http://www12.statcan.ca/english/census06/data/highlights/ethnic/pages/Page.cfm?Lang=E&Geo=CMA&Code=01&Table=1&Data=Count&StartRec=126&Sort=2&Display=Page&CSDFilter=5000>

Statistics Canada. (2008c). Visible minority groups, 2006 counts, for Canada, provinces and territories, and census metropolitan areas and census agglomerations - 20% sample (table). *Ethnocultural portrait of Canada Highlight Tables, 2006 Census*. Statistics Canada Catalogue no. 97-562-XWE 2006002. Ottawa. April 2, 2008. Retrieved May 22, 2008, from [datahttp://www12.statcan.ca/english/census06/data/highlights/ethnic/pages/Page.cfm?Lang=E&Geo=CMA&Code=59&Table=1&Data=Count&StartRec=1&Sort=2&Display=Page&CSDFilter=5000](http://www12.statcan.ca/english/census06/data/highlights/ethnic/pages/Page.cfm?Lang=E&Geo=CMA&Code=59&Table=1&Data=Count&StartRec=1&Sort=2&Display=Page&CSDFilter=5000)

- Statistics Canada. (2008d). Population by immigrant status and period of immigration, 2006 counts, for Canada, provinces and territories – 20% sample data (table). *Immigration and Citizenship Highlight Tables, 2006 Census*. Statistics Canada Catalogue no. 97-557-XWE2006002. Ottawa. December 4, 2007. Retrieved May 22, 2008, from <http://www12.statcan.ca/english/census06/data/highlights/Immigration/Table403.cfm?Lang=E&T=403&GH=4&SC=1&S=99&O=A>
- Stevenson, W. (1999). Colonialism and First Nations women in Canada. In E. Dua & A. Robertson (Eds.), *Scratching the surface: Canadian anti-racism feminist thought* (pp. 49-82). Toronto: Women's Press.
- Strauss, A.L. (1987). *Qualitative analysis for social scientists*. Cambridge and New York: Cambridge University Press.
- Strauss, A.L., & Corbin, J. (1990). *Basics of qualitative research*. Newbury Park, CA: Sage.
- Sutherland, M.E., & Harrell, J.P. (1986). Individual differences in physiological responses to fearful, racially noxious and neutral imagery. *Imagination Cognition, and Personality*, 6, 133-150.
- Taylor, T. & Doherty, A. (2005). Adolescent sport, recreation and physical education: Experiences of recent arrivals to Canada. *Sport, Education and Society*, 10(2), 211-238.
- Teelucksingh, C. (2006). Toward claiming space: Theorizing racialized spaces in Canadian cities. In C. Teelucksingh's (Ed.), *Claiming space: Racialization in Canadian cities* (pp. 1 - 17). Waterloo, ON: Wilfred Laurier University Press.

- Teske, R.L. (2000). Political space: The importance of the inbetween. In R.L. Teske & M.A. Tetreault's (Eds.), *Feminist approaches to social movements, community, and power* (pp. 72-90). Columbia: University of South Carolina Press.
- Tijerina, A. (1994). Notes on oppression and violence. In G. Anzaldúa's (Ed.), *Making face, making soul, haciendo caras: Creative and critical perspectives by feminists of color*. San Francisco: Aunt Lute Books.
- Tirone, S. & Pedlar, A. (2000). Understanding the leisure experiences of a minority ethnic group: South Asian teens and young adults in Canada. *Society and Leisure*, 23(1), 145-169.
- Tremblay, M.S., Bryan, S.N., Perez, C.E., Aldern, C.I., & Katzmarzyk, P.T. (2006). Physical activity and immigrant status: Evidence from the Canadian Community Health Survey. *Canadian Journal of Public Health*, 97(4), 277-282.
- van Ryn, M., & Fu, S.S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health*, 93(2), 248-255.
- Vanucci, G.J. (1999). Photography used to solve problems. *East Village*, 37(4), 4.
- Varcoe, C. (2006). Doing participatory action research in a racist world. *Western Journal of Nursing Research*, 28(5), 525-540.
- Varcoe, C., Dick, S., & Walther, M. (2004). Crossing our differences toward hope and healing: Preventing HIV/AIDS in the context of inequity and violence against women. Final report and planning document. Williams Lake, BC: Canadian Mental Health Association.

- Varcoe, C., Hankivsky, O., & Morrow, M. (2007). Introduction: Beyond gender matters. In M. Morrow, O. Hankivsky & C. Varcoe's (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 3-30). Toronto: University of Toronto Press.
- Vertinsky, P., Batth, I., & Naidu, M. (1996). Racism in motion: Sport, physical activity, and the Indo-Canadian female. *Avante*, 2(3), 1-23.
- Vissandjee, B., Thurston, W., Apale, A., & Nahar, K. (2007). Women's health at the intersection of gender and the experience of international migration. In M. Morrow, O. Hankivsky & C. Varcoe's (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 221-243). Toronto: University of Toronto Press.
- Wang, C.C. (1999). *Photovoice: A participatory action research strategy applied to women's health*. *Journal of Women's Health*, 8(2), 185-192.
- Wang, C.C. (2003). Using Photovoice as a participatory assessment and issue selection tool: A case study with the homeless in Ann Arbor. In M. Minkler & N. Wallerstein's (Eds.), *Community based participatory research for health* (pp. 179-196). San Fransisco, CA: Jossey-Bass.
- Wang, C.C., & Burris, M.A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior*, 24(3), 369-387.
- Wang, C.C., & Redwood-Jones, Y.A. (2001) Photovoice Ethics: Perspectives from Flint Photovoice. *Health Education and Behavior*, 28, 560-572.
- Wang, C.C., Yi, W.K., Tao, Z.W. & Carovano, K. (1998). Photovoice as a participatory health promotion strategy. *Health Promotion International*, 13(1), 75-86.

- Waters, M. (1995). *Globalization*. London: Routledge.
- Weber, L. (2006). Reconstructing the landscape of health disparities research: Promoting dialogue and collaboration between feminist intersectional and biomedical paradigms. In A.J. Schulz & L. Mullings' (Eds.), *Gender, race, class, & health: Intersectional approaches* (pp. 21-59). San Francisco, CA: Jossey-Bass.
- Weber, L., & Fore, M. E. (2007). Race, ethnicity, and health: An intersectional approach. In H. Vera & J. R. Feagan's (Eds.), *Handbooks of the sociology of racial and ethnic relations* (pp. 191-218). New York: Springer US.
- Williams, D.R. (1997). Race and health: Basic questions, emerging directions. *Annals of Epidemiology*, 7(5), 322-33.
- Williams, D.R. (1999). Race, socioeconomic status, and health: The added effects of racism and discrimination. *Annals of New York Academy of Sciences*, 896, 173-188.
- Williams, D.R. (2002). Racial/ethnic variations in women's health: The social embeddedness of health. *American Journal of Public Health*, 92(4), 588-597.
- Williams, D.R., Neighbors, H.W., & Jackson, J.S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health*, 93(2).
- Williams, D.R., Spencer, M.C., Jackson, J.S. (1997). Race, stress and physical health: The role of group identity. In R.J. Contrada & R.D. Ashmore's (Eds.), *Self, social identity and physical health* (pp. 71-100). New York, Oxford University Press.
- Willis, K., & Yeoh, B. (Eds.) (2000). *Gender and migration*. Cheltenham: Edward Elgar.

- Women's Health in Women's Hands (WHIWH). (2003). Racial discrimination as a health risk for female youth: Implications for policy and healthcare delivery in Canada. Toronto, ON: The Canadian Race Relations Foundation. Retrieved May 22, 2008, from [http://www.whiwh.com/Research/ePub\\_RacialDiscrimination.pdf](http://www.whiwh.com/Research/ePub_RacialDiscrimination.pdf)
- World Health Organization. (1948). *Definition of health*. Retrieved on April 5, 2007, from <http://www.who.int/about/definition/en/>
- Wu, K.Y., Burris, M., Li, V., Wang, Y., Zhan, W.T., Xiang, Y.P., et al. (Eds.). (1995). *Visual voices: 100 photographs of village China by the women of Yunnan Province*. Yunnan: Yunnan People's Publishing House.
- Yon, D.A. [foreword by Stuart Hall]. (2000). *Elusive culture: Schooling, race, and identity in global times*. Albany, NY: State University of New York Press.
- Zhou, M., & Lee, J. (Eds.) (2004). *Asian American Youth: Culture, identity and ethnicity*. New York & London: Routledge.

## Appendix A

### About Anti-Dote

Anti-Dote is a non-profit organization in Greater Victoria that works to increase the visibility of racialized minority and Indigenous girls and women in schools, the media, ethno-cultural communities, and social services organizations. Anti-Dote's programs promote community development and social change in areas of diversity and cross-cultural understanding. Anti-DOTE stands for

Anti- Discrimination

Oppression

Tyranny

Exclusion

The following information was extracted from the Anti-Dote website at [www.anti-dote.org](http://www.anti-dote.org).

As a grassroots, voluntary based organization of racialised minority and Aboriginal girls and women, Anti-dote is committed to:

- Increasing psychological and social well-being of racialised minority and Aboriginal women and girls in their schools, social service organizations, families and in our communities;
- Promoting visibility and needs of racialised minority and Aboriginal women and girls in the greater community;
- Promoting community development and social change through participatory action approaches at the local level, which places decision-making and planning in the hands of those who will participate in and who will be directly affected by the initiative.

A major catalyst for the formation of our network was a SSHRC funded community-based, participatory action research project on Racialised Girls and Social Cohesion under the direction of Dr. Jo-Anne Lee (Department of Women's Studies - University of Victoria) beginning in Spring 2001. Focusing on community development, the study's research team and participants brought minority and Aboriginal girls together to talk about their issues in a July 2002 conference held at the University of Victoria: It's About Us: A Conference for Girls on Race and Identities. The girls and women at this conference wanted an organization to continue the work that the conference began; leading to the creation of Anti-dote.

Dr. Jo-Anne Lee's study confirmed that racialised minority women and girls, whether immigrant, refugee, or Canadian born, experience isolation from each other and marginalization in the larger community. Isolation and the erasure of ethnic/racial identities under a dominant culture of whiteness helps to develop an ambiguous sense of citizenship and belonging.

Aboriginal girls and women, and immigrant, refugee and racialised minority Canadian-born girls and women share many common concerns. Yet, these two groups are isolated from each other. Government and non-government organizations tend not to take seriously the specific concerns of racialised minority and Aboriginal women and girls. As a result, many racialised minority and Aboriginal women and girls internalize negative social messages, viewing themselves as second-class citizens with fewer rights than the dominant groups. This belief is contrary to Canadian principles of liberal democracy where citizenship rights, responsibilities and benefits are supposedly universally accessible to all citizens, and all citizens are thought and expected to belong to and identify with the nation.

Processes and effects of social exclusion and marginalization are experienced at many levels in Victoria:

Individually, at the level of identity formation, young women tend to internalize experiences of racism and sexism, as normal and natural. Consequently, young women may experience risk factors such as poor self-esteem, social isolation, depression, substance use, disordered eating and suicide, violence and prostitution.

At the group level, some youth cling to their ethnic difference as a form of defense-forming racially or ethnically exclusive peer groups.

At the local level, few services in educational institutions or youth service organizations support racialised immigrant, refugee and Canadian-born youth, and Aboriginal youth, especially those who are female. Research practitioners and school counselors often fail to understand the circumstances of their lives. Advice and supports given may be tokenistic or inappropriate, further alienating youth from the systems that are supposed to work on their behalf.

Anti-dote works to build community networks and self-advocacy among girls and women. We work to uncover unspoken experiences and help bring about social justice and equality, and foster respect for diversity.

© 2005 Anti-dote - Jo-Anne Lee

Appendix B  
Letter of Information

**MULTIPLE EXPOSURES: WHAT DOES HEALTH LOOK LIKE TO US?**  
**Letter of Information**

You are being invited to participate in a study entitled *Multiple Exposures: What does Health Look Like to US?* that is being conducted by Alison Sum, as part of her Master's thesis requirements from the department of Exercise Science, Physical and Health Education (EPHE) at the University of Victoria. Alison has been a part of Anti-Dote since September, 2006 and was elected on to the Board of Directors as a Sistah's Representative in March, 2007. Her thesis supervisors are Dr. PJ Naylor (EPHE) and Dr. Jo-Anne Lee (WOST). The partnering organization for this study is Anti-dote Multi-racial Girls and Women's Network.

**Background**

There is evidence in Canada and globally that social inequities give rise to racial disparities in health. Women and racialized individuals are often recognized as members of "socially excluded" groups; however, the perspectives of women of color are seldom present in the health literature. This research project aims to dismantle the forces that serve to oppress, marginalize and silence women of color who live in Canada, and examine health and well-being from their unique perspectives. How do the intersections of race, gender, class, sexuality and age affect the health and well-being of understudied populations in Canada?

**Purpose**

The purpose of this research project is to explore the lived experiences of young, racialized women (aged 18-30) living in Victoria. Participation in this project will allow the participants to: 1) build solidarity and capacity amongst young, racialized women living in Victoria, 2) talk about and share their unique experiences growing up as a minority in Canada, 3) use creativity and visual imagery to pursue social change, and 4) have a voice in matters that affect the health and well-being of racialized women in Victoria.

**Method**

The strategy that we will be using to story-tell about our lives is called *Photovoice*, a photo documentary process that will allow you, as a researcher, to use photos and writing to represent issues that pertain to your health and well-being. You will be involved in all aspects of the research process, which includes brainstorming issues and themes that relate to your health and well-being, documenting your lived realities through photography and written thought and critically reflecting on the issues that affect your health and well-being.

I hope to fulfill the last part of my Master's degree by writing about each aspect of the project in the form of a thesis. In addition, I anticipate that the results of this study may

be shared with others in the following ways: articles about the project may be published in academic journals, research reports, conference presentations and a public dissemination of the Photovoice projects that you complete. You will be invited to participate in some of these public presentations. Your decision to attend is completely voluntary. If your work is included in public presentations or publications, you will have the option of using a code name to represent your work. Participants who want their voices to be heard through photography and written words are encouraged to participate.

If you know the researcher in one or more capacities (e.g., fellow member of Anti-Dote, classmate, friend), please do not let your relationship with the researcher affect your decision to participate in this research study. You are under no pressure or obligation to participate. Your participation is entirely voluntary. If you decide not to participate, it will not affect how the researcher or members of Anti-Dote will treat you.

To find out more about the research project or if you are interested in participating in the study, please contact Alison Sum at [asum@uvic.ca](mailto:asum@uvic.ca) or (250) 857-4012.

## Appendix C

### Guide for discussions and Photovoice workshop activities

#### **Situating ourselves:**

How would you identify yourself (E.G., culture or ethnic background, gender, sexuality, social class, religious or spiritual background)?

What other words would you use to describe your identity?

How long have you been involved in Anti-Dote?

In what capacity are you involved with Anti-Dote?

#### **Group questions:**

1) Why are we here?

2) What do we have in common (if anything)?

3) What goals do we want to reach (individually or as a group)?

#### **Brainstorming activity on health and well-being:**

What does it mean to be healthy?

What does well-being mean to you?

#### **Story telling:**

When do we feel healthy or well? Think of times/experiences/stories that relate to the words from brainstorming activity.

When do we feel unhealthy/unwell? Think of times/experiences/stories that relate to the words from brainstorming activity.

What is your current state of health/wellness? Where does it fit onto this map?

#### **Thinking critically:**

What issues in your life affect your health or well-being (as you define it)? What prevents you from achieving optimal health? Map out the issues and barriers that are discussed onto the diagram.

#### Probes:

- Have you ever felt excluded from mainstream society because of your appearance, cultural/ethnic background, age, class, sexuality or any other part of your identity? Give some examples.
- How does it feel to be excluded or to not belong?
- What are some direct or indirect impacts that these issues have on your health or well-being?

#### **Finding common themes:**

From this mapping activity, are there common feelings or themes that need to be expressed?

#### **Photovoice assignment:**

How can this feeling or theme be expressed through visual and written imagery?

- Take pictures (places, people, objects, symbols, etc.) that tell stories about issues that affect your health and well-being.
- Keep a journal of your thoughts and feelings while you are taking these photos.
- Keep in mind the goals that we set out for ourselves.
- If you feel your background and identity (race, gender, class, sexuality, age, etc.) mediate your health, take pictures that represent your background and identity.

Here are some questions that will help guide your photo taking process over the following week:

- 1) How can my background and identity be represented?
- 2) What does my optimal level of health and well-being look like?
- 3) What does my current state of health and well-being look like?
- 4) What does it look like when I am feeling unhealthy or unwell?
- 5) How can some of the issues that affect my health and well-being be represented (e.g., What does exclusion look like? What does feeling “silenced” look like?)

Appendix D  
Invitation to participate

**INVITATION TO YOUNG RACIALIZED AND INDIGENOUS WOMEN TO PARTICIPATE IN *PHOTOVOICE* PROJECT**

**Project title:** *Multiple Exposures: What does Health Look Like to US?*

**Principle Investigator:** Alison Sum, School of Exercise Science, Physical and Health Education (EPHE), University of Victoria

**Project Information:** This research project will be in partial fulfillment of Alison's Master's thesis requirements. Alison has been a part of Anti-Dote since September, 2006 and was elected on to the Board of Directors as a Sistah's Representative in March, 2007. Her thesis supervisors are Dr. PJ Naylor (EPHE) and Dr. Jo-Anne Lee (WOST). The partnering organization for this study is Anti-dote Multi-racial Girls and Women's Network.

**Background**

There is evidence in Canada and globally that social inequities give rise to racial disparities in health. This research project aims to dismantle the forces that serve to oppress, marginalize and silence women of color who live in Canada, and examine health and well-being from their unique perspectives.

**Purpose**

The purpose of this research project is to explore the lived experiences of young, racialized women (aged 18-30) living in Victoria. Participation in this project will allow participants to: 1) build solidarity and capacity amongst young, racialized women living in Victoria, 2) talk about and share their unique experiences growing up as a minority in Canada, 3) use creativity and visual imagery to pursue social change, and 4) have a voice in policies and systems that affect the health and well-being of racialized women in Victoria.

**Method**

*Photovoice* techniques will be used to engage participants in all aspects of the research process. This includes brainstorming issues and themes that relate to your health and well-being, documenting your lived realities through photography and written thought, and using the photos taken to critically reflect upon race, gender, class, sexuality and age in relation to your health and well-being.

**Rough Time frame:**

August 14 – *Photovoice* workshop – 5:30-8:30 @ Women's Centre in SUB at UVIC

August 14 - 20 - Take photos and write in journal (approx. 3-4 hours total)

August 20 – Submit photos (negatives or digital files)

August 21 – Debriefing workshop - 5:30-8:30 @ Women's Centre in SUB at UVIC

*If you know the researcher in one or more capacities (ie, fellow member of Anti-Dote, classmate, friend), please do not let this affect your decision to participate in the research study. Participants who want their voices to be heard are encouraged participate.*

To find out more about the research project or if you are interested in participating in the study, please contact Alison Sum at [asum@uvic.ca](mailto:asum@uvic.ca) or (250) 857-4012.

## Appendix E Information on Photovoice

*Photovoice* is a research method that you will use to document your lives. The camera will be your tool to capture images that represent meaningful messages that you would like to convey.

### **Goals of Photovoice (www.Photovoice.com):**

- 1) to record and reflect personal and community strengths and concerns
- 2) to promote critical dialogue and knowledge about personal and community issues through group discussions of photographs
- 3) to reach policymakers

### **Key concepts (www.Photovoice.com):**

- Images contribute to how we see ourselves, how we define and relate to the world, and what we perceive as significant or different
- Images can be used to influence our focus and world view by analyzing: a) the production of the images, b) the reception of the images and meanings attributed to them by audiences, and c) the content of the images.
- The lesson an image teaches does not reside in its physical structure but rather in how people interpret the image in question
- The process requires that people define the images
- Photovoice* entails people's discussing the images that they have produced, and by doing so, they give meaning to, or interpret their images.
- Images can influence policy by helping to set the public agenda about what people talk about and pay attention to (as opposed to the media telling people what to think)
- The potential for using *Photovoice* as a tool to influence policy resides in the exchanges among community people, health workers, and policymakers over the images of interest
- Photovoice* is grounded in the understanding that policies derived from the integration of local knowledge, skills and resources within affected populations will more effectively contribute to healthful public policy

### **Things to think about when taking photos:**

- 1) If you are taking a picture of someone, first ask them if it's ok. Use the consent/image release form that is provided to you.
- 2) Do not put yourself at risk when trying to take photos.
- 3) Be creative with your camera. Try using different techniques, perspectives and themes when taking photos.

### **Basic photography tips:**

- keep fingers out of camera's eye
- place sun at your back if possible
- avoid putting subject or center of interest in the middle of each photograph
- When using disposable cameras, ALWAYS USE A FLASH, even when outdoors.

Appendix F  
Participant consent form

**PARTICIPANT CONSENT FORM (adapted from Dr. Jo-Anne Lee's PROJECTS FOR PEACE Research Assistant Handbook)**

***Multiple Exposures: What does Health Look Like to US?***

You are being invited to participate in a study entitled *Multiple Exposures: What does Health Look Like to US?* that is being conducted by Alison Sum, as part of her Master's thesis requirement from the department of Exercise Science, Physical and Health Education (EPHE) at the University of Victoria. Alison has been a part of Anti-Dote since September, 2006, and was elected on to the Board of Directors as a Sistah's Representative in March, 2007. Her thesis supervisors are Dr. PJ Naylor (EPHE) and Dr. Jo-Anne Lee (WOST). The sponsoring organization for this study is Anti-dote Multi-racial Girls and Women's Network.

We will be using *Photovoice*, a participatory research strategy that allows people to identify, represent and enhance their community through a specific photographic technique. The purpose of this research project is to explore the lived experiences of young, racialized women (aged 18-30) living in Victoria. Participation in this project will allow the participants to: 1) build solidarity and capacity amongst young, racialized women living in Victoria, 2) talk about and share their unique experiences growing up as a minority in Canada, 3) use creativity and visual imagery to pursue social change, and 4) have a voice in policies and systems that affect the health and well-being of racialized women in Victoria.

Participation in this study requires that you are available for an initial informational/planning meeting (approx. 1 hour), a *Photovoice* workshop (approx. 3 hours), a debriefing workshop (approx. 3 hours) and 6 days of photo taking and journaling between the *Photovoice* and debriefing workshops (approx. 3-4 hours total).

Participation in this study may cause some inconvenience to you, including taking time away from employment and other summer activities. I will do my best to make the workshop locations and times as convenient and conducive to your busy schedules as possible.

Some of you may know the researcher in one or more capacities (e.g., as a fellow member of Anti-Dote, classmate or friend). Please do not let your multiple-role relationships with the researcher affect your decision to participate in this research study. You are under no pressure or obligation to participate. Your participation is entirely voluntary. If you decide not to participate, it will not affect how the researcher or members of Anti-Dote will treat you. If any of the activities or processes make you feel uncomfortable, you do not have to participate in them. You can leave the group or stop participating in the project at any time, without negative consequences. I want to make sure your experience is positive and enjoyable should you wish to participate.

If you decide to leave towards the end of the study, the photographs and written entries provided during your participation in the study may be used in subsequent reports and publications under the use of a code name. Group discussion data are difficult to remove and may still be used in the analysis should you withdraw. There are check boxes provided at the end of this consent form, where you can indicate whether or not you agree to these statements.

I will also be taking field notes and/or tape recording throughout discussions and focus groups, and possibly taking photographs throughout the workshops. After I transcribe the discussions and focus groups, I will destroy the tapes. When I write up the results and develop the photos for academic uses, I will make sure that I change your name if you so wish. For public presentations that you attend, you will have the option to identify yourself or use a different name.

During discussion group sessions I will ask everyone not to discuss with others outside the group what other group members say in the group. However, I cannot guarantee that all group members will keep everything that is said in the group confidential.

I will be asking you to disclose information about your ethnicity, sexuality, religion/spirituality, social class, health status and family background in the form of a written questionnaire and in a group setting. You are free to disclose as much or as little information about yourself as you wish. We will also be discussing issues about your experiences as racialized or Indigenous young women and topics relating to your health and well-being. Some of these topics and experiences might be difficult to talk about. If any of the discussions or activities make you feel uncomfortable, you do not have to participate. You can leave the group or withdraw from discussions or activities any time you wish.

This research will help people understand how the multiple exclusions connected by race, gender, sexuality, class and age are related to the social gradient in health in Canada and globally. The study findings will help build solidarity and capacity amongst young, racialized women living in Victoria, put racialized and gendered perspectives of health and well-being on the political and academic agenda and broaden health researchers' and policy makers' understandings of the social determinants of health.

I hope to fulfill the last part of my Master's degree by writing about each aspect of the project in the form of a thesis. In addition, I anticipate that the results of this study may be shared with others in the following ways: articles about the project may be published in academic journals, research reports and conference presentation. You will have the opportunity to present your work through public engagements sponsored by Anti-Dote; however, your participation in these events will be completely voluntary.

Where the data are used in publication or public dissemination, including my thesis write-up, I will ensure that all identifying information provided by the participants is changed, including participants' names, details about their lives, jobs and families. However, due to the public nature of the group activities, and as you will be taking photos in your

communities, complete confidentiality and anonymity cannot be guaranteed. Specifically, the images of the subjects of your photos (including yourself and other project participants) cannot be changed so as to protect your anonymity and theirs. Participants who want their voices to be heard through photographs and written words are encouraged to participate.

All the raw information (transcripts, photo negatives, audio tapes, field notes) from this study will be destroyed in 5 years. All printed materials will be shredded, all electronic files will be deleted, all photograph negatives will be disposed of and recorded audio-tapes will be erased. The original photographs and written descriptions that you have created will be archived indefinitely and will be made available for future use to participants and other Anti-Dote members. Original copies of all final products will belong to the project and Anti-Dote, but you will receive copies.

If you have any questions or comments, you can contact Alison Sum at [asum@uvic.ca](mailto:asum@uvic.ca) or 250-857-4012, or either of her supervisors, Dr. Jo-Anne Lee (250-472-4278 or [jalee@uvic.ca](mailto:jalee@uvic.ca)), and Dr. PJ Naylor (250-721-7844 or [pjnaylor@uvic.ca](mailto:pjnaylor@uvic.ca)). In addition to being able to contact the researcher and her thesis supervisors, you may verify the ethical approval of this study, or raise any concerns you might have by contacting the Human Research Ethics Office at the University of Victoria at 250-472-4545 or [ethics@uvic.ca](mailto:ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

*Name of Participant:*

*Signature:*

*Date:*

---

I agree to have the focus groups and discussions that I participate in audiotaped

Yes No

I agree to have my image photographed by the researcher throughout the workshops.

Yes No

If I leave before the project is complete, I understand that any comments that I make during group discussions may be used in the analysis of the data.

Yes No

If I leave before the project is complete, I understand that the images and words that I provide may be used in subsequent reports or publications under the use of my code name.

Yes No

I wish to review the transcripts of these activities.

Yes No

**On-going consent: Please write your initials to indicate your consent at the Photovoice Debriefing workshop.**

My initials: \_\_\_\_\_ Date: \_\_\_\_\_

*A copy of this consent will be left with you, and a copy will be taken by the researcher.*

Appendix G  
Image release form for participants' images

**IMAGE RELEASE FORM for researcher taking photos of participants (adapted from Dr. Jo-Anne Lee's PROJECTS FOR PEACE Research Assistant Handbook)**

*Multiple Exposures: What does Health Look Like to US?*

I hereby agree that the *Multiple Exposures: What does Health Look Like to US?* Project (University of Victoria), and all persons authorized by or claiming through or under it, shall be entitled to:

1. Photograph my likeness during focus groups, discussions, workshops and activities;
2. Make copies of the photographs taken;
3. Publish and use the photographs and any copies so made that the participants, researchers and facilitators have taken throughout the project;
4. Publish, transfer and otherwise use the photos and any copies so made, or any part therefore, and,
5. Use my name or a code name chosen by me, and use my likeness, for the purposes of promotion and dissemination of research findings photos and any copies so made.

**Date** \_\_\_\_\_

**Name (print)** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Address** \_\_\_\_\_ **Postal code:** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Witnessed by (print)** \_\_\_\_\_ **Signature** \_\_\_\_\_

This information has been collected, and will be used and maintained, in accordance with the policies and procedures of the Human Research Ethics Committee of the University of Victoria. Should you have any questions about the above, please contact investigator: Alison Sum: 250-857-4012 or Supervisors: Dr. Jo-Anne Lee: 250-472-4278 and Dr. PJ Naylor: 250-721-7844

Appendix H  
Image release form for images created by participant

**Multiple Exposures: What Does Health Look like to US?**

Image Release Form for images created by participant

I give my permission to Multiple Exposures: What Does Health Look like to US? Project (University of Victoria), and all persons authorized by or claiming through or under it to:

1. Collect any images, photographs and accompanying words that I make, for the purposes of production whether by photography, computer devices, or otherwise;
2. Make copies of the images, photographs and written work that I create;
3. Publish, exhibit, transfer, and otherwise use the images, photographs, written work and any copies that I make, or any part therefore, and,
4. Use my name or a code name chosen by me (Code name is \_\_\_\_\_) and use the images I have made for the purposes of promotion and dissemination of research findings in the form of photographs and written work, and any copies of the originals.

**Date** \_\_\_\_\_

**Name (print)** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Address** \_\_\_\_\_ **Postal code:** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Witnessed by (print)** \_\_\_\_\_ **Signature** \_\_\_\_\_

This information has been collected, and will be used and maintained, in accordance with the policies and procedures of the Human Research Ethics Committee of the University of Victoria. Should you have any questions about the above, please contact investigators  
Should you have any questions about the above, please contact investigator:  
Alison Sum: 250-857-4012 or supervisors: Dr. Jo-Anne Lee: 250-472-4278 and Dr. PJ Naylor: 250-721-7844

Appendix I  
Image release form for subjects of participant's photos and accompanying letter of  
information

**Image Release Form for subjects of photos taken by participants and attached letter  
of information for subject of photographs**

Multiple Exposures: What Does Health Look like to US? Project

I give my permission to \_\_\_\_\_ (name of research participant)  
to photograph my likeness for use in the Multiple Exposures: What does Health Look like  
to US? Project (SEE INFORMATION SHEET ATTACHED);

I give my permission to the Multiple Exposures: What does Health Look like to US?  
Project (University of Victoria), and all persons authorized by or claiming through or  
under it to:

1. Make copies of my image in photographs and printed matter for the sole purposes  
of the research project;
2. Publish, exhibit, transfer and otherwise use my image, photographs and any  
copies so made, or any part therefore, and,
3. Use my image for the purposes of promotion and dissemination of research  
findings in presentations and public engagements.

I understand that the photographs will become property of the Project and the research  
participant should the participant wish to retain copies.

Date	Name	Age	Phone #	Address	Signature	Signature of parent/guardian if subject is under age 18

This information has been collected, and will be used and maintained, in accordance with the policies and procedures of the Human Research Ethics Committee of the University of Victoria. Should you have any questions about the above, please contact the please contact investigator, Alison Sum: 250-857-4012, or supervisors - Dr. Jo-Anne Lee: 250-472-4278 and Dr. PJ Naylor: 250-721-7844

## **MULTIPLE EXPOSURES: WHAT DOES HEALTH LOOK LIKE TO US?**

### **Letter of Information**

You are being asked for your image in the photo taken by the research participant to be released to a study entitled *Multiple Exposures: What does Health Look Like to US?* that is being conducted by Alison Sum, as part of her Master's thesis requirements from the department of Exercise Science, Physical and Health Education (EPHE) at the University of Victoria. Alison has been a part of Anti-Dote since September, 2006 and was elected on to the Board of Directors as a Sistah's Representative in March, 2007. Her thesis supervisors are Dr. PJ Naylor (EPHE) and Dr. Jo-Anne Lee (WOST). The partnering organization for this study is Anti-dote Multi-racial Girls and Women's Network.

### **Background**

There is evidence in Canada and globally that social inequities give rise to racial disparities in health. Women and racialized individuals are often recognized as members of "socially excluded" groups; however, the perspectives of women of color are seldom present in the health literature. This research project aims to dismantle the forces that serve to oppress, marginalize and silence women of color who live in Canada, and examine health and well-being from their unique perspectives. How do the intersections of race, gender, class, sexuality and age affect the health and well-being of understudied populations in Canada?

### **Purpose**

The purpose of this research project is to explore the lived experiences of young, racialized women (aged 18-30) living in Victoria. Participation in this project will allow the participants to: 1) build solidarity and capacity amongst young, racialized women living in Victoria, 2) talk about and share their unique experiences growing up as a minority in Canada, 3) use creativity and visual imagery to pursue social change, and 4) have a voice in matters that affect the health and well-being of racialized women in Victoria.

### **Method**

The strategy that the research participants will be using to story-tell about their lives is called *Photovoice*, a photo documentary process that will allow them to use photos and writing to represent issues that pertain to their health and well-being. The participants will be involved in all aspects of the research process, which includes brainstorming issues and themes that relate to their health and well-being, documenting their lived realities through photography and written thought and critically reflecting on the issues that affect their health and well-being.

The researcher (Alison Sum) hopes to fulfill the last part of her Master's degree by writing about each aspect of the project in the form of a thesis. In addition, she anticipates that the results of this study may be shared with others in the following ways: articles about the project may be published in academic journals, research reports, conference presentations and a public dissemination of the Photovoice projects that the participants complete. The participants will be invited to participate in some of these public

presentations on a completely voluntary basis. If their work is included in public presentations or publications, they will have the option of using a code name to represent their work. If your image is included in their work, your name and personal information will not be identified. However, your image cannot be changed so as to protect your anonymity.

To find out more about the research project, please contact Alison Sum at [asum@uvic.ca](mailto:asum@uvic.ca) or (250) 857-4012.

Appendix J  
Anti-Dote Board Approval

**Excerpt from Anti-dote Board Meeting Minutes (as proof of Anti-Dote approval for my research)**

**Anti-Dote Board Meeting Minutes**

Monday July 9, 2007

Place: 915 Island Road, Victoria, BC

Attendees: Jin-Sun Yoon, Veronica Pacini-Ketchabaw, Jo-Anne Lee, Alison Sum, Sandrina Definney, Winnie Chow, Emma Tang, Saori Tsukamoto, Linley Faulkner, Kemi Craig, Angela Polifroni (recorder)

Meeting time start: 6:53 pm

1. Alison's Thesis Project

- Alison wants to conduct a Photo Voice project with the Sistahs as her thesis research project, so Anti-Dote becomes a site for her research
  - Project is about Health & Well-Being, as linked to Identity
- As part of the Photovoice project, Alison also plans on doing outreach, which would benefit Anti-Dote (capacity building)
- This project would allow the Sistahs the opportunity to share their stories in their own voices
- Alison asked to leave the room for motion or expressed concerns
- Saori puts forth a motion to support this project & Veronica seconds this motion.
  - All in favor, none opposed

## Appendix K

### Point-form contents of ongoing verbal consent script

- Your participation is entirely voluntary. It is up to you to choose whether or not you wish to participate.
- If you decide not to participate, it will not affect how the researcher or members of Anti-Dote will treat you.
- If any of the activities or processes make you feel uncomfortable, you do not have to participate in them.
- You can leave the group or stop participating in the project at any time.
- If you decide to leave towards the end of the study, the photographs and written entries that you provided during your participation may be used in subsequent reports and publications.
- Group discussion data are difficult to remove and may still be used should you withdraw.
- I will be taking field notes and/or tape recording throughout discussions and focus groups, and possibly taking photographs throughout the workshops and other components of the project.
- All notes, photograph negatives, audio tapes and transcripts will be stored in locked cabinets and password protected computer files.
- During discussion group sessions please do not discuss with others outside the group what other group members say in the group.
- If any of the discussions or activities make you feel uncomfortable, you do not have to participate.
- I anticipate that the results of this study may be shared with others in the following ways: articles about the project may be published in academic journals, research reports and conference presentations, and we, as a group, will hold at least one public engagement that will disseminate our work.
- All the raw information (transcripts, photo negatives, audio tapes, field notes) from this study will be destroyed in 5 years.
- Original photographs and written descriptions that you have created are will be archived indefinitely and will be made available for future use to participants and other Anti-Dote members.
- Original copies of all final products will belong to the project and Anti-Dote, but you will receive copies.
- If you have any concerns regarding any of this, you may contact me, my supervisors, Dr. Jo-Anne Lee or Dr. PJ Naylor, or the president elect of Anti-Dote, Sandrina DeFinney.

Participant's Ongoing Consent - Please provide your initials if you agree to partake in the following components/methodologies of this study under the above conditions:

<b>Component/ Methodology</b>	Initial Meeting	Photovoice Workshop	Debriefing Session	Review of Transcripts
<b>Initials</b>				