

**Racial Discrimination as a Health Risk for Female Youth:
Implications for Policy and Healthcare Delivery
in Canada**

by
**Women's Health in Women's Hands
Community Health Centre
(Toronto, Ontario)**

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EXECUTIVE SUMMARY

Healthcare is a fundamental right that should be guaranteed to all members of Canadian society. Unfortunately, there are existing obstacles which deny many communities of colour equal access to quality healthcare. Our report titled “**Racial Discrimination as a Health Risk for Female Youth: Implications for Policy and Healthcare Delivery in Canada**” is the summary of a one year participatory research process. The research presented in this report was aimed at exploring racial discrimination as a health risk for female youth. The research also aims to generate recommendations for policies and strategies to develop anti-racist modes of practice for this population within Canada’s healthcare system.

Research can play an important role in outlining the risks associated with racial discrimination in a particular society. With this goal in mind, we integrated feminist, anti-racist, and participatory approaches in the research design and implementation of this project. Each of these three approaches contributed to the overall conceptualization of the project, and each brought a valuable perspective to the exploration of racism and health in the lives of young women of colour.

In order to stay true to these theoretical concepts our exploration of the impact of racism on the health of young women of colour involved not only exploring our own experiences as researchers of colour but included the perspectives of service providers who operated from an anti-racist framework. Most importantly the central focus of the research process was the engagement of young women of colour in every aspect of the research study. This ensured that the voices of this segment of the population were the guiding force in our final report.

Our research highlighted the existing obstacle of racism which results in the denial of young women of colour to equal access to quality healthcare, health education and health information. The resulting disparities in health access and modes of treatment are varied and complex but it is undeniable that racism plays a major role and must be considered a viable determinant of health in the lives of young women of colour.

Our report concludes with an outline of specific recommendations for policy and program development provided by the young women and service providers who participated in this study. We hope to offer the readers this expression of our experience over the past year as an opportunity to consciously re-examine racism as a determinant of health and contribute to the transformation of this reality.

It is our hope that this research will be of practical use to healthcare practitioners, especially those actively committed to the elimination of racism. The research will directly benefit young women of colour by developing concrete strategies and policies to provide healthcare delivery that meets their needs in a sensitive and culturally competent manner. The implementation of such service delivery is a significant step towards equality in that it will ensure improved quality of life for a vulnerable segment of Canada’s population. Engaging young women in a research process which aims to articulate their life experience is a form of empowerment that can greatly strengthen the ability of these young women to make healthy personal choices for their futures. In this way we hope our research will provide direction for change which must be implemented to ensure a positive foundation of health and well-being for these young women to fulfill their potential in Canadian society.

NOTISHA MASSAQUOI
WOMEN’S HEALTH IN WOMEN’S HANDS

INTRODUCTION

The general premise of this report is that racism in its many forms acts as a barrier in the access to healthcare of young women of colour in Canada. Whereas it is an obvious statement that racism and other forms of discrimination could negatively impact access to the health care system, it is however, a much more difficult, and indeed a more useful enterprise to connect the specific problematic policies and practices to the viewpoints and experiences of young women of colour who must navigate the obstacles to maintain and improve their own health.

Ultimately such connections are most useful when incorporated into strategies designed to eliminate the gaps between the aims of the healthcare “system” that is presently navigated by young women of colour and the goal of equitable health outcomes. For the following study to be inherently efficacious, it must fulfill a dual function. Firstly, it must focus on the identification and analysis of health service gaps from the perspective of young women of colour. Secondly, it must honour their voices and experiences by incorporating their perspectives into the development of practical, anti-racist approaches for the elimination of the detrimental effects of racial discrimination on young women of colour (Henry, 1995).

Many studies in North American and European contexts have found that mainstream agencies have failed to provide accessible and equitable services. Doyle and Visano’s major study of social services in the Toronto area found that institutional discrimination as well as specific discriminatory practices reflected the lack of commitment of mainstream providers to enact the changes that would fulfill the needs of their diverse client bases. White human-service professionals frequently held negative judgments of minority communities which only exacerbated the already systemic alienating factors experienced by these communities such as language barriers, poor access to childcare and transportation. (Doyle and Visano, 1987).

For young women of colour the fragility of the link between the healthcare system and their experiences of well-being may be further weakened by barriers of race, gender, language, culture and poverty (Essed, 1991). These young women cannot take for granted that their medical practitioners will respect their experience, speak their language, understand their culture and that the medical advice they receive will be consistent with both their world view and their material resources. Racial discrimination in the healthcare system at the extreme renders the perspectives and health concerns of young women of colour marginal and pathological.

The mono cultural medical model of healthcare in mainstream Canada renders the dominant cultures’ perspectives as normal, neutral and universal – whether by accident, design, or as a by-product of systemic discrimination, young women of colour become problematic in this system by virtue of their difference from what is presented to be the norm. (Razack, 1998). A young woman of colour thus must first struggle to overcome the systemic barriers to healthcare only to possibly find a system and service providers which may not be able to treat her overall needs.

Appropriate and effective research is integral to and can play an important role in outlining the risks associated with racial discrimination in the lives of young women of colour. Methodological questions and the resulting methodology must encompass much more than practices and techniques of data collection. Many feminist and anti-racist theorists would insist that the philosophy behind methodology, data collection and the specific methods stem from each other, and must be linked to the empowerment of women. Only by investigating the multiplicity and complexity of the research subject’s lives may the researcher cease being an interested observer and become a skilled participant investigator (Essed, 1991). Therefore we have integrated feminist, anti-racist, and participatory approaches in the research design and implementation of this project. Singularly, each of these three approaches would have contributed to the overall conceptualization of the project, yet integrated they become aspects of

a much greater framework, one that combines pragmatism and complexity to reflect those aspects of young women of colour with multiple subject locations.

In this report we employ a critical integrative approach to explore the possibilities of feminist and anti-racist healthcare. This integrative approach stresses that the socially constructed concepts of race, class and gender are fundamental to comprehending the nature and function of the process of obtaining good health. Specifically, a feminist and anti-racist participatory framework critiques practices that negate or omit the total lived experiences of marginalized clients and practitioners (Dei, 1996)

A comprehensive feminist approach centres the perspectives of the experiences of women and girls by addressing the objectification or “othering” of women and girls (Wallston, 1981; Wittig, 1985). However, it is not enough to study women and girls, it is also important to acknowledge the gaps of previous androcentric research, (Morawski, 1985). Instead of inserting young women into male-centered paradigms, the investigators must consider the effects of the sociopolitical context on the lives of women and girls (Fine, 1985). A feminist approach emphasizes egalitarian relationships between researchers and research participants. This principle focuses upon the implementation of the research project to ensure that power is not disproportionate toward the decisions and influences of the researcher. The focus is also on the fact that women and girls who are participants in research projects bring to a project their own valuable expertise. (Crawford & Marecek, 1989) A most important principle that guides feminist research is advocating for the rights and needs of women and girls through research, which must be reflected in research design as well as the crucial decisions that must be made by researchers when choosing research topics, formulating research questions, and disseminating research findings.

One of the hallmark principles of anti-racist research is an emphasis on the ways in which racial discrimination influences the lives of people of colour. Anti-racist researchers seek to identify and expose the impact of racial discrimination on the experiences and opportunities of people of colour by systematically exploring the risks and effects of racism in various contexts (Jones, 1991). A related principle is the goal of including diverse perspectives in conducting research related to racism (McFarland, Dalton, & Walsh, 1989). Following this principle involves valuing the contributions of members of communities that have been affected by racism. This principle entails actively seeking out representatives from such communities and encouraging the participation of individuals who adopt anti-racist practices as part of the research process. A final relevant principle of anti-racist research is a focus on the systemic and structural mechanisms of society that serve to perpetuate racism and its effects (Appiah, 1990). According to this principle, research must always consider the constructed nature of racism and the institutions that function to maintain a racist environment.

The participatory approach to conducting research primarily involves the principle of including members of the community that is the focus of the research as active members of the research team (Chataway, 1997). This involvement contributes to the inclusiveness of the research process and allows researchers to benefit from the experience and expertise of individuals whose lives have been influenced by the issues being studied. Moreover, adherence to this principle provides valuable collaboration between researchers and community members by creating a generative process in which different knowledges are conveyed between the researchers and the participant members of the project team. A second key principle in participatory research is an emphasis on creating a positive and educational experience for the participant team members (Yeich & Levine, 1992). The onus is on the researchers to ensure that the team members gain new skills as well as new knowledge about the research topics. The researchers must also ensure that the participant members are comfortable with the methods and procedures that are adopted in the research project.

Finally, a principle of participatory research is the collection of the research data in a manner that is respectful and empowering for the participant team members (Brown, 1985). This principle focuses specifically on the methodological and procedural aspects of the research project. The emphasis here is on the importance of involving the team members in the data collection and on using methods that acknowledge existing strengths among the team members. These strengths can include certain communication skills and fluency in various languages. Accordingly, participatory research projects often employ qualitative methods for data collection; these methods usually involve data gathering through interviewing conducted by the participant team members.

Feminist and anti-racist participatory research acknowledges the realities of various marginalizing forces that can serve to disempower women and girls. Such forces include discrimination in workplace and educational settings, as well as various forms of oppression and violence that can occur in interpersonal and familial settings. (Razack, 1998).

A feminist and anti-racist participatory research framework acknowledges the reality of racism in society and the potential for equity in the healthcare system. A feminist and anti-racist framework addresses the disparities of power, rather than merely appreciating difference and diversity. It recognizes that race and social difference constitute the context in the struggle for power and domination in healthcare institutions and society. We contend that all social oppressions intersect with each other, and that a discussion of one such oppression, racism, necessarily entails a discussion of class, gender, and sexual inequalities in healthcare and other public service provisions.

THE PRESENT PROJECT

This research project integrated the three approaches outlined above in both its research objectives and in its methodology. This project adopted the feminist approach in its aim of giving voice to issues in the lives of young women of colour from their own perspectives, and in its aim of outlining risks associated with the marginalization of the needs of these young women. The feminist perspective is also emphasized in the project's goal of developing strategies and policy directives to address these risks. This project integrated the anti-racist approach by having a focus on the effects of racism and by actively involving a diverse team of young women of colour and anti-racist practitioners. The anti-racist approach is also evident in the project's focus on the healthcare system as a potential setting for racial discrimination.

Finally, the participatory approach was adopted in this project by including an active participant team consisting of young women of colour. In further implementation of the participatory approach, the members of this team were trained in interviewing techniques, and data collection was conducted using a qualitative approach in which the participant team members interviewed their peers.

In adopting a combined feminist, anti-racist, and participatory approach to investigating health risks associated with racial discrimination in young women of colour, this project aimed to gather information on an under-researched topic. The existing literature on the health and well-being of young women includes very little addressing the question of how racism may be associated with physical and mental health difficulties experienced by young women of colour (Kagawa-Singer, Katz, Taylor, & Vanderryn, 1986; Williams, Morris, 1996). Dougherty (1999) argues that factors influencing health and well-being in the lives of young women have been largely neglected by research. She states that this neglect is due to a lack of researchers investigating issues in young women's health, and to a belief that these issues are somehow less important than issues in adult health. Moreover, she states that there is a particular paucity of research reflecting young women's own perspectives on their health needs. These arguments therefore support the notion that there is a critical need to investigate factors impacting the health of young women.

Racism is a particular instance of societal oppression that can have damaging effects at both the community level and the individual level. Recently, theorists have posited that there is a connection between the stress of racism encountered by young women of colour as individuals and subsequent health problems they may experience. For example, de las Fuentes & Vasquez (1999) argue that society's racist views of young women of colour impede their healthy development by disrupting their sense of identity. These authors state that this disruption can lead to an increased risk of mental health problems as well as a diminished ability to successfully navigate the healthcare system. Guthrie, Caldwell, & Hunter (1997) report that health-promoting behaviours among this population are hindered by societal messages that foster a belief that their health concerns are not valid or important. Similarly, Javed (1995) argues that societal notions of the "strangeness" of non-white members of Canadian society pose a threat to the health and well-being of women of colour by implying that their health problems can be dismissed as cultural anomalies. Javed (1995) further states that this dismissal has been linked to subsequent depression, anxiety, and insomnia.

In other research, female youth who immigrate to Canada with their families have been shown to suffer from adverse stereotypes, low self-esteem, and negative self-perceptions, all of which can impact their health and well-being (Douglas, 1995; Maceda-Villanueva, 1990). Vasquez and de las Fuentes (1999) report that existing healthcare services do not adequately consider the effects of immigration and acculturation on the health of young women of colour.

This segment of the population has also been identified as particularly vulnerable due to the intersecting prejudices that pervade their existence: being young, being female, and being a person of colour are all factors that can serve to disempower and thereby lead to feelings of helplessness and low self-efficacy (Boyer et al., 1997; Fernando, 1991; Henry et al., 1995; Turner, 1995). Taylor, Gilligan and Sullivan (1995) argue that this intersection of marginalized identities make young women of colour feel isolated and misunderstood, thereby placing them at risk for depression, eating disorders, substance abuse, and unwanted pregnancies. In our own experience working with young women of colour in healthcare settings, we have found additional risks of hypertension and sexually-transmitted diseases.

While some of the health issues affecting young women of colour have been investigated, there remains a serious lack of data directly addressing the interplay between the health needs of this population and existing gaps in services designed to meet these needs. This project therefore focused on the identification and analysis of such gaps from the perspective of young women of colour. This project focused as well on the development of practical, anti-racist approaches to eliminating racial discrimination within healthcare delivery.

RESEARCH OBJECTIVES

The specific research question addressed in this project was: What improvements need to be made in the delivery of anti-racist healthcare for young women of colour? The first objective of the project was to explore racial discrimination as a health risk for young women of colour between the ages of 16 and 22. The project therefore involved the articulation of health concerns affecting young women of colour from their own perspectives. This project also looked at the need for policy change with respect to the unique health needs of young women of colour. Existing healthcare policy does not sufficiently address aspects of racial discrimination affecting this segment of the population. The health needs of young women of colour require special consideration because young women of colour are currently under-served and because there is a critical need for the formalized implementation of anti-racist directives which can serve to empower them both mentally and physically. These directives must be strategically initiated both in specific healthcare settings and in the broader context of Canada's healthcare system. Therefore, an important component of this report is the presentation of practical policy recommendations for anti-racist care for young women at both the institutional and governmental levels.

METHODOLOGY

Recruitment of Female Youth for Focus Group

The research team recruited young women of colour for a focus group looking at how racism affects the lives of young women of colour. The recruitment stage involved the development of a flyer, press release, list of community agencies, and a list of local and cultural newspapers.

The target group was young women of colour between the age of 16 and 22, thus the overall appearance of the flyer would have to attract this particular group by encompassing images that they could identify with. Throughout the project and specifically in the development of the flyer, the research team had to keep in mind the complexity of the lives of young women of colour, who often perform multiple roles as students, workers, daughters and mothers. Various mechanisms were used to accommodate the characteristics and roles specific to the target group when developing the flyer. A photograph of a young woman of colour was used as the backdrop of the flyer, fading it to allow for the written content. Secondly, the use of "casual" words within the flyer would let the young women know that it is an informal group, stating that "we would like to speak to you about your experiences, strengths, and challenges as young women of colour." Lastly, the flyer informed the young women that they would be paid an honourarium for their valuable time, in addition to the provision of food, transportation and childcare. (See Appendix 1)

The flyer was distributed to agencies throughout the Greater Toronto Area, particularly those serving young women of colour. A flyer was also sent to local newspapers and community newsletters, many of which were known to have a young readership. (See Appendix 2) The flyers were also sent to clients of Women's Health in Women's Hands who reflected the target population. Hence, through a combination of the above distribution techniques, as well as through word of mouth, fifteen young women of colour were recruited to participate in the focus group representing various cultural backgrounds. (See Appendix 3)

Focus Group with Young Women

The focus group was held on August 18, 2000 from 6:00p.m. to 9:00p.m. at Women's Health in Women's Hands, where the 15 recruited young women of colour attended. Given the

nature of the topic of racism, combined with the sensitivity of the young women, Women's Health in Women's Hands was chosen as the location for the focus group as a means to provide appropriate emotional support and care for the young women when needed. The location also served as an opportunity to introduce the young women to the services provided by Women's Health in Women's Hands. Each of the young women who attended the focus group was paid a \$30.00 honourarium and provided with food, transportation and childcare where applicable.

The purpose of the focus group was to:

- Gain information on the experiences and feelings of young women of colour with respect to racism and its impact on their lives.
- Use the articulated feelings and experiences of the young women as a foundation for the development of interview questions to be conducted by the young women throughout the year.
- Create a project advisory committee consisting of those young women interested in participating in the project for a full year.

The focus group began with introductions between the fifteen young women and the research team. Following the introductions an overview of the projects' rationale, goals and objectives was given to the young women. The young women then broke out into smaller more comfortable groups, where each group was given the following three discussion questions:

- What is Racism?
- What are some examples of racism?
- How can racism affect your health and/or how you feel?

Subsequently, the young women came together as a larger group to report on the issues that emerged from the discussion questions. The themes that emerged from the focus group encompassed issues around identity, self-esteem, reproductive health, the educational system and the media. The young women expressed feelings such as guilt, frustration, fear, anger and insecurity when asked how racism affects their health and how they feel. When the young women were asked to give examples of racism, some women expressed feelings of humiliation during physical health examinations; others felt that their health practitioner did not validate any illness they were concerned about. There were several themes that emerged from the focus group, many of which were later used during the formulation of interview questions. (See Appendix 4)

Finally, the young women were offered a role in the research process through membership on a project advisory committee. The project advisory committee entailed developing questions for individual interviews; assisting in the recruitment of interviewees; conducting the individual interviews; participating in a survey of existing healthcare services; and participating in the analysis and summary of the project finding. Of the 15 young women involved, 12 women volunteered to commit their time to the project for a full year.

Focus Group with Anti-Racist Practitioners

The practitioner focus group was held on September 7, 2000 from 7:00p.m. to 9:00p.m. at Women's Health in Women's Hands. In this phase of the project, we conducted a focus group consisting of anti-racist practitioners who have worked with young women of colour. We chose practitioners who identified themselves as anti-racist, those who acknowledge in practice the long lasting impact of racism on the health and well being of an individual.

The practitioners were recruited through social service agencies, many of which were known to us through community work. Nine practitioners attended the focus group, and all of them were women of colour. Due to the nature of the project, in particular the target population of young women of colour, we chose only female practitioners who could best identify with the issues facing young women of colour.

The practitioner focus group questions were developed based on the issues and concerns expressed in the focus group with the young women. The focus group members discussed the following questions:

- What are the existing barriers faced by young women of colour in the healthcare system?
- How can we eliminate these barriers?
- What are the main health problems affecting young women of colour?
- What does anti-racist practice mean to you?

The focus group was audio taped with the written consent of all members; however the practitioners requested that their agencies remain anonymous. The audiotape of the focus group was transcribed verbatim for qualitative analysis.

Advisory Committee Meeting

The first advisory committee meeting was held on September 08, 2000. The purpose of the meeting was as follows:

- To discuss the objectives and the timeline of the research project
- To review the issues and themes from the focus group with the young women
- To begin developing questions to be asked in the individual interviews

The young women were informed that an honourarium, food, transportation and childcare would be provided at every meeting. Each member of the advisory committee was given a timeline of the project and a summary of the issues discussed in the first focus group.

The following issues emerged as important domains considered by the committee:

- Their physical and mental health concerns
- Their beliefs about the role of racial discrimination as a contributing factor to their health problems
- Their experience of barriers within the healthcare system, particularly in the context of racism
- Their opinions of what changes should take place in healthcare services to make them more accessible to them as young women of colour

After detailed discussions, the young women developed tentative interview questions. (See Appendix 5)

Training Sessions on Interviewing Techniques

The members of the advisory committee were trained on interviewing techniques conducted by skilled researcher. Due to the conflicting schedules of the advisory committee, the training sessions were conducted on two separate days. A researcher facilitated the first training session. The researcher trained the young women on interviewing techniques such as: establishing a communicative atmosphere, listening to the respondent, probing and concluding the interview. One of the advisory committee members who felt comfortable with her knowledge

of the interviewing techniques, volunteered to facilitate the second training session. During the last part of the training session the young women reviewed the draft of the interview questions. Based on their training, the young women modified and refined the interview questions. (See Appendix 5)

Interview Package

The interview package was developed and ready for distribution at the next advisory committee meeting on October 13, 2000. (See Appendix 6) The interview package consisted of the following:

- One information sheet (explaining what the project is about and how long the interview would take)
- Two consent forms to be signed by the interviewee
- Interview questions
- Participant invoice (for payment)
- Interviewer invoice (for payment)
- Audio tape
- Small envelope

In order to protect the identity of the interviewee, the following items contained identification numbers:

- The audio tape
- The set of interview questions
- The small envelope

The audiotape and interview questions were to be placed in the corresponding envelope. Each interviewer received a tape recorder with batteries and a laminated instructions sheet containing each step within the interview process. A payment of \$10.00 was given to both interviewer and interviewee upon receipt of a completed interview package.

The interviews were conducted according to the following steps:

1. The interviewer and the interviewee agree upon a mutually convenient time. Arrangements are made for the interview to be conducted privately and in a quiet place.
2. Before the interview begins, the interviewer introduces herself and provides the interviewee with a copy of the information sheet which they read through together.
3. The interviewer gives the interviewee a copy of the consent form. The interviewee reads and signs the consent form.
4. Before asking the interview questions, the interviewer turns on the cassette recorder to begin audio-taping. The audio will later be transcribed so that qualitative analysis can be performed.
5. The interviewer asks the interview questions, allowing the interviewee as much time as she needs to answer question fully.

When the interview is complete, the interviewer turns off the cassette recorder. She gives the interviewee an invoice to complete in order for the interviewee to receive her payment of \$10.00 for participating. The interviewer then thanks the interviewee for her time.

Advisory Committee Meeting

The purpose of the meeting was to:

- Provide the advisory committee members with the interview packages
- Provide the advisory committee with the opportunity to practice interviewing techniques through mock interviews
- Discuss recruitment methods for interviewees

The meeting began with a thorough explanation of the contents of the interview packages. Each young woman was then given no more than ten packages each. When the young women completed the interviews, they picked up additional packages at Women's Health in Women's Hands. The young women proceeded to split into pairs to begin the mock interviews, switching roles when the interview was finished. The mock interviews continued until all the young women felt comfortable with the interview process. Following the mock interviews, the young women brainstormed around recruitment strategies for interviewees. It was decided that recruitment would be done through their existing social networks, their respective high schools, and other educational/recreational settings.

Advisory Committee Meeting

The purpose of the meeting was to:

- Encourage the interest level amongst the young women
- Show appreciation to the young women for dedicating their time and energy to the project thus far
- Give the young women an opportunity to assess the interview process and make any necessary changes

Although we did not anticipate having another meeting, due to school examinations and the Christmas holidays, the number of interviews completed by the young women was at a minimum. Thus, it was felt that a meeting after the Christmas holidays would allow us to encourage and thank the young women for their work. The meeting began with a presentation of thanks and appreciation to the young women with a Women's Health in Women's Hands T-shirt. Many of the women expressed their continued commitment to the project, explaining that the previous months were particularly busy with school, work and the Christmas holidays.

The young women proceeded to talk about issues and concerns regarding the interview questions. Many felt the interviews were cold, abrupt and choppy. Some young women observed that the responses to the questions were very short and the interview felt too structured. It was decided that changes to the interview questions were needed. As a result, warm-up questions were added to the beginning of the interview to create a more comfortable, relaxed atmosphere. Some questions were also re-worded or changed to what the young women thought to be more suitable and effective. (See Appendix 7)

We made the necessary changes to the interview questions and mailed copies to each advisory committee member. It was also expressed by some of the young women that they needed help in recruiting interviewees; thus, it was decided that we would recruit interviewees to attend two mass interview sessions. The mass interviews were held on April 27th and May 24th. The mass interview sessions made the recruitment process much easier and less time consuming for the young women interviewers.

Transcription of Individual Interviews

Advertisements for transcribers were sent to various colleges within the greater Toronto area. Four transcribers were hired at a rate of \$20.00 per tape. Each transcriber signed a contract and a confidentiality statement and began transcription as each interview was completed.

Healthcare Survey

During this phase of the project, the research team formulated 16 survey questions for healthcare services in the Greater Toronto Area to examine the accessibility and availability of services for female youth of colour. We chose agencies that provided comprehensive services, from several different regions within the Greater Toronto area. Each agency was sent a letter via fax or e-mail, outlining the purpose of the research project and the survey. After continued follow-up, seven of the sixteen organizations responded to the survey by fax or e-mail.

RESULTS AND DISCUSSION

Focus Group with Anti-Racist Practitioners

A. *Demographic Characteristics of the Sample*

Of the nine health care providers that participated in the practitioner focus group, seven completed a brief demographic survey. The survey contained questions regarding their age, place of birth, ethnic background and employment information. The participants ranged from 25 to 49 years of age, with an average age of 35.5 years. Their place of birth varied: three from Ontario; one from Cleveland, Ohio; one from London, England; one from Jamaica; and one from South Africa. They represented various self-identified ethnic backgrounds: two South Asian; two Caribbean; one Afro-Caribbean; one Black and one non-specified.

Regarding their employment, one of the practitioners was a hospital-based project consultant, one was a hospital psychotherapist, one was a service manager in a hospital setting and one was a manager in a substance abuse treatment setting. One participant was employed as a police constable and another was a mental health counsellor at a community health centre. A former part-time faculty member from a community college also was amongst the participants.

In terms of describing the composition of the staff at their current place of employment, four participants reported that the staff was predominantly white. None of the health care providers indicated any age-specific information. However, one participant reported staff members belonging to a specific religion (Christian). Only one participant reported a staff composed solely of female members. All of the seven health care providers reported working with young women of colour, although they widely ranged in terms of years of experience in this area. On average, the participants reported working with young women of colour for 11 years, ranging from nine months to 27 years.

B. *Findings from Focus Group*

The transcript of the focus group of anti-racist practitioners was analyzed according to the four questions that formed the basis for the focus group discussion. The findings are therefore presented according to each of these questions in the order that they were discussed:

Question 1: What are the existing barriers faced by young women of colour in the health care system?

Participants expressed that mainstream healthcare providers do not name *racism*, but rather use the term “multiculturalism”. They identified this as a barrier to acknowledging the reality of racism. As one of the practitioners stated:

“When I want to talk about anti-racism, I can be very aggressive. But when doing diversity training with white people, you got to water it down to: ‘Oh, let’s do multiculturalism.’”

The participants discussed the fact that, on a daily basis, young women of colour face many barriers in the health care system. The system was described by the practitioners as presenting challenges to young women of colour that include: racial stereotypes, language barriers, and lack of multi-racial health care workers. Participants particularly emphasized the lack of multi-racial, multi-lingual healthcare workers as a major problem in the healthcare

system with regard to meeting the needs of young women of colour. They suggested that including more non-white front-line workers in medical settings would allow for a greater comfort level among young women of colour who are seeking healthcare. According to one of the practitioners:

“One of the things that I find working with young black women is the big barrier... when they go to centres and they are not aware of a place where there is women of colour and they walk in and there is a white person, and it's not just the white person or the white face... it is that lack of validation, a lack of being taken seriously.”

The practitioners further commented that the lack of comfort a young woman feels with a healthcare provider can be especially problematic when it comes to the need for a close relationship between the provider and the client. As one participant stated:

“That lack of relationship that [a] person has with the provider [means] you can't have an effective relationship or treatment if that person is not going to open up. So I think that's a major problem between the client and the provider.”

The practitioners also discussed the difficulties associated with being a sole non-white practitioner in any particular setting. They discussed the fact that non-white practitioners are often stereotyped by white patients as being less professional. They also pointed out that being a sole non-white practitioner can be a very isolating experience. One participant recounted such an experience:

“I have been in this business for over twenty-two years. I have been one of the first directors/managers around for many, many years, and going to different meetings and conferences all over the place. And every time I walk in that room and I see only me, it's a whole new feeling in the stomach, you know”

As another barrier, the practitioners discussed the lack of inclusion of women of colour in the research process. Specifically, they emphasized the paucity of researchers of colour as a major problem. They also emphasized problems inherent in not including women of colour as research participants. One participant summed up the problem as follows:

“I worked in research before I started this, and all the researchers were white. The majority was male and the populations they did research on were middle class white males and females. And that's the research that the practitioners...based their therapy on.”

The participants also stated that most healthcare providers are only trained to look at the individual rather than acknowledging societal factors or holistic factors in health. Another problem they identified was that healthcare providers do not make the connection between the physical, mental and spiritual domains. They also pointed to the problem of having narrow definitions of health and illness:

“In psychiatry we have an awful tendency of having a very narrow view of what is normal. Any small infraction on the part of our clients, we quickly have a label for it, we diagnose it, we chart it.”

So we can see that the focus group participants identified several barriers affecting young women of colour in the healthcare system. There was considerable consensus among the practitioners regarding these barriers, and their comments indicate that they acknowledge the need for an anti-racist approach in addressing these barriers. In particular, they discussed racism as being responsible for people of colour blaming themselves for their

physical and mental health problems. One participant reflected a common sentiment among the participants in this way:

“Racism...is a social construct ...that ensure[s] that we end up with mental issues. There comes the depression, there comes the lack of self-esteem, there comes the job, there comes the moving away from the family, there comes everything that’s happening. [It’s seen as] a result of me and not the system out there.”

Question 2: How can we eliminate these barriers?

The practitioners expressed that these barriers can be eliminated through education of service providers and young women of colour. In particular, they stated that it is essential to increase awareness about the lack of communication between service providers and clients within the healthcare system. Regarding the need for education and improved communication about healthcare options, one participant stated:

“I...think that it is important for providers to be educated, but I think it’s almost more important for that person, that woman of colour to be educated. Because if you are educated it can empower you and you can then make decisions on who you want to be your provider.”

The practitioners emphasized the fact that healthcare providers should address the social, spiritual and cultural influences on health and wellness. They also stated that healthcare providers should allow space and time for their patients to speak freely and feel validated when voicing their health concerns. Also, they commented that, in order to provide the appropriate services, healthcare providers should be able to identify the social issues affecting young women of colour. They further stated that providers should be more open to a range of different approaches to healthcare. One participant used the example of spirituality as an approach that is often dismissed by healthcare providers:

“A very young woman who came here from the Caribbean...got pregnant and ended up at one of the major hospitals in Toronto to give birth to her baby. She is accustomed to some kind of ritual around that, and her perspective of health is within strong roots of spiritualism. So she brought her Bible...and she wanted her grandmother in the room with her...In about fifteen minutes the whole room was filled with all the nurses and doctors, you know, they think she’s crazy.”

It is therefore important to consider such biases in the healthcare system as potential areas of change. Resistance to racist stereotypes can serve to empower young women of colour if enacted in a range of settings, including mainstream hospital settings.

Question 3: What are the main health problems affecting young women of colour?

The practitioners identified mental health problems, life stress, depression, family violence, sexually-transmitted diseases, and eating disorders as the main health problems affecting young women of colour. In particular, they focused on life stress as a contributing factor for a host of health problems. The participants revealed that they too suffer from lack of sleep, increased blood pressure, and sleep disturbance. Related to these symptoms are social isolation, lack of quality time with family, and work overload. They reported that, as anti-racist advocates, they spend great amounts of energy and time trying to combat racism, and they start falling behind on their work. As one participant stated:

“The constant bucking your head against the wall, increased blood pressure, lack of sleep, insomnia, isolation among colleagues who might think you are a pain in the butt,

lack of quality time away from family, work overload because you spend so much energy trying to fight that system that your own work that you are being paid to do gets left behind.”

It is important to realize that the practitioners agreed that they experience many of the health problems that they identified as health issues for young women of colour. This raises the point that many of the threats to wellness that racism poses can affect a wide range of people of colour and is a constant in the lives of people of colour from a young age.

The practitioners also stated that many of the health problems encountered by young women of colour occur because society does not empower them to engage in anti-racist action. One participant described the problem this way:

“The commitment is so needed, but it’s such a treacherous terrain. You have to have some kind of grounding and it kind of really goes back to young kids...you know, getting them from young. [Otherwise], it’s so cyclical, it’s very frustrating.”

This notion of the cyclical nature of the effects of racism on health was voiced by many of the practitioners. Overall, they expressed the opinion that racism can lead to feelings of shame that are shared by many people of colour in Canadian society. This cycle, they argue, can only be changed through collective anti-racist action:

“We each have our organization and the different game we have to play. We have to learn the game and learn to attack it in different ways...So it’s about networking, connecting, and being with different people so that we can strategically deal with that.”

Therefore, we can see the importance of anti-racist initiatives in bringing about widespread change that can make the healthcare system more responsive to the needs of young women of colour. The consensus among the practitioners was that young women should be encouraged to participate in advocacy on their own behalf. They reported feeling that such advocacy could be very empowering for young women and could in itself reduce their personal health risks. This reduction of health risks could be achieved through increased self-efficacy associated with taking action against racism in its various forms.

Question 4: What does anti-racist practice mean to you?

The practitioners stated that anti-racist practice means that practitioners should “practice what they preach”. They emphasized the importance of practitioners of colour serving as role models for their clients of colour. The practitioners also stated that anti-racist healthcare allows the client to talk about any problem without fear of being stereotyped or judged. In this way, they stated, a trusting relationship can be developed between client and service provider.

They also suggested that practitioners should take risks and challenges by being advocates for their clients. They further emphasized that anti-racist practitioners should have strong contacts with communities of colour and work to increase public awareness of the risks associated with racism.

The participants expressed that anti-racist practice should be a collaborative effort in which practitioners work with each other and with their clients to address racism. Specifically, they stated that this effort should focus on making people of colour more resistant to stereotypical notions of racial and cultural differences. Many of the comments by participants dealt with the importance of working both as an individual and as part of a group:

“Emulating what it is that you want to see and being grounded enough and well aware of yourself enough and your community to remain strong and progressive and to affect that change and learning. Not only the education for the youth, but for yourself, learning the organization that you are in and learning what makes it run, how is this animal working, learning about your own community, because even though I'm part of the community, I have much to learn and then that's how you mesh the two, that's how you, you know, fit things here and there. So diversity training is great but it's a lot about individual action.”

These perspectives on racism, anti-racism, and the health of young women of colour reflect the values and beliefs of the practitioners who participated in the focus group. They value advocacy and collective action as well a focus on the needs of each client as an individual. We can see from their comments that there are significant challenges to combating racism in the healthcare system.

Individual Interviews with Young Women of Colour

A. Demographic Characteristics of the Sample

Individual interviews were conducted with a total of 81 young women of colour. The average age of the participants was 18.2 with the majority being between the ages of 16 and 19. The interview participants' self-identified cultural background is presented in the table below. The majority of the participants (87%) had lived in Canada for at least 14 years. Fifty-three percent currently lived at home with two parents, 20% lived at home in a single mother –headed family, 8% lived with extended family, 5% lived with housemates, and 5% lived on their own. Fifty percent spoke at least one other language in addition to English. Eighty-seven percent of the participants indicated that they had a family doctor and 59% stated that they visited their family doctor at least once a year.

Breakdown of Interviewees by Cultural Background:

Ethnicity	Percentage
African	6.0%
Caribbean	40%
East Asian	20%
Latin American	2.6%
South Asian	25%
Canadian	3.8%
Other	2.6%

B. Interview Results

The interviews were audiotaped and the tapes were transcribed. Using NUD*IST qualitative analysis software, the transcripts were broken down into analyzable units. Each unit consisted of the participant's response to a particular question. Each of these text units was then coded according to thematic content. Every new idea emerging from the transcripts was given a code. Two independent coders coded each transcript. A particular text unit could be coded for multiple themes. For example, a young woman spoke of maintaining her health by

going to the gym, eating balanced meals, and meditating to release stress. In this case, the text unit would be coded for the major themes of maintaining physical health and maintaining psychological health. As well, it would be coded for exercise, nutrition and meditation. In this way, all of the thematic content contained in the text unit is accounted for.

The results that emerged from the interviews largely reflect the interview protocol. They can be categorized into eight major categories:

1. A personal definition of health
2. Methods used to maintain personal health
3. Health services the young women use and sources that they turn to for information on health related issues
4. Experiences with the healthcare system in Canada
5. A personal definition of racism
6. Experiences of racism in the healthcare system
7. Experiences of racism outside of the healthcare system
8. Thoughts on how racism impacts health

Since the young women were sharing their personal stories and views, there were many differences from person to person in terms of the issues brought forward. However, there were also many similarities. It is these similarities which are the focus of the following discussion. Results are presented in terms of the percentage of respondents who discussed a theme during their interview. In all cases, this is the percentage of all 81 participants and never refers to the percentage of participants in a particular subgroup or category. It should be noted at this point that the interview protocol changed somewhat over the course of the project and the young women varied in their interviewing styles. Therefore, in some cases, percentages may underestimate the actual number of respondents who would have discussed a theme or issue had they been asked the additional or reworded questions included in the revised interview format or had they been prompted differently by the interviewer.

Health Definition

When the young women were asked what health meant to them, they came up with a wide range of responses. Some of the participants simply stated the importance of health in their lives. As one participant stated:

“Health is very important to me. It helps you sustain yourself throughout a day, throughout your years. So basically, it is important to maintain your body. It helps you focus your mind.”

Others offered a more specific, personal definition of health. Physical health was given the greatest attention with 79.0% of respondents naming some aspect of physical health in their answer. For example:

“Staying in shape. Not just outside but also your organs inside. Staying healthy, eating the right foods. Maintaining a healthy lifestyle.”

For 21.0% of the young women, physical health was seen as a lack of illness, disease or injury. For example:

“Health is important to me. It all relates to everything you do. With jobs and school, if you are sick, for example, you can’t go to school.”

Many of the participants also defined an active lifestyle (16.0%) and healthy eating (13.6%) as important aspects of physical health:

“I guess [health] means my well-being. For me, it’s also my fitness because I’m an athlete. When I am fit, I am also healthy mentally and physically.”

While some of the young women defined health in terms of what they were doing properly, others defined health by using examples of what they are not doing that they feel they should be doing.

“Just eating properly, exercising on a regular basis. It’s also the environment around me, like my family life. Like, we are Persians, so the food we eat is very greasy, you know what I mean? So I don’t eat healthy.”

Interestingly, both diet and exercise are themes that will be discussed again as ways to maintain physical health. It seems then that, for some of the participants, being fit and having a healthy diet are seen both as the state of being healthy and processes that ensure good health.

A substantial proportion of participants (35.8%) also discussed psychological aspects of health when forming their personal definition.

“There are two types of health. One is your physical health, which is physically how well you are and how able you are. And the other one is your mental health. Your mental health means the state of mind you are in, your internal happiness, a sense of accomplishment, or how you are feeling from inside.”

When discussing mental health, the participants were less specific in their answers, though maintaining a positive outlook and strong self-esteem were seen as crucial aspects of psychological well-being by 7.4% of respondents. As well, maintaining balance in one’s life was seen as contributing to mental health by some of the participants (4.9%). As one participant stated:

“Health means to be in control with your emotional part and your physical part. So you keep a balance in life.”

What is particularly striking when examining the responses to this question is that many of the answers often touched on several of the above-mentioned areas. While physical health dominated the definitions, many of the young women included mental and spiritual health within the same answer, suggesting a broad and multi-faceted view of health.

“Health is the right things. Healthy mind, education. Health for your soul, health for your spirit. Medicine is health. Exercise is health to me. Love is health to me. I guess really it’s a combination of a whole bunch of things that mean health to me.”

Health Maintenance

There was a good deal of overlap between the answer to the question of how do the young women maintain their health and their personal definitions of health. Again we see a predominant focus on physical health, with 90.1% of the young women describing ways in which they maintain their physical health.

“I take care of myself, I don’t poison it. I don’t smoke, I don’t eat excessive meat. I try to protect it as much as I can knowing that if I do bad things, bad things will happen to my

body. So I try to maintain a healthy diet, always keeping up with my physical activity and I surround myself with happy people.”

The majority of their efforts centered on exercise (74.1%) and diet (46.9%). For example:

“How do I maintain my health? Through exercising, through eating, health tonics. Through conversations with other people, learning the experiences of others and health issues. Trying to eat healthy. Trying to incorporate stuff like that.”

Along with diet and exercise, visiting the doctor regularly (16.0%), getting sufficient rest (6.2%) and taking necessary vitamins or medicines (7.4%) were named as methods for maintaining physical health. A large number of participants also described methods they use to maintain their mental health (39.5%).

“Mental and emotional [health]? Well, I know that I can’t scream and have outbursts when I want to so I write. I usually put how I am feeling into writing. That keeps me healthy mentally and emotionally. I write poetry and stories. Whatever I am feeling at the time.”

Talking to others and sharing thoughts and emotions was also seen as contributing positively to mental health by 11.1% of the young women. As an example:

“Mentally, I talk to people. I have friends. I also talk to myself. I have a bubble bath and relax like that too.”

Stress management was identified by 16.0% of participants as crucial to mental health.

“Mentally... it’s just talking to people. I like, I have really good best friends where I talk to them.... So I don’t, I don’t stress myself. That’s one thing, stressing yourself will make you very unhappy.”

A much larger proportion of participants (29.6%) addressed their spiritual health when answering this question than when discussing their personal definitions of health. This is likely the result of revisions to the interview questions that specifically prompted them to consider how they maintain their physical, emotional and spiritual health. It could be that many of the participants who were asked the original interview questions would have expanded their answers to include methods of maintaining emotional and spiritual health had they received similar prompts. Therefore, the actual number of young women who engage in activities that promote these aspects of health is likely underestimated here.

In terms of maintaining spiritual health, most of the approaches identified by the young women involved engaging in prayer (12.3%) or attending religious services (8.6%):

“Physically I’m so into my studies, I hardly have time for that. As for my mental and spiritual health, I try to pray. I’m Muslim, so I just try and get into my prayers. I feel that whenever I pray, it releases whatever is suppressing my mind.”

Again we see a style of responding that suggests a multi-faceted approach to health. This remains true despite the fact that only some of the young women were prompted to consider several aspects of health, as evidenced by the fact that many participants that did not receive this prompt but still addressed more than one area of health.

Services Used and Information Sources

As part of the interview, the young women in the study were asked to report which healthcare services they used. Again we see the predominance of physical health with 63.0% of respondents indicating that they visit their family doctor or a local general practitioner:

“I use the regular doctor, general health doctor. She does everything, you know?”

Thirty-two percent (32.1%) spoke of engaging in sports, participating on their school teams or other physical activities. It is important to note that answers to this question changed somewhat throughout the study, as responses to this topic were significantly influenced by the revision of the interview protocol. Specifically, being prompted to consider physical, mental and spiritual health when describing how they maintained their health seemed to lead many more participants to interpret the term “services” much more broadly. For example, many of the later respondents spoke of exercise activities and services like school teams and gyms, but were less likely to speak of their doctor as compared to earlier interviewees.

As well, those who received the revised prompts were more likely include spiritual health services in their answers to the question of services used. Thirty percent (29.6%) of the young women described making use of spiritual services, whether it is attending religious services or seeking the advice of a spiritual leader:

“For my spiritual health I go to the temple a lot. My mom, when I was younger, she used to force me a lot to go to the temple but now I go on my own. I guess because it gives me a sense of peace and relaxation.”

Only one participant reported ever having seen a psychologist. Many of the young women stated that they regularly visited their dentist (19.8%). Eleven percent (11.1%) of the interviewees reported making use of specialists at some point. These specialists included a chiropractor, a massage therapist, a sports doctor, an optometrist, an OB-GYN, a dermatologist, and an orthodontist. As well, 3.7% of the young women reported using birth control or family planning clinics. Five percent (4.9%) of the young women stated that they had not used any health care services in Canada.

The young women were found to be referring to a wide range of sources for their health information. Seventy-five percent (75.3%) of the participants were turning to medical sources for information. This included their doctor and his medical staff (59.3%), community clinics (16.0%), school clinics (4.9%), hospitals (4.9%), and medical journals (2.5%). Thirty-two percent (32.1%) of the young women reported looking to other people in their lives for information. For example:

“People around me. People that I can trust. Teachers, because I know a lot of teachers are not racist. Mostly my parents, and also my family doctor.”

In many cases, family was cited as a source of information (27.2%) but several respondents stated they asked their friends as well (11.1%). The media was another popular sources for information (25.9%), especially the Internet (19.8%). Television (7.4%), magazines (3.7%) and newspapers (2.5%) were mentioned as other media sources of information. School was identified as a good health information source (25.9%) and teachers were specifically mentioned by 16.0% of the young women. Many participants reported doing their own medical research using books or the local library (19.8%).

Experiences with the Health Care System

When the young women were asked to describe their experiences with the health care system, they expressed strong and varied feelings on the subject. Many of the young women reported having positive experiences (43.2%), including having good relationships with their doctors:

“My experiences have been pretty well positive. I haven’t had any type of negative experiences. I’ve had the same doctor from birth and he’s been quite good with my needs.”

However, a substantial proportion of the participants reported having negative experiences with the health care system in Canada (29.6%).

“It’s pathetic, like, if you ask me. It’s honestly pathetic. There’s no one to relate to me, no one seems to care and you’re pretty much just in and out and that’s about it. They don’t explain what I need.... For me personally, I haven’t even been shown my options and the options that I am shown are so unrealistic that I’m almost just like, “Forget it. I can’t be bothered with it. I’d rather just go with the kin than go through the things you’re telling me because I refuse to believe there’s not an easier option than what you’re giving me” type of thing. And it’s just very impersonal.... The service that I get has been really, really bad. And so it’s completely turned me off, like completely. I’ve promised myself that if the next one doesn’t work out, I am not going back to see another doctor.”

For some of the young women, this was due to personal discomfort (8.6%). Several indicated that this discomfort was caused by a lack of trust.

“I don’t like going to the hospital or doctor. I don’t trust them. They may say I have something and may make a mistake. I had strep throat and they put me on penicillin. I believe in not taking pills. If I have the flu, I’m not going to take even any herbal remedies. I’m just going to let my body work naturally.”

As well, some young women spoke of poor communication between doctor and patient as contributing to their difficulty with doctors (6.2%).

“It is kind of awkward. They don’t ask you questions. They expect you to tell them something. But you don’t know what you are supposed to be telling them. You may tell them in a wrong way, therefore they may examine you in a wrong way.”

Several participants felt that their doctors did not possess sufficient knowledge or adequate skills for dealing with patients (6.2%).

“Well, the doctor that I have, I don’t think she is that good. Like, she is a good family doctor, but you have to suggest things to her. I don’t go to her a lot. She may know things, but she won’t tell you unless you probe her and probe her. So it is, it gets tiring.”

Others found that their doctors’ offices are simply too busy to give their concerns adequate attention (7.4%):

“It’s pretty much at the health clinic. It’s just they have to deal with so many people, it’s a really busy place. So they don’t really have time, especially if you have questions. They don’t really answer it as properly, like the way you want it to be answered. It’s more like ‘Here are some things you can read up on.’”

For others, even if the time with the doctor is adequate, the wait to see him or her is problematic (4.9%):

“Sometimes I don’t really want to go because I have to wait so long. I have to wait between thirty and forty minutes because there are so many people.”

Definitions of Racism

After discussing their ideas regarding health and the health care system, the interview shifted to focus on racism. To open up the topic, the young women were asked for their personal definition of racism. Again, the discussion elicited strong emotions:

“One of the worst prejudicial ways of thinking. It is extremely unjust and unfair.”

Many of the participants described racism as prejudice (35.8%):

“Racism to me means being judged because of your ethnicity or skin colour or religious choice and being judged different when it does not coincide with the majority or the growing race.”

Others spoke of racism in terms that went beyond judgement, identifying it as active discrimination (35.8%). For example:

“[Racism is] holding someone back because of their skin. Treating someone in a negative way because of their skin. The negative aspect based on race.”

Some of the interviewees felt that as discrimination becomes less overt in Canadian society, it becomes harder to fight:

“I would say it’s very subtle. Just having barriers to all the services and access to them. Opportunity and things like that. In terms of overt racism, it does coexist and then, of course it exists, but I think it’s gotten so much worse. Just because it’s so much more hidden and people doesn’t see it and so they think it doesn’t exist. But the fact is it does exist, so the more people keep on saying it doesn’t, the harder it is to fight it, because they don’t believe it’s there. I’d probably define it more as just, being restricted in your way of life. You’re made to feel like you’re not as good because of what you look like.”

Several participants felt that the core of racism could be easily identified as hatred towards another group based on their skin colour or ethnicity (6.2%). Others saw racism as being caused less by hatred and more by ignorance (13.6%):

“It is confusion. They don’t understand you and your background or where you come from. Racism comes from a lack of self-esteem. A person takes out their confusion and anger on someone else.”

This ignorance was not only a lack of understanding of other cultures but also a failure to recognize the fundamental equality of all human beings:

“What does racism mean to me? Ignorance basically. It’s sad that racism exists cause there should be no need for it at all. I mean, everyone’s equal. Everyone’s the same. We’re all human, we all have eyes, ears, mouth, nose, hands. Nothing is different about each person. It’s really just ignorance. It’s lack of knowledge, lack of education for those people who perceive that type of negative energy.”

Racism in the Health Care System

One in five young women reported having experienced racism when using the healthcare system in Canada (17.3%). For some of the young women, these incidents had serious consequences.

“They put me into the Clarke Institute from a shelter. This girl and me got into an argument and they charged me instead of charging the both of us. I decided I won’t leave the property so the police come and put me into the mental institution. I didn’t think I deserved to go there because I didn’t think I had a mental problem. From being there, they were giving me medication that made me feel like I did have a mental problem. They told me I have schizophrenia.”

For some the experience was less overt but still greatly troubling.

“I guess it was racism. Just because, when someone tries to make themselves, you know, superior to you because of their culture and their ways, it is racism. So I mean, it didn’t affect me greatly but the fact that it was there scared me. Because I mean, who knows what levels that could have been taken to. That’s in their practice and who knows what they’re preaching subconsciously to people.”

Some of the young women described facing doctors who were culturally insensitive or ignorant (8.6%):

“I don’t think I’ve experienced racism but I’ve experienced ignorance.... I’m going in for a simple test and they ask me questions, if you are pregnant. I went in for something totally different, I didn’t come in for that.”

Such doctors were often influenced by stereotypes and let it affect their perceptions and treatment of their patients:

“It’s a place you don’t want to be in because you don’t feel that it is an environment you feel comfortable in. There are not a lot of black workers... The last time I went to the hospital, I went with my aunt. I could see in their faces that they thought I didn’t have parents. That’s why I probably wanted to leave. I had to stay there for a couple of nights. I didn’t want to. How they act and how they treat you....‘Oh, you don’t have to pay for this and that.’ What they don’t know is that my parents have a plan and that I don’t have to pay for it directly. They say, ‘Why don’t you get this instead of the other.’ One medicine will cure you faster, but they will give you the other because that is what they think you can afford.”

Name-calling emerged as another experience of racism in the healthcare system (2.5%). One participant described a highly distressing incident with her massage therapist:

“I was in class one day being worked on during massage treatment. A young lady . . . just out of nowhere just asked me if I prefer being called either black or nigger. And at the time it just completely shocked me. I didn’t know what to say, what to do. I really froze. And there was an instructor there. I don’t know if she really, if she overheard it. I think she did, cause she didn’t say anything. But it really shocked me and I was, like, really surprised because I didn’t expect anything from her. Because we had a really good relationship, we talked, we hang out, we had fun, you know? And it really just shocked me.”

Receiving an inferior quality of care (6.2%) and being overcharged for services (2.5%) were other reported incidents of racism in the healthcare system. One participant described being overcharged for dental work:

“Once there was a time I went to a doctor to take care of my teeth.... And he took a thousand dollars for something very simple. And I think he did it because my English is not perfect.”

Another felt that her doctor viewed her culture as inferior.

“They were coming from a completely different culture... They didn’t understand my culture and it didn’t seem like they made an effort to either. It was more just like, ‘Well, it shouldn’t be that way’ and it’s almost like my own culture was being put down.”

Other of the interviewees expressed concerns about the care they might receive from doctors of other races (6.2%). Some were specifically concerned about Caucasian doctors:

“[Racism] could have an effect [on health] because most of the doctors in the health care system are white and they don’t treat us equally.”

They were concerned about this happening not only with family physicians and clinic doctors but also in the hospital environment

“There are times you go into the hospital and they would want to serve the Caucasian people first.”

It is important to note that though several participants raised concern about the quality of care received from a doctor of a different race, few said that they had personally experienced this. Others indicated they would prefer a same race doctor, not out of fear of receiving inferior care from a doctor of a different race, but because a same-race doctor might be better able to relate to them (2.5%):

“I have a black doctor. I feel much more comfortable with her because she is black and because she is female. I am not saying that I wouldn’t see a white doctor because my doctor before her was a white doctor.... I can relate more to her. She’s got the same background, same background issues, we think along the same lines.”

Non-Health Care Related Experiences of Racism

When asked for their definition of racism or whether or not they had ever experienced racism in the health care system, 19.8% of participants also related stories of their personal experiences with racism outside of the health care system. As will be discussed below, racist incidents do not need to occur within the health care environment to have serious detrimental effects on health. These experiences included incidents of name-calling and harassment that left them feeling angry or hurt:

“When I was small, some people made fun of me because I was Chinese. It made me feel so mad. They made me feel like an alien.”

Others reported episodes of discrimination based on stereotypical thinking.

“Teachers sometimes will ask me to take off my bandana. They don’t ask the white or Asian kids too. They say that they don’t see them with it on. They assume that because I’m black and have on a bandana that I’m in a gang. I tell them that I’m not.”

In all cases, the young women recounting the stories described these incidents as being significantly distressing.

Impact of Racism on Health

Many interviewees felt that racism was likely to be detrimental to one's psychological well-being (39.5%). One participant felt that newcomers to Canada could be especially at risk.

"I can see where it would impact on somebody from another country, that doesn't speak the language, doesn't speak English. It's very easy for them to become alienated. And if, especially if they don't have family here or people they can speak to about their mental health, mental stability. It's very easy for someone like that to lose their mind."

Many young women were able to identify ways in which racism could impact health negatively. Participants indicated that racism could have a detrimental effect on physical health (19.8%). Some suggested that this could be due to physical attacks that were motivated by racist attitudes (2.5%). Others indicated that people might be fearful to use health care services because of anticipated racism (2.5%). One young woman had experienced this personally.

"Sometimes I am afraid of going to a white doctor. Sometimes I get a look like I shouldn't be there. It bugs me and it makes me feel like I don't want to go there again. He or she is a doctor and they are supposed to be there to help. Sometimes I'm afraid to go and so I don't get any help."

Racism was seen as a source of stress by many of the young women (18.5%). Again, newcomers to Canada were seen as especially vulnerable.:

"I guess the pressure and whatnot. Especially for a newcomer to Canada. They don't really know exactly what to expect and having people call them names like paki or nigger or whatnot, you know, it doesn't exactly help them."

Along with the deleterious effects of stress, many participants believed that racism would lower self-esteem (11.1%):

"I would probably say on your self-esteem. If someone were to make [racist remarks]. . . I think it would be very uncomfortable and it would definitely impact my on my mental health. I would probably have low self-esteem and I would start to believe it."

Again the link between mental health and physical health was noted.

"It affects your emotional and mental health. If someone calls you a nigger, it would affect you emotionally and cause you to have low self-esteem. Once emotions are affected, it affects your mental health. It's a chain reaction. Once your mental health is affected, so is your physical health."

Many participants spoke of feeling angry, hurt or distressed by racist events and indicated that these feelings are harmful to mental health (14.8%). Several participants mentioned that a young woman could become preoccupied with thoughts of the racist incident, which could negatively impact her psychological well-being (6.2%):

"I think that if you are exposed to a lot of racism, it can mentally disrupt you. Because you start to think, "Why are people saying this to me?" It begins to bug you in your head."

After the interview protocol was revised, young women in the later part of the study were asked whether or not they had ever considered this issue before. Out of the 19 participants who were asked this question, 15 said they had not considered the impact of racism on health before compared to only 4 who indicated they had. It should be noted, that once the question was asked, however, many who had not considered the issue before were able to identify ways in which racism could impact health.

SUMMARY

The young women who participated in this study shared their personal views and experiences during the interview process. Their discussion provided many valuable insights on their ideas regarding health and racism in the Canadian healthcare system. Many of the young women described having a multi-faceted view of health. Although physical health dominated the participants personal definitions (79.0%), mental (35.8%) and spiritual health (6.2%) were also addressed. This same complex view of health was seen when the young women shared how they tried to maintain their health. Almost all of the respondents indicated they engaged in (or felt they should engage in) activities that maintained their physical health (90.1%), but many also took part in activities that enhanced their mental (39.5%) and spiritual health (29.6%) as well.

The young women were found to be making use of a wide range of health care services. Though most reported using a family doctor (63.0%), spiritual services (29.6%), dentists (19.8%), specialists (11.1%) and less formal health services, like gyms or sports teams, (32.1%) were also identified. The participants also indicated that they were using a wide range of sources to obtain health information. Medical sources, such as their family doctor, proved to be the most popular source of information (75.3%). However, the young women also turned to other people in their lives (32.1%), media sources (25.9%), school (25.9%), and their own research at the library (19.8%) and on the Internet (19.8%) for health information.

Many of the young women indicated that their experiences had been quite negative (29.6%). Personal discomfort (8.6%), poor doctor-patient communication (6.2%), and doctors lacking sufficient skill or knowledge (6.2%) were some of the reasons cited for these poor experiences. Other participants described their doctors as being too busy to adequately address their needs and concerns (7.4%). For others, the wait to see the doctor posed a substantial problem (4.9%).

As the discussion turned to racism, the young women again provided valuable insights and shared personal experiences. When asked to define racism, their answers focused on prejudice (35.8%), discrimination (35.8%), hatred (6.2%), and ignorance (13.6%). One in five young women reported that they had encountered racism in the health care system. These experiences included cultural insensitivity or ignorance from their doctors (8.6%), name-calling or racial slurs (2.5%), receiving an inferior quality of care (6.2%) and being overcharged for services (2.5%). Some respondents expressed concerns about seeing doctors of another race because of possible racism (6.2%). Others felt that same-race doctors were preferable not for fear of racism but because they could better relate to the patient (2.5%). Several young women shared stories of racism that did not occur in the health care environment but still affected their well-being (19.8%).

Many of the young women had thought about the ways in which racism could impact their health prior to the interview. However, even those who had not were able to describe possible impact when asked. While some participants indicated it could have an effect on physical health (19.8%), through race-motivated violence (2.5%) or avoidance of healthcare services (2.5%) for example, the majority of responses focused on its detrimental effect on psychological well-being (39.5%). Racism was seen as increasing stress (18.5%), lowering self-esteem (11.1%), and causing negative emotional reactions (14.8%). Several young women described becoming preoccupied with thoughts of the racist event (6.2%), even to the point of sleep disruption. It is important to note, that 64.2 % of interviewees felt that racism had a negative impact on health.

Survey of Existing Healthcare Services

Seven different healthcare services in the Greater Toronto Area were surveyed. The question-by-question responses to the surveys are presented in (Appendix 8) The majority of the agencies surveyed were non-profit and dealt with in some way youth issues or women's issues. The specific services they provided included clinical services for mental health, health promotion, as well as family support and counselling. The majority of agencies included employees from 10-15 different countries, and five of the seven agencies reported some form of providing language interpreters for their clients. Four out of the seven agencies reported having programs that cater specifically to youth; these programs generally took the form of peer support groups, and age-specific after-school or drop-in programs. However, the major finding from the survey revealed that only two out of the seven agencies surveyed had programs specifically for female youth of colour. Moreover, most agencies reported that only 11-14% of their youth clients were female youth of colour.

More encouraging were the agencies' identification of the importance of anti-racist healthcare. Six out of seven of the agencies stated that they had anti-racist policies; these policies included advocacy, increasing access to resources, education, and housing, and workshops for staff. The issues that were identified as being important to young women of colour primarily included issues of self-esteem, anti-racism, education, employment, life skills, social development, and culturally-sensitive healthcare. Finally, six out of the seven agencies stated that they believed racism could have effects of health.

POLICY AND PROGRAM RECOMMENDATIONS

An important component of this research process was to deal with the question of practical and political relevance of the research findings. It was important for the researchers as women of colour and representatives of marginalized communities to show that our work can contribute to the possibility of social change. Our employment of a critical anti-racist feminist framework and participatory methodology necessitated that we combine academic, community development and political advocacy goals in our research process if the pressing social inequities of communities of colour were to be addressed.

Adequate institutional mechanisms and resources are required for the successful achievement of inclusive racist free policies and programs. If we are to develop a system of inclusive healthcare we are required to create healthcare policies and programs that reflect the realities of all citizens lives including experiences of racism and the subsequent impact on ones' health. Racism, as we have learned through the knowledge gained from the young women we have worked with over the course of this study, has created a significant impact on the lives of young women of colour. They have identified how stress related to racism creates particular psychosocial effects that can have a deleterious impact on ones' health. They clearly articulated that racism limited their access to care and their trust of healthcare professionals. They insightfully addressed systemic issues such as the lack of available healthcare providers from particular ethnic groups, the availability of culturally/linguistically appropriate services and health information, and the subsequent limiting of the number of places available for them to obtain this information. These findings have significant implications in service delivery, program development, research and policy development as they pertain to the healthcare needs of young women of colour.

The discussion of racism as a determinant of health is a discussion of the value that the healthcare system and ultimately society at large places on the lives of marginalized communities or in the case of this study the lives of young women of colour. A multitude of issues could be highlighted in this discussion but it is sufficient to focus on the fact that due to racism, the mainstream healthcare system fails to consider:

- The socio-cultural factors which create barriers to healthcare and healthcare services for young women of colour
- The provision of racially, culturally and linguistically appropriate healthcare information to increase knowledge and education of young women of colour and enable them to make informed decisions about their health
- The lack of research and desegregated data available on health issues that impact young women of colour

Healthcare is a fundamental right that should be guaranteed to all members of Canadian society. From a holistic point of view we see health as a necessary resource for everyday living, not the objective of living. Our research has highlighted the existing obstacle of racism which results in the denial of many young women of colour to equal access to quality healthcare, health education and health information. The resulting disparities in healthcare access and modes of treatment are varied and complex, but it is undeniable that racism plays a major role and must be considered a viable determinant of health in the lives of young women of colour. It should also be noted that some discriminatory practices are systemic in nature while others are the product of privately held and expressed attitudes. These practices are deeply embedded in individuals and uncontested by the healthcare system that many young women of colour are seeking care and service.

In order to provide the most effective healthcare services for young women of colour, to raise their awareness of the services available to address these needs, and to provide tools for these women to advocate for themselves in the healthcare system, we are proposing a framework to address racism as a key determinant of health which impacts negatively on the health and well being of young women of colour. This framework is guided by the understanding that:

- Belonging to a particular race or ethnic group leaves one more vulnerable to and at higher risk for particular social and health concerns
- Providing effective healthcare recognizes the unique psycho-social needs of young women of colour and addresses the intersection of race, class, gender age and other oppressions on their lives
- Creating social environments that support healthy choices and lifestyles, enhances ones knowledge base, coping skills and increases the capacity to deal with life circumstances
- Developing social support networks increases effective responses to stress and acts as a buffer against the impact of racism on the health of young women of colour

The young women who were interviewed in the study expressed how racism limited their choices as young women, compromised their health and eroded their self esteem. The reality of racism has become intertwined in the everyday lives of the young women who participated in the study and therefore must be clearly understood by those who provide service and develop programs which impact these women if they are to be effective. From the collective views of the young women of colour interviewed it is recommended that healthcare providers who work with young women of colour must:

- Recognize that racism is a determinant of health and is first and foremost a question of inequality and by extension a denial of human rights.
- Employ holistic approaches (i.e., physical, emotional, spiritual) to the understanding of racism and its impact on young women of colour in particular in order to design more effective prevention strategies and programs
- Develop and share anti-racist best practice models for working with young women of colour
- Address the exploration of personal biases and be willing to address racism in personal and professional life
- Incorporate anti-racist education and training in the standard education of all service providers
- Acknowledge the need for improvements in communication between service provider and young women of colour
- Advocate for the development of social infrastructures to provide young women of colour the choice of seeking secure healthcare services that are culturally and linguistically appropriate and free from racial bias and oppression
- Ensure that the intervention we bring into the lives of young women of colour experiencing racism does not undermine their sense of empowerment, autonomy and control over their own lives

Throughout the course of our research it was highlighted that there was a lack of healthcare programs specifically available for young women of colour to address their health queries and needs. We noted from the survey of agencies in Toronto and surrounding areas that there is a definite lack of services for young women in general and women of colour in particular. Although many of these agencies clearly had staff from a variety of cultural backgrounds and anti-racist policies they lacked services which specifically addressed the needs of young women of colour. The interviewed antiracist service providers noted the lack of adequately trained healthcare professionals as well as the limited number of healthcare professionals of colour working within the system. The young women themselves also emphasized their desire for service providers who reflected them culturally and linguistically as well as the lack of diverse services that they felt comfortable accessing as young women of colour.

The anti-racist service providers clearly articulated the importance of service providers and their interactions with young women which need to involve empowering and educative experiences for the young women. They need to engage in experiences which teach them to live contrary to the negative stereotypes which plague them. They also highlighted that programs designed for young women must increase opportunities for self-efficacy associated with taking action against racism. If we are to suggest the need for the creation and development of health programs, services and agencies for young women of colour we must first suggest that they are developed within a framework which addresses racism as a determinant of health.

It is also paramount that these healthcare programs and services are based on the realities of young women of colour's lives. Health programs and services need to take the issues identified by young women of colour into consideration and support the elimination of barriers to disease prevention, support, treatment and care, information and services. It is recommended that programs and services for young women of colour must:

- Involve input from young women of colour in decision making at all levels of healthcare organizations
- Ensure that healthcare providers are culturally and linguistically representative of the communities from which the young women of colour come
- Move away from having one worker of colour assigned to address the issues of young women of colour and use an integrative approach to their needs
- Create "women only spaces" in healthcare settings
- Ensure that all services look at the specific risks faced by young women of colour
- Provide anti racist health education workshops in places accessed by young women of colour, namely, schools, drop-in centres and religious institutions
- Ensure that health determinants address social, economic and cultural factors and explore gender roles and responsibilities of young women of colour
- Offer integrated multidisciplinary services which address the complexity of the lives of young women of colour

- Be willing to take healthcare service to the communities in which the young women of colour belong, and to the mediums they access such as internet, schools, libraries, peers, parents and religious institutions
- Use social marketing strategies which are appealing to young women of colour, and which reflect their realities in language they can relate to in order to promote health education and information
- Engage in continuous monitoring and evaluation of services by young women of colour to assess quality of care
- Insist on high quality, responsive and anti-racist provision of healthcare during the client-provider interaction and acknowledge power differentials between healthcare providers and young women of colour
- Develop services based on client definitions of accessibility, cultural acceptability and availability of services
- Use the knowledge gained from interactions with young women of colour to influence practice and policy

From our own engagement in the research process and the knowledge gained from our consultations with service providers it is evident that the existing lack of racial and sex disaggregated data and information hinders the ability of decision makers to develop effective inclusive health policies and programs. Adequate institutional mechanisms and resources are required for the successful achievement of inclusive health policies and programs. The issues highlighted in the study extend far beyond the gaps in healthcare service delivery for young women of colour and speak to the inherent concerns raised when particular segments of society are completely absent from discussions at policy levels of decision making. We therefore recommend that advocacy by or on behalf of young women of colour must encourage:

- Decision makers to review and carefully analyze the potential impact of all their policies and programs on young women of colour; take steps to prevent any negative consequences; and ensure that policies contribute to the communities' health.
- Decision makers to take stronger measures to eliminate discrimination against young women in access to health services, through social and public education programs, legislation and resource allocation.
- Policies and programs to be designed and implemented to meet the social, economic and health needs of the growing and changing immigrant population in Canada.
- Healthcare and academic institutions to train and equip healthcare workers at all levels to help prevent, identify and treat healthcare needs based on cultural norms. Training should be improved for all healthcare providers including interpersonal and communication skills and counseling, incorporating anti-racist and gender perspectives that emphasize sensitive and respectful care as well as technical competence.
- Decision makers to monitor and systematically report discrimination in health status, access to services, quality of health care and health outcomes for young women of colour.
- Governments should require the adoption by all health care organizations of methods to collect information that will assess disparities in clinical diagnosis and treatment based on

race, gender and other social biases. With the data collected, governments should establish and implement strategies to eliminate disparities based on race, gender or other social basis of discrimination in relation to access to and quality of health care.

- Governments should develop effective anti racism policies that provide an adequate institutional framework for redress that is specific to the issues of racial discrimination in health care.
- Governments should fund ongoing research which addresses the health care needs of young women of colour and the impact of racism on their lives.

CONCLUSION

Gender, race and class-based difference are consequential in the experiences of young women of colour within the family, larger community and contact with mainstream institutions. In order for us to provide effective healthcare services young women of colour must feel that they have the same access to equal and quality healthcare as their white counterparts. As advocates we must guard against the devolution and down-loading of the needs of young women into marginalized and under-resourced institutions. If the young women's voices are ignored or subsumed they are effectively being silenced and the purpose of seeking access will be confounded.

We seek long-term systemic changes rather than remedial patchwork and celebratory efforts of the present healthcare system, whether in ethno-cultural agencies or mainstream health institutions. The parceling of diminishing government funding may force marginalized groups to compete for access to resources although the inequity of their positions compounds the difficulty in breaking the cycle of domination and subordination (Henry, 1995).

Furthermore, a myriad histories and experiences, as well as social, cultural and economic conditions have produced social diversity. Thus, to address inequality and the dynamics of social difference efforts should be directed at both removing structural disadvantages and incorporating resources in the family and local communities (Dei, 1996). The search for an understanding of a common humanness and the need to learn about our social difference should not be seen in conflict. In fact far from being mutually exclusive the goals of diversity and equality are necessarily interdependent. We cannot abandon the search for understanding and appreciating human differences in a desire simply to accentuate our commonalities. Understanding social, gender and racial differences and their implications to health is basic to the development of inclusive and effective healthcare system.

We must learn to move beyond superficial multiculturalism overlaying of Euro centric structures that emphasize a bio-medical universality which treats the symptoms of patients who must first present themselves to medical practitioners. Instead we must learn to address the root causes of inequality and develop resources, education and outreach programs, skills training for service providers and throughout, develop networks among mainstream and service providers of colour.

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