The Health Experiences of Low-Income Church-Going Black Women: The Importance of Spirituality

by

Nike Yetunde Ashabo

A thesis submitted to the School of

Kinesiology and Health Studies

in conformity with the requirements for the degree of

Master of Arts

Queen's University

Kingston, Ontario, Canada

November, 2007

Copyright © Nike Yetunde Ashabo, 2007

ABSTRACT

Health research and services are dominated by a biomedical model which understands health as the absence of disease in the physical body. The dominance of this approach has resulted in the absence, silence and refutation of lay perspectives on health, particularly those of visible minority groups. Using qualitative interview methods, this study provides an avenue to hear the voices and stories of church-going, low-income Black women who live in Toronto, Canada. Analysis of the data shows that for this group of women, the meanings of health and the way it is experienced can be seen as an amalgamation of spiritual principles which holistically touches the various domains of their lives. The women in this study experience health as emotional, social, communal, personal, physical, material and above all in spiritual dimensions. These findings would be useful in guiding the development of meaningful and effective health care services that are sensitive to the diverse experiences of health.

ACKNOWLEDGEMENTS

I would like to start off by thanking my supervisor Elaine Power, if it had not been for the academic freedom she has granted to me, the doors to this thesis topic may have remained closed and I may have never come across this area of research. Your openness to different ideas has been liberating, along with your support, encouragement and patience which has all contributed to making this MA experience one that I can honestly say I have enjoyed rather than endured. I am truly grateful and I look forward to developing and excelling as a qualitative researcher.

I am also very thankful to my beloved husband for being my number one cheerleader, my alarm clock, my reservoir of encouragement and support, my helper, my motivator, and being just as passionate as I am, if not even more about my success. Honey, the list surely does not end here, but just know that I am truly, truly grateful for the tremendous blessing of having you as my life partner; love, kisses, and hugs from me to you forever.

A deep sense of gratitude and appreciation also goes to my mom, again, I am truly blessed with such wonderful people in my life, words will never suffice to express my true thankfulness. You have always been a source of help for me in a time of need, a great inspiration and my number one role model. Your hand in this thesis has been great, and has greatly helped to shape this project to be what it has become. I will always be thankful to you mama for your special kind of love.

Nicky and Omar, what can I say, the past two years at Queen's definitely would not have been complete without having to close buddies to spend hours with talking about everything and nothing, to share my thoughts and concerns with, to laugh and play

with and so on. You guys have both made my time at Queen's University memorable and fun; I think of times we have spent together and I automatically begin to smile as joy bubbles up within me. Not only did I get an MA degree from this program, but I also got two lifelong friends, again, I must say I am blessed.

My dear friend Phyllis, you are not just a friend, but you are family; your warmness, your sweetness, opening up your home to me, our endless conversations, and the love we have developed has all added to my Kingston experience leaving it as a warm place in my heart, Phyllis and Phillip, you are deeply loved. My Pastors Paul and Fay, and the rest of the Faith Alive crew, the greatest gift of all does not lie in the natural world, but comes from the spiritual world, you have all greatly contributed to removing the veil from my eyes and helping me to see in a dimension I never knew before, you have in your own ways, knowingly or unknowingly taught me, supported me and pushed me along the greatest journey anyone could take, and that is the walk with Christ; much love and blessings unto the church now, always and forever.

Most importantly above all I give my deepest gratitude to my Lord my God who is my source of everything that is good; strength, endurance, encouragement, inspiration and even the people who He has used as vessels in my life, the list is truly endless, all glory goes to Him.

TABLE OF CONTENTS

ABSTRACT **ii**

ACKNOWLEDGEMENTS **iii**

TABLE OF CONTENTS **v**

CHAPTER 1: INTRODUCTION………………………………………………… 1

CHAPTER 2: LITERATURE REVIEW………………………………………… 4

Black Women's Health Research and the Search for Plurality...…………………....... 4
Lay Perspectives of Health and the Significance of Spirituality....………..………….. 12

CHAPTER 3: METHOD……………………………………………………….. 18

Sampling and Participant Characteristics…………………………………………........ 18
Data Collection………………………………………………………………………........ 19
Data Analysis Procedures……………………………………………………………........ 21

CHAPTER 4: ETHICAL CONSIDERATIONS: POWER, REPRESENTATION AND REFLEXIVITY……………………………………………………….…... 23

CHAPTER 5: FINDINGS………………………………………………………. 25

Health, Well-being and Quality of Life: The Difference Terminology Makes……...... 25
Outline of Findings……………………………………………………………………….. 26
Spiritual Enlightenment and Putting God First…………………………………….... 26
Peace of Mind Heart and Soul……………………………………………………………. 34
The Helping Community…………………………………………………………………. 39
Family Relationships and Friendships……………………………………………………. 45
Shopping, Hair and Nails and Other Regimes of Self-Care…………………………… 50
Diet and Exercise Strategies and Apologies……………………………………….... 52
Job Dis/satisfaction and Dreams of Financial Freedom………………………….......... 58

CHAPTER 6: DISCUSSION…………………………………………………… 63

Summary of Findings and New Insights………………………………………………… 63
Underlying Influences…………………………………………………………………… 64
    Gender, Race and Class: The Unspoken Variables……………………………… 64
    Spiritual Exercise………………………………………………………………… 66
    Spiritual Teachings and Literal Interpretations………………………………... 68
    Physical Exercise………………………………………………………………. 70
Misleading Myths and Misconceptions………………………………………….......... 76
Confessions and Reflections of a Qualitative Interviewer…………………………...... 78

Implications for Health Promotion and Health Care……………………………………... 80
Limitations………………………………………………………………………....... 81
Directions for Future Research………………………………………………………… 81

CONCLUSION…………………………………………………………………….. 84

REFERENCES…………………………………………………………………….. 85

APPENDIX A: LETTER OF INFORMATION……………………………………. 89

APPENDIX B: CONSENT FORM………………………………………………….. 90

APPENDIX C: PILOT INTERVIEW GUIDE……………………………………... 91

APPENDIX D: MAIN INTERVIEW GUIDE………………………………………. 92

APPENDIX E: REFLECTION QUESTIONS……………………………………… 94

APPENDIX F: BIOGRAPHICAL NOTES ON PARTICIPANTS……………….. 95

CHAPTER ONE - INTRODUCTION

Throughout my experience as an undergraduate student and now a graduate student in Kinesiology and Health Studies Departments, I have continuously wondered: where are the non-dominant representations of health? I entered my undergraduate Kinesiology and Health Studies program in the Arts stream with the awareness that the Kinesiology aspect of the program would be heavily based on biomedical models, but with great anticipation for the other end of the title which would focus on health, a concept I understand to be multidimensional and dynamic, that can be approached from many angles. I was disappointed. It was not long after I began that I realized that even in the Arts stream, the title Kinesiology and Health Studies was in fact just a title, and even Health Studies was dominated by the biomedical model.

Frustrated with the lack of varied representations of health within my prior years of formal education, I was glad when the opportunity arose during my Master's program to venture out and explore diverse ways of experiencing and conceiving of health. My first and main assumption was that alternative perspectives on health do exist, particularly in diverse settings. My approach was to set out and explore those who are among the most marginalized and whose perceptions, stories and voices have traditionally been silenced. My second assumption was that those who are most demographically distant from the dominant class, the group responsible for mediating how social conceptions of health "should" be experienced and perceived, would also show a greater distancing in their own experiences of health, including those pertaining to their health. Based on this I chose to explore conceptions of health among Black women who were living on low-incomes because I felt they met this social condition.

I began the research process by going through the literature on Black women's health within the context of gender, race and class, three analytical concepts which I assumed would be paramount in shaping the intended research group's perceptions and experiences of health given their well-known social inequalities. I approached Community Health Centres located in Toronto neighbourhoods with high proportions of Black people, thinking that this would be a prime location where I could recruit participants meeting my criteria. To my dismay, this approach failed, as I was faced with the obstacle of gaining access coupled with the few Black women on low-incomes found in these centres. However, where I incidentally found this population of women to be in great numbers was at church.

This switch from using Community Health Centres as a dominant site of recruitment, to a church frequented by low-income Black women had the effect of refocusing this study from Black women who are on low-incomes to Black women who are church-goers and on low-income. This shift in recruitment fundamentally affected the results, because the women understand spirituality as the foundation of their health and well-being. I assume that spirituality would not have been such a strong theme had I been able to recruit participants from the secular setting of the Community Health Centres. However, the role of church in the lives of many Canadian Black women, particularly those who are immigrants to Canada, which all the participants in this study are, has been found to be highly significant, when compared to the rest of the population (Clark & Schelleberg, 2006).

There has been a division between lay perspectives of health, represented by my participants, and the perspective of the dominant biomedical model, represented in both

health research and health care. This study examines this distinction based on the insight provided by participants as to what health means to them and how it is experienced. Further examination is carried out to understand how and why participants use their Christian faith, a fundamental theme found among them, to inform their health beliefs and practices.

If we are to improve health services, and thus health outcomes, for those who are marginalized in our society, it is important to understand what health means to them. The assumption of a universal conception of health is a fundamental flaw which perhaps helps explain why many health promotion strategies, though fervently promoted, are not readily adopted by the intended populations. With this in mind, the purpose of this study is to explore the meanings, experiences and perceptions of health among a group of church-going Black women living on low-incomes. The central research question is: What does health mean to Black women who are church-goers and are living on low-incomes?

CHAPTER TWO – LITERATURE REVIEW

Black Women's Health Research and the Search for Plurality

Health research has traditionally been dominated by a biomedical model which has placed the physical body at the centre of what it means to be healthy. Through this, health has been perceived to be modified and controlled through bodily means such as physical activity and diet. The evidence of the benefits of physical activity to the body goes without question, however, the concept of health is contested. The biomedical model perceives health in terms of biological criteria and defines it as the absence of disease (Hewa & Hetherington, 1995). However, there are others such as the World Health Organization which perceives health as having many domains beyond the corporal, representing the dynamism and plurality of the social and cultural contexts in which people experience it. In Canada, and particularly Toronto, the location of this study, there is a great diversity of people representing a variety of social classes, ethnicities and cultures, which all have the potential to shape lived experiences and life philosophies. Amid this diversity one can assume that there are also overlapping and distinct conceptions of what it means to be healthy which have yet to be tapped into by mainstream health promotion.

The very essence of the question "What does health mean to Black women living on low-incomes in Toronto?" is a reaction to this over presumptuous and ethno and class-centric notion, if you will, of a universal unilateral standard of health which favours the biomedical precept of bodily control. Consequently, physical activity and diet, the crux of this dominion, as is made evident by the literature, is vigorously promoted with an essentialistic audacity. All are expected to pay heed and submit to doctrines of frequency,

intensity and type of physical exercise. Those who reject these orders and fail to strive for the ideal bodily form are classified as either unhealthy and in need of political or clinical intervention, or are critically analyzed in attempt to rationalize their defiant behaviour and "under-participation". Lack of access, domestic care and workplace physical activity have all been such attempts to understand why these ethnocentric and class-centric tenets have not been eagerly embraced by specific groups of people, particularly racially marginalized women (Banks-Wallace, 2000). However, the conclusion that the primacy placed on the physical body by way of the biomedical model is simply unimportant or even irrelevant to various groups of people is seldom considered. Rather it is assumed that those who do not meet such standards wish that they could, but fail to do so due to unfortunate circumstances.

While the focus of this research will be on Black women, there is a lack of research among most racialized groups in Canada, impacting and suppressing their experiences of health and well-being. However, I have decided to focus on this particular group as a starting point in understanding diverse perspectives of health due to the exceptional degree of social stigmatization that Blacks experience which is evident through their consistent ranking at the bottom of the social hierarchy. Blacks are also faced with the greatest injustice in terms of residential segregation and socioeconomic mobility (Williams, 1997). It is important to mention that these findings, as well as much of the other health research specific to Black populations that will be presented in this section, are highly based on data collected from the United States; the lack of Canadian data is due to the fact that the Canadian government has not, historically, collected

general health information based on race and ethnicity, with the marked exception of Aboriginal people.

The existing research that does explore issues related to Black women's health tends to focus around a general theme of morbidity, mortality and physical inactivity as is consistent with the biological disease-centred tenets of the biomedical model. Though these aspects are relevant to overall health, they are also quite limited in that they say little about one's self-perceptions of health and well-being. As previously stated, this area of research essentializes the physical aspect of health, placing it as the quintessential marker of what it means to be healthy. As a result, research on Black women's health has largely been reduced to rates of heart disease, stroke, blood pressure, diabetes and rates of physical activity, the synopsis of which is encapsulated just below.

Many racial minorities both in the United States and in Canada suffer from greater rates of morbidity and mortality than the dominant White population. Three out of the four major ethnic groups in the United States, African Americans, Hispanics, and Native Americans die younger than the white population (Lillie-Blanton, Parsons, Gayle, & Dievler, 1996). African Americans are more likely to develop coronary heart disease, hypertension, diabetes and suffer from a stroke; African American women are twice as likely as White women to be obese (Young, Miller, Wilder, Yanek, & Becker, 1998). African immigrants to Canada will die at double the rate from cardiovascular disease than other Canadians, despite coming to this country in healthier condition than the general population (Enang, Edmonds, Amaratunga, & Atwell, 2001). Rates of physical activity which have shown to provide a degree of protection against all these diseases, is found to be lagging behind among the Black North American population relative to the overall

population rate (Young et al., 1998). Essentially, African American women are found to be among the least physically active sub-population in the United States in addition to fairing poorly on standard measures of health (Bank-Wallace & Conn, 2002). Yet ironically, despite these impediments to Black women's health, they are also among the least researched group in the health field, particularly within the Canadian context. As a result, very little is actually known about their experiences of health, what health means to them and how they may cope with or interpret such hindrances to their overall health (Enang et al., 2001; Barksdale, Willis, Davidson, van Roosmalen, Loppie, Kirkland, Unruh, Stewart & Williams, 2001).

Much of the health promotion research investigating health issues specific to Black women has done so in relation to the dominant biomedical view of physical activity participation, problematizing and theorizing what has been deemed as the problem of "under-participation". This review of the literature will present these findings and highlight the limitations of such a narrow approach to health.

Health promotion researchers have constructed four sociocultural theories to explain the lack of physical activity participation among racial minority groups: the marginality theory, the ethnicity hypothesis, the assimilation approach and the discrimination theory (Henderson & Ainsworth, 2000). The marginality theory explains "under-participation" by the virtue of having a minority status. This theory proposes that with minority status comes a disadvantage in access to facilities and material resources (Henderson & Ainsworth, 2000). Further, this theory maintains that material deprivation hinders one's ability to achieve and sustain health. It is well known that socio-economic position measured by income, occupation and education are positively related to health in

various ways. With sufficient income there is a certain degree of freedom, power and control that a low class status may not offer. However, it is a critical, yet common mistake to assume that these specific health outcomes, which are related to low social class are the most relevant health variables for those with low-incomes, or any other group for that matter. The assumption here is that health measures are standard, generalizable and universal concepts possessing the same meaning for all, failing to consider the very real possibility that the way health is perceived and the values attached to its various domains likely have cultural, regional and even spiritual foundations. Therefore, it is important that we as health researchers and promoters ask ourselves when labeling certain populations as healthy, or even as physically active or inactive, whose standards and values are we using?

The second theory used to understand physical activity "under-participation" is the ethnicity hypothesis. This theory places culture as the central factor in understanding why racial minorities have been found to be less physically active than non-racialized groups (Henderson & Ainsworth 2000). Furthermore, the ethnicity hypothesis suggests that if only ethnic minorities would leave their cultural practices behind and adopt majority culture such proposed health disparities would cease to exist. As previously mentioned above, and consistent with this theory, culture is an important parameter determining the values and perceptions diverse groups of people place on various behaviours and concepts such as physical activity and health. However, where the ethnicity hypothesis falls short is by again placing physical activity as the foremost standard, an ethnocentric tendency all too common in health studies research. Therefore, cultural and social variances that do not pay heed to physical activity as a fundamental

concept to health are then rendered as sub-standard behaviour. The assimilation theory embraces this ethnocentric approach by suggesting that assimilation is the answer to ethnic and racial health differences.

Finally, the discrimination theory is based on the idea that interpersonal interactions involving actual or perceived, overt or covert discrimination have detrimental affects on health (Henderson, 2000). The strength of this theory is that rather than blaming minorities for their deviant "under-participation" it takes a greater look at society as a whole, bringing to light the gravity of one of our nation's greatest social illnesses, racism and discrimination. Despite this theoretical approach, few studies have yet to further investigate the implications of racism on health. Though these theories present various degrees of both insight and problems on the matter of physical activity "under-participation" among minority groups, it is my prerogative to move beyond these theories which are built upon an essentialistic precept of physical activity, and search for the potential of nuanced ways of perceiving health; this is in contrast to starting off with the problematic assumption of a universal standard of what health means and how it is experienced.

Nevertheless, in order to make a claim for diverse health experiences and gain a full appreciation for this proposed plurality, it is useful to have an understanding of the dominant approaches to health with respects to Black women. In line with placing physical activity as the basis of achieving "good" health, and problematizing "under-participation", there is also a tendency to interpret such behaviour or lack thereof in light of barriers and constraints to physical activity involvement. With respects to visible minorities in general and Black women specifically, there has been a dominant recurring

theme in the literature of familial and communal values and environmental and personal barriers as obstacles to physical activity and thereby obstacles to health.

In one US study that used focus groups to look at cultural base factors related to health among Black women with various levels of education, Banks-Wallace (2000) identified a "Strong Black Women" theme, adopted from Patricia Hill Collins in *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (2000). Banks-Wallace found that the women were preoccupied with caring for family and the community, leaving them too tired and with little time to engage in leisure time physical activity. Another study, conducted by Lee (2005), examined sociocultural aspects of African American and American Indian women's experiences of health. This study illuminates some of the complexities of communal and familial responsibilities among this group of minority women. The women interviewed in this particular study identified caretaking as primarily their responsibility in the household, and often described this duty as extending beyond the nuclear family to the care of grandchildren as well as parents.

Such exploratory research, which investigates aspects of health among minority women, has similarities to the present study. However, there is a crucial difference in the approach taken in these studies which present familial and communal interests and priorities as disadvantageous to health due to the barrier they place against leisure time physical activity. This is in contrast to the position that such interpersonal relationships and community partnerships are rather significant aspects of health in and of itself which produce further health yielding outcomes that are perhaps more relevant to these groups of women than those outcomes attained through leisure time physical activity.

Another sociocultural concept that has been cited in health research pertaining to Black women is the predominance of spirituality in the lives of many of these women. For Black women, spirituality includes the value of helping and caring for others, even if that means at times placing other people's needs before their own (Banks-Wallace, 2000). This cultural characteristic is presented by Banks-Wallace as yet another hindrance to physical activity. However, as will be seen later in the literature review on lay perspectives of health, spirituality is highly valued as a component of health with both tangible and intangible health outcomes, not only among Black women, but among diverse populations.

Other personal barriers to physical activity often cited in the literature include health concerns, lack of motivation, lack of time, and lack of social support (Eyler, Baker, Cromer, King, Brownson, & Donatelle, 1998). However, this literature raises the questions of whether the proposed group of women are in fact passive victims to such barriers in their lives, and whether these barriers to physical activity are even relevant to Black women living on low-incomes.

When we consider lay perspectives on health, the biomedical understanding of the importance of physical activity, and other attributes of health related to the physical body, are less prominent. Lay perspectives tend to emphasize more holistic concepts of health, including spiritual faith. I will say more about this in the following section dedicated to lay understandings of health, however suffice it to say for now that subjective experiences of health represent a diversity that is often bypassed in traditional biomedical approaches to health.

Within the context of the social diversity that is so prevalent within Canada, particularly Toronto, the location of this research, it is important that we do not assume a unitary perception of how health is experienced and understood. Instead health research and promotion must be approached in ways which are truly relevant and meaningful to those whom help is targeted. Unfortunately, there is presently very little known about the health experiences of visible minorities within the Canadian context, leaving a lack of understanding and a gap in the literature of how such groups, and in particular Black women, experience and understand health (Enang et al., 2001). This gap in the literature can be overcome by using qualitative research methods to further our understanding of the health experiences and perceptions of marginalized groups.

Lay Perspectives of Health and the Significance of Spirituality

The need to understand lay perspectives of health is in part due to the gap between what health professionals and researchers tend to believe are the important domains of health among populations, and that which is actually reported by such populations themselves. As just discussed above, health professionals and researchers have tended to lean towards physical domains of health as the quintessential defining characteristic of what it means to be healthy; however, when exploring conceptions of health among diverse lay groups it is not physical health and well-being that is found as most salient, rather far more elusive and immaterial ideologies have been consistently shown to inform what it means to be healthy among lay populations. Abstract concepts such as holism, equilibrium, and the ability to cope with life problems are just a few of

the ways lay people are experiencing health (Hughner & Kleine, 2004; McKague & Verhoef, 2003).

Spirituality, which is conceptually distinct yet related to religiosity can be in part described as a relationship with a Higher Power (e.g. God) (Mattis, 2000); this concept has also been another important marker of health for a number of groups ranging from the elderly, the mentally and physically ill to visible minority groups (WHOQOL SRPB Group, 2006; Lee & Newberg, 2005; Marks, Nesteruk, Swanson, Garrison & Davis, 2005; Larson & Larson, 2003; Maselko & Kubzansky, 2005; Mattis, 2000; Clark & Schellenberg, 2006; Statistics Canada, 2006). Research on the spirituality-health connection has gained momentum over the past ten years and the findings have been significant. This dimension of self-perceived health has not only shown to have positive effects on health outcomes (Marks et al.; 2005; Ellison, 1991), but in addition, for many people it is the very basis by which understandings of health and well-being are formed.

Having an in-depth understanding of what health means to lay populations offers the potential to improve both the quality and applicability of research and services provided by health professionals. As previously mentioned there is a strong tendency for such researchers and professionals to emphasize the physical, and to a lesser extent the mental, in their conceptions of health. I do not wish to downplay the importance of the research and health services for the physical body, for such work has been vital to our longevity and our quality of life. Rather the aim of this review is to highlight the additional components of health which have traditionally been neglected yet also contribute significantly to both our longevity and quality of life, and furthermore, are

held to be important by the lay public that health researchers and professionals aim to help.

Common health themes that have consistently been found among lay perspectives include health as multidimensional, health as equilibrium, health as the ability to function according to one's own standards, as well as the ability to cope with life problems among other conceptions (McKague & Verhoef, 2003; Hughner & Kleine, 2004). A perceived sense of balance, strength and perseverance in the face of tribulation is found to be the basis of much of these perceptions of what it means to be healthy. However, among the general themes of well-being, studies have shown that such concepts do vary in the emphasis placed on them among diverse populations. Lower social class groups have frequently been cited to perceive health in more functional terms such as having the physical capabilities to work and the absence of disease or illness. On the contrary, upper social classes have been found to perceive health in more self-actualizing multi-dimensional terms such as having a balance between the body, mind and spirit (Hughner & Kleine, 2004).

However, there is somewhat of a contradiction in the literature: investigations into spirituality as an additional dimension in the lay perspectives of health shows that it is the lower social classes, including Blacks (Marks et al., 2005; Ellison, 1991), the elderly, women, immigrants and the less educated who are most likely to hold this existential perspective of health (Clark & Schellenberg, 2006). As previously mentioned, spirituality has been defined as a divine relationship between humans and a Higher Power, frequently named "God", and often affiliated with an organized religious sect (Mattis, 2000; Thoresen & Harris, 2002). The experience of this spiritual relationship may include a

sense of direction and guidance through one's life, as well as other desirable attributes such as peace, calmness, centredness, life meaning and purpose (Mattis, 2000). Numerous studies on spirituality and health have found this relational phenomenon to be associated with many health yielding benefits and outcomes such as superior mental health, higher levels of self-esteem, greater self-satisfaction (Marks et al., 2005; Ellison, 1991; Larson & Larson, 2003), and even decreased mortality (Hummer, Rogers, Nam & Ellison, 1999) have all been consistently shown to be higher among those practicing spiritual faith. Regular church-goers, meaning those attending worship services at least once a week, have also been found to be more likely to improve and maintain health promoting behaviours such as abstaining from smoking, excessive alcohol consumption, depression, and engaging in regular physical activity, medical check-ups and social interactions (Marks et al., 2005; Larson & Larson, 2003).

Attempts to understand this spirituality-health connection have focused on the social support and fellowship that comes from being a part of an organized religion. An additional hypothesis is the positive outlook associated with spiritual beliefs. For example, in their study of African Americans, Marks et al. (2005) found that participants claimed to cast their cares, worries and burdens on the Lord, trusting that an all-powerful God would look after them.

In the United States, African Americans have shown to have a greater spiritual focus than their White counterparts; African American women report even higher levels of spiritual beliefs and practices than African American men (Lee & Newberg, 2005; Mattis, 2000). Similarly in Canada, women in general and visible minority immigrant women in particular also score higher than men and Canadian born residents on the

different markers of spirituality (Clark & Schellenberg, 2006; Statistics Canada, 2006). The influence of their faith in their ability to understand and respond to issues related to oppression, forgiveness, justice, hope and purpose in life are just a few of the implications for well-being (Mattis, 2000).

Clinical patients facing medical and mental health issues are another group that is more likely to embrace the power of spiritual faith. The personal significance of spirituality tends to increase in conjunction with the severity of the illness. Coping resources stemming from spiritual principles are often used by such patients to help provide them with a sense of hope and comfort in the midst of their illness. Such resources may include regularly attending worship services, prayer, reading scriptural material, worshipping God and meeting with spiritual leaders (Larson & Larson, 2003).

There is no established research indicating negative outcomes of spirituality on health (Miller & Thoresen, 2003). Indeed, the positive associations between spirituality and health have lead to changes in medical education. Medical schools across the United States have introduced courses to help doctors effectively address patients' spirituality, primary care and psychiatric residences are also increasingly implementing training on spiritual faith and health (Larson & Larson, 2003).

There still remains much to be known about how spirituality impacts health such as the possible mechanisms involved which may include having a greater social support as well as a more optimistic view of life. Also, investigation into why certain groups of people are more likely to internalize spiritual principles compared to other groups may also provide additional insight. In order to further the understanding of this spirituality-

health relationship, a greater openness and acceptance of varied experiences and perspectives of health need to be more readily embraced and investigated.

CHAPTER THREE - METHOD

I have chosen to use a qualitative approach in this study because qualitative methods are best for hearing the voices of those who seldom get to tell their stories. Qualitative methods are also useful to investigate phenomena about which little is known (Mckague & Verhoef, 2003).

Sampling and Participant Characteristics

Thirteen participants were interviewed to explore their meanings, experiences and perceptions of health. Participants were recruited by directly approaching them after church services, or using snowball sampling. Recruitment was discontinued after the thirteen interviews were conducted and it appeared that data saturation had been reached, with no further new themes emerging (Ritchie & Lewis, 2003).

The thirteen women who were interviewed for this study all share similar demographical characteristics: they are all members of charismatic Christian churches in Toronto, they are between the ages of thirty-five and sixty-five years, and they are all Black women. Twelve participants immigrated to Canada from various countries in the Caribbean; eleven of these came as adults, at least ten years ago, and one came as a child The thirteenth participant immigrated to Canada from Nigeria five years ago.

At the time interviews were conducted, twelve participants were living in Toronto; the other participant was living in a suburb that is a part of the Greater Toronto Area. Three of the women in this study were married while the rest were single; eleven have a least one child. The nine women who were employed at the time of the interviews worked in one of three sectors: health care, care giving, and assembly line manufacturing.

The four women who at the time were not working were unemployed for various reasons, two due to medical health problems, one on maternity leave and the other temporarily unemployed. Participants' level of formal education varied from no secondary school, some college, to a completed college degree.

The vast majority of the women approached to participate in this study agreed, however, five women declined. Those who chose not to participate either did so indirectly, as indicated by not returning my phone calls after leaving two telephone messages. One woman refused directly because she did not trust my true intentions. She had previous experiences of reporters coming into the church and interviewing congregation under the guise of good intentions and then manipulating their words to paint a bad impression of the church. I am uncertain why the second woman who directly declined to be interviewed did, however I speculate that my approach in asking her was inadequate as I wrongly presented the study to her as my attempt to help this intended population, rather than the participants who were in fact greatly helping me.

Data Collection

Data were collected through face-to-face semi-structured interviews. The interview is a dominant form of data collection in qualitative research. It is well suited for investigating responses to complex experiences, meanings and perceptions, particularly those rooted in social, economical, political and historical contexts. A key feature of the interview is the undiluted focus that it places on participants; this facilitates detailed responses as well as the opportunity for clarification which further enhances understanding (Ritchie & Lewis, 2003).

The interviews were scheduled at a time and location convenient for the participants; five interviews were conducted in participants' home church, five were conducted at participants' places of residence, one interview was conducted at a neighbour's home, one was conducted at a participant's place of employment, and one interview took place at a Tim Horton's coffee shop. Each participant was interviewed once for approximately one hour. All interviews with the exception of one were audio-taped and transcribed verbatim, with consent of the participant. Accidentally, one interview was not recorded; no quotes from this interview are presented here.

Of the thirteen interviews conducted in total, two were pilot interviews carried out with an interview guide consisting of eleven main questions and two sub-questions, all open-ended (presented in appendix 'C'). After the pilot interviews were conducted and analyzed, a new interview guide was devised and used with the remainder eleven participants. The analysis with in this text is based upon these eleven women's experiences rather than all thirteen women who were interviewed. The revised interview guide consists of twenty open-ended questions (presented in appendix D). Through the pilot interviews, I realized that my original questions were not broad enough to capture participants' understandings of health; I changed terminology from "health" to "health and well-being", as well as changing the questions to reflect what I learned from the pilot interviews. The interviews were semi-structured, and thus not strictly limited to the questions in the interview guide. The data analysis presented below only includes the eleven participants recruited after the pilot study.

An additional data collection method that was used in this study is the reflexive journal. This journal is a useful tool that was used to keep track of my own thoughts,

observations and feelings after each interview conducted. Immediately after performing an interview I would write my personal reflections in the journal enabling me to capture and maintain a great degree of the initial experience of the interview process which can often be lost after transcription. This journal was also used in tracking my thought processes and reflections of self throughout the research. Furthermore, the reflexive journal was an aid in confirming the dependability of some of the analysis that was made.

Data Analysis Procedures

As detailed by Ritchie & Lewis (2003) a critical analytical hierarchy was used to organize and analyze data. This process was divided into three main stages: data management, descriptive accounts and explanatory accounts (Ritchie & Lewis, 2003). During the data management stage I identified concepts and themes based on the raw verbatim transcripts, following this I sorted and labeled data which provided a summary of the findings. Though this stage of analysis involved identifying main themes, I also made sure to pay attention to the distinctions and inconsistencies found in each interview. The mundane was also included in the coding process to avoid the tendency of only describing the exotic and exciting ethnographic descriptions (Fine, Weis, Wessen & Wong, 2000).

In the second stage of the analysis I formulated a descriptive account of the findings. I used the words of the participants to map out patterns, themes and distinct phenomena. The third stage of my analysis involved developing explanations for the identified patterns, this explanatory account did not focus on causal explanations, but

rather focused on gaining an understanding of why and how certain meanings are formed (Ritchie & Lewis, 2003).

Spencer, Ritchie, Lewis & Dillon (2003) offer a detailed framework for evaluating qualitative studies which was initially designed for those undertaking qualitative research for the UK government. This assessment tool, has also acted as an aid in guiding my own evaluation of the quality this research**.** The following is a sample from the Findings section of this rubric: (Appraisal question) “How credible are the findings?”(Quality indicators) “Findings/conclusions are supported by data/study evidence. Findings/conclusion make sense/have coherent logic. Findings/conclusions are resonant with other knowledge and experience.”

In addition to the analytical approaches mentioned above, a number of other strategies were also employed to facilitate credibility of results. These include the use of a reflexive journal (as explained above), identification of researcher’s preconceptions, weighting of data depending on frequency of recurring ideas, incorporating outliers and inconsistencies into the analysis process and the use of participant’s quotes (McKague & Verhoef, 2003).

CHAPTER FOUR - ETHICAL CONSIDERATIONS: POWER, REPRESENTATION AND REFLEXIVITY

When researching marginalized populations exceptional ethical responsibility must be taken to avoid hierarchal approaches which can reinforce subordination and lead to the further objectification, othering, and stigmatization of minority groups. Therefore, the approach I have taken in interviewing participants was one of collaboration. I took on the role of the active listener and student while the knowledgeable participants educated me about their experiences and perceptions. I did not challenge their perspectives, but rather remained open for further explanation of the things I did not understand.

Marginalized populations are subject to a number demeaning stereotypes. Therefore it was necessary for me to be cautious in my representation of Black women living on low-incomes to ensure not to further fuel these stereotypes. Fine, Weis, Wessen & Wong (2000) suggest a number of reflection questions that the researcher should ask her/himself throughout the analysis process; these questions are designed to help facilitate social responsibility and proper representation of those whose voices I am presenting. Such questions include *"Have I worked to explain to the reader the position from which informants speak? How might data be heard and misread? Do I need to add a warning sign in the introduction about potential misuse?"* (adapted version of reflection questions presented in appendix 'E').

Participants were each given a letter of information and informed consent form to notify them of the nature of this study. The forms were all read aloud to each participant. The letter of information and informed consent form explained that confidentiality is a priority and efforts will be taken to ensure the anonymity of all participants by using

pseudonyms throughout the research process. Participants were also informed of their right to pass over any questions they wished not to answer or withdraw from the study completely at any time without consequence. Ethical approval to conduct this research was granted by the Queen's University General Research Ethics Board.

CHAPTER FIVE - FINDINGS

Health and Well-being: The Difference Terminology Makes

As already stated, the purpose of this study was to gain a broader, deeper understanding of the perceptions, experiences and meanings of health among a particular group of women. In line with this objective was to move beyond traditional mainstream discourse of how health is conceived and explore the potential for nuances in understanding health by diverse communities. After the two pilot interviews were completed, it was evident to me that the combination of the term "health", coupled with the recognition of being affiliated with a Kinesiology and Health Studies Department elicited from participants the very traditional and limiting notions of health restricted to the physical body I wished to go beyond. However, my assumption that health is more than this was illuminated when the similar (and according to some, synonymous) term "well-being" was inserted alongside the term health. It was not until I observed the participants in the study using such terms that I then mimicked their language and included these terms in subsequent interviews. For example, rather than simply asking "What are some of the dreams and wishes you have that you believe would enhance your health?" I realized that it would be more fruitful to ask "What are some of the dreams and wishes you have that you believe will enhance your health and well-being?" By using these terms interchangeably, in combination and in isolation facilitated more rich and elaborate responses by participants. Health was no longer limited to its physical domains as reported by the women in this study, rather it became a multi-dimensional force, action and reaction to the many faces and phases of life.

Outline of Findings

The results of these interviews showed that health is unanimously perceived by the women in this study as a highly dynamic multi-dimensional concept. Among the various dimensions of health that consistently arose in interviewing these women, spirituality related to their Christian faith was by far the most dominant and underlined how they would perceive other domains of health. Other conceptions of health which are also prevalent through the interviews include: peace of mind, a helping spirit, the value of family relationships and friendships, self-care through beautifying regiments and esthetics, acknowledgement, apologies, and strategies for exercise and diet doctrines, work as beneficial to health and work as a hindrance to health, and the importance of money matters and financial freedom. These themes will all be further discussed below.

Spiritual Enlightenment and Putting God First

Given that the participants in this study were church-goers, I was not surprised that they held deep-seated values pertaining to their Christian faith. However, I was surprised to learn how significant their faith was in forming the foundation of their understanding, experiences and meanings of health. Though I never asked about spirituality in the interviews, tenets of the participants' Christian faith were ubiquitous throughout virtually every interview conducted, with the exception of the two pilot studies. It was clear that their faith in God and Jesus Christ formed the basis of their perceptions on health; indeed, this belief system also appeared to serve as the basis of how they perceived life on a whole.

The concept of “putting God first” was consistent throughout the interviews. This spiritual framework structures their days and their priorities. In response to the question, “What is a typical day in your life like for you?” the dominant reply referenced starting the day with prayer and getting into the Word of God. The following quotes presented here by some of the women in this study are a representation of this theme: “Well in the morning time when I get up, I get up in the morning, pray, then read the Word of God, have a shower, make something, leave for seven-thirty to go to work. I am a personal support worker, and then I go out to the fields” (April). “A typical day is like getting up, taking care of my cats, feed them, give them water, get dressed, pray and listen to music…” (Jackie).

Spending time with God each morning is presented by these women of faith as a standard routine one normally goes through, just as one may take a shower each morning or feed their pets, engaging in spiritual activities such as praying and reading the Bible starts off their days before heading out into the world. Expressions of these practices have been referred to by some of these women as the source of their strength day by day and the factor which grounds them and grants them the mindset and grace to face what may at times seem like a chaotic world.

“I try to wake up in the morning sometimes around four or four-thirty, sometimes five, I start my day with prayer because that keeps me going through the day… Personally, for me if I don’t pray in the morning and have that full time to read my Bible and pray, I don’t feel good, you know, I don’t feel that lightening thing in the morning, I don’t feel it” (Bernice). Bernice later goes to state in response to the question “What deep values in living do you believe are important to your health and overall well-being?” that

her “prayer life and spending time with the Lord is the most important…Yes, oh man, this is top because if I don’t have that I can’t function, so with my prayer life and everything that has to be the top priority, my husband and family come second”.

Celina also shared similar sentiments about her Christian faith as being top priority in response to the question regarding deep values that are important to her sense of health and overall well-being, “Again, where that comes in is my relationship with Jesus Christ, that’s up most, I can’t say enough about that, that alone gives me the balance that I have right now. I need to spend more time developing that aspect of my life right now.” These spiritual activities are a habitual part of these women’s daily routine as Celina suggests, however, they are also much more than that. Their faith and the practices that go along with it are based on a personal and intimate relationship with their Higher Power; it is not a relationship which they take for granted, but rather one which they are conscious of and place deep value in, it is a relationship that they believe is worth spending the time needed to foster it so that it may develop and flourish.

Hannah’s description about her typical day is worth quoting at length as it nicely summarizes the priority these women place on putting God first, the strength they derive from His fellowship to face an often hectic world, and the effort that is taken to make morning fellowship and spiritual activities a habitual pattern.

> My typical day, the first thing before I come out to face anyone, I have to get in the presence of the Lord, I have to be in the presence of God, and I love coffee, even before I open my bedroom door, otherwise everything becomes chaotic, I’m rushing to work, I’m waking up my son, so I have to get before God first and get into the Word, because most of the time there is no opportunity to come back before work and I like to spend time with the Lord before I get into anything else, because that is my strength, that is where I get my strength for the day, if I don’t do that my

> whole day is messed up. And it becomes a pattern for me, and it's a good pattern, so I try to make it a habit as much as possible, and if I'm late then I will still, sometimes I will take my Bible on the bus, which is not a substitute because God then for me is not first, it's like second. Then as long as I get up, I have my coffee and then I'm out the door. I'm not a breakfast person, I don't eat breakfast most of the time unless on weekends, and then I'm out the door, that's my typical day, and then the day just rolls on, that's my priority.

These women's faith is not simply limited to time spent in morning devotion, but rather permeates their daily and weekly activities and furthermore, the way they perceive and experience health and well-being which will be demonstrated throughout this chapter.

When the researcher asked the participants to describe their typical day as one of the opening questions to the interviews, the intention was to simply open up general discussion before getting into more focused conversation; however, the responses given by the women showed that their faith was at the heart of their lives, including their understandings and experiences of health and well-being. Along with their morning devotion, participants also engaged in other spiritual activities throughout the day, during the week and on the weekends. Mary, a woman who has not only lost a great degree of her independence due to her deteriorating eyesight which has left her nearly blind, but has also a number of other diseases and illness explains her reasoning behind spending so much time in church related activities:

> Right now, because of health problems I spend most of my time in church… In the morning there are prayers from five to nine o'clock in the mornings, so I try to get there three times a week… And then on Wednesday afternoon we have meetings, so I go then, sometimes we practice choir, and then I go for Sunday service, so that's more or less four or five days of the week… Before when I could do things for myself, yes, I would like to go out and visit friends and family, but now that I can't do that, I've since been born

> again, and for me I want to become closer to God now, now that I'm getting older; so I want to serve God now, so this is why I try to spend so much time in church… that's my happiness.

Though faced with a number of health problems such as diabetes which has left her nearly blind, a heart condition, a nerve problem in her leg which prevents her from walking and standing for lengthy periods of time, asthma as well as other health conditions, Mary is still able to find hope and joy in her life which stems from her Christian faith and provides her with a sense of well-being even in the face of these hardships. Now that she has become "born again", that is, "given her life to Christ", her desire is to become closer to God; this, she states, is her source of happiness. She places hope in the belief that one day, "God willing", she will be healed of her infirmities, which is expressed by her enjoyment in watching the Christian channel, particularly programs where healing is the focus. "…for now I don't look at too much television, apart from putting on the Christian channel, and I love to watch it especially when I see healing…" This statement made by Mary was in response to the question "what are some of the other ways that you care for yourself, or things that you do to promote your sense of well-being or sense of health?" By developing her spirituality through engaging in related activities and behaviours, is to keep her faith alive, and a strong faith in God is what brings her joy. This is the essence of how Mary, like the other women in this study, maintains a good sense of health and well-being, even in the face of the most dire or troubling circumstances. Though these women may be challenged with physical afflictions of the body or of the material realm such as in their finances, their spirits still wax strong.

The daily and weekly activities that foster this spiritual strength are also described by Sandra:

> …and then I come home at the end of the night, some nights I don't, some nights I just go straight to church, Bible study or prayer meeting, and then I have a women's prayer group that I go to some nights, so my week is pretty busy… Sunday is just church, I do nothing on Sunday, because I come in the morning, I'm fully involved in my church, so Sunday I have nothing for Sunday because by the time church is finished sometimes I go home, by the time I get home I have to go back because my kids are involved in choir so they have to be here for four-thirty, pray and practice. So Sunday I do absolutely nothing, no shopping, no going over to anybody's house, that's the Lord's day and I'm very serious about it, so Sunday I do absolutely nothing for no one on that day.

The great degree of time these women invest into engaging in group spiritual activities shows the seriousness and dedication they have to developing their faith. Though they talk of their busy and hectic schedules, which often start early in the morning and involve going to work, running a house as a single parent, and as will later be discussed, involving themselves in volunteer work, the priority of putting their spiritual practices first remains.

By putting their spiritual practices first, participants believe that God will see them through any difficulties or crises. As Hannah states,

> once you know who is first, and it's about putting the Creator first, once you know what is first in your life, I believe everything else is taken care of, trials will come but there will be a peace with it because the assuredness of knowing I don't have to go to God like a sugar daddy because I know I put Him first, so He's able to bring me out no matter, I just have to call His name because the relationship is there, it's a relationship…

As Hannah has stated and has also been demonstrated by Mary's physical condition, these women are not immune to the trials of life. Like any other person, these women also face barriers, constraints and challenges that can get in the way of promoting their

ideal sense of health and well-being; however, the distinction is in the way these women cope with such hindrances to their health and well-being. In fact, they state that it is not they that cope with it but it is God, as they cast all their cares, burdens and worries unto Him. When the researcher asked the participants this question pertaining to how they cope with such hindrances to their health and overall well-being, it was in this very way they responded: “I don’t, God does, God just gives me a peace, it’s just the grace of God” (Hannah). The omnipresent omnipotent nature of God as perceived by these women is shown here as sufficient to bring peace and calm in the midst of difficulties.

Participants also used other spiritual tools, principles and activities to fight against hindrances to health; these include prayer and reading the Bible, as exemplified here by April:

> Well you know how I cope with it is through my prayer. In prayer I go in before God, I bring it to Him, I pray, I read the Word of God and everything, and then take authority over these hindrances, the things that would try to keep you back… So when we see those things we know that it is not of God, so we have to stand against those things and let those things know that they are not greater than us, it’s not more than us, we are more than it because the Word of God says “we are more than conquerors through Him who loved us”.

Living “as a conqueror” and believing that God is always with you also provides participants with a supernatural strength capable of withstanding the challenges of life without crumbling underneath them.

> I’m hoping that my faith in God would give me strength to cope, and that is the only thing that I would have to depend on to keep me strong. Because, you know you’re strong individually, but when certain things happen, you’re human and you kind of fall apart, so you have to have something that would hold you up and keep you… (Deedra)

For these women, not only do they see God as constantly there to take up their burdens and keep them from stumbling through the course of life, they also see Him as a loving companion to turn to when seeking guidance or in need of a listening ear. Rachel speaks of this as she laments over her past experience of being hurt by friends: "I don't have much friends, just a few friends that I have, I don't know, maybe it's me that I'm too selfish, but I was hurt through friends, and I'm so scared to keep friends, so that's why if I have a problem I relate it to God, I'm so scared to talk to anybody".

These women's accounts of how they cope with hindrances to their health and well-being mimics that of their daily routine as presented earlier in this section. By acknowledging God's presence day by day, and actively engaging in spiritual activities such as prayer and reading the Bible, they derive the strength, comfort and peace they need to meet their daily challenges gracefully and overcome major life challenges. Victoria's bout with depression is a testament to this spiritual reality and is quoted at length here to depict the fullness of her story of how she rejected the biomedical solution to her depression and conquered it instead through her spiritual practices.

> A couple of years ago before the light bulb got turned on in my head I used to be very depressed, things that were going on in my life, I used to be very depressed, and I actually went to the doctor about it and he gave me some anti-depressants, and I think I took about three, and one day I stood up, I think it was a Sunday morning I was getting ready to go to church, and I stood up in the mirror in the bathroom, I had the bottle of medication in my hand, and I looked at it, and I'm looking at myself in the mirror and I'm like, you know what, I know somebody that is more powerful than this medication, and I said you know what, no, I'm not going to take it. And I just dumped it in the garbage, and I went to church early, went to the alter, spent some time at the alter and just started praying and praying. Just for me, for me really how I cope with stress and other things in my life, I just look at it as God is able, God is

> able. When you look at the corporate world they don't think about those things, but because we know God, I know God, so I always think that God is able to deliver me, maybe He may not deliver me right now, maybe not tomorrow, whatever, but I believe, I believe, and I learned that the power of the mind is very important, so you maintain the positive mind and believe that it's going to happen. So that's how I conquered it, prayer and just believing that I am going to be okay, I am going to be okay, free from what's going on.

The testimonies of faith shared by the women in this study exhibit the very real peace, joy and strength that sustain them and provide their sense of well-being. The participants' deep Christian faith, which is at the root of their well-being, structures their lives day by day as they spend time in their spiritual practices. Their faith provides them with the resources they need to cope with and overcome obstacles that act as hindrances to their health and well-being. Their faith also provides them with a deep sense of peace, despite lacking material resources and, for some, the physical qualities we associate with health. For the women in this study, their faith is fundamental to their understanding of their health and well-being. As Grace stated in response to the question regarding the deep values that she believes are important to her health and overall well-being, "Make God the centre of your life, it's the most important thing, let Christ be the centre of your life".

Peace of Mind, Heart and Soul

Having a sense of mental stability and clarity of mind, or what the women in this study often referred to as peace, is another virtue that the participants found to be essential to their well-being and overall health. The peace that these women found in their lives was highly valued, it was not a constant, but rather varied in degree throughout

their lives depending on the amount of rest they were able to attain, the extent of balance in their lives, as well as other contributing factors. When asked what are some of the indications or signs of good health and well-being for themselves, the responses tended to generate around notions of being relaxed, less irritable, more focused and stress free, which has been grouped here under the umbrella term "peace", a phrase used by some of the women in this study to describe these characteristics.

Consistent with the values of these women, God is again placed at the forefront as being the source of their peace as well as the joy and happiness which follows it. April expresses this peace as she explains to the researcher what the signs and indications of good health are for her:

> Well this shows me that things are looking up for me, because my mind is settled, I feel the peace in my heart, peace in my soul, I feel that joy, and I just keep thanking God, praising Him for all He is doing because I know it is not me, it is He, especially when my mind is not going here and there, functioning right, that's it. Because sometimes your mind is worrying, you can't even think, things happen but you can't even think because what is going ahead in your mind. But when you take off your mind on those things and just put it on the Lord, or you get a book and you start reading, it brings a joy, it bring that healthiness, then you forget.

As is demonstrated here, April acknowledges God as the source of her peace; however, she references her mind as the point of contact in which this peace prevails. A stable mind free from worry elicits for her feelings of joy and healthiness. She later describes when she is feeling her healthiest as a time when her mind is well rested, which again brings about joy and happiness. This experience of health described by April transcends the material corporeal conceptions of what it means to be healthy by portraying health in more elusive intangible terms: "You know when I feel like my healthiest is when my

mind is rested (laughter), I feel so light, I feel so happy that songs come to me, I just sing it, and sometimes I feel like dancing and I'm praising the Lord, glorifying Him" (April).

Many of the other women in this study also attributed their serenity to their faith. For Hannah, this peace that comes from God, which she sees as a personal sign of good health, is priceless and cannot be bought; despite her low-income status she holds this peace as more valuable than monetary riches and wealth: "To me health is priceless, to know that I'm not suicidal, I'm not oppressed, I'm not in depression, I don't have to go into therapy, that is priceless because the millionaires would want to buy that, just to have that peace of God, and that comes with health, that comes with good health and that is above everything else" (Hannah). For Hannah, like the other women in this study, health and peace go hand-in-hand and derives from their faith. Participants highly value a sense of peace in their lives; it is something they do not take for granted but rather cherish as a precious gift from God. They are able sustain this quality in their lives by following their faith practices regularly.

Hannah describes the steps she takes in order to maintain a life of peace free from anxiety and worry. She focuses on the day at hand and deals with tomorrow when it comes; sufficient for her are the cares of the day, tomorrow she believes will take care of itself.

> …let me get through today, and it's so much easier for me, let me get through today and tomorrow will take care of itself, I will deal with that when it comes. The peace and the grace of God, everyday is a new day for me and it's fresh, step by step by step, and that's what the Lord taught me, focus on today, tomorrow might never come… the things of tomorrow, I will deal with tomorrow and one step at a time, that's how I get through and that's how I keep my sanity, and my peace and my joy. God doesn't change, why should I, if I change let Him change me for the better, not

> to go downhill and be like 'oh my gosh I'm panicking, what's going to happen if I can't pay my bills', let them come and cut-off everything, I don't care, I honestly don't, let them cut everything, how were we surviving before? I have a cell phone and if I don't get to paying it let them take it, honestly, the phone booth is still there, if you need me so badly you'll find me, and that's how it helps me day by day by day, I'm not lying, that's how I have to take it.

As shown here, Hannah finds her sense of peace in her life by living one day at a time; for some of the other women in this study, their sense of peace, again rooted in their faith practices, is expressed through having a balanced lifestyle. Jackie explains here what a balanced lifestyle would look like for herself with the concept of peace again being at the forefront:

> Happiness, peace… peace, yeah, I need that, I need that balance, I think it's very, very important for everyone to have it because without it you're not at peace, you're not at ease, you're not relaxed, you're just not happy, so balance is good… I read my Bible a lot, and I like to hang out with my cats, and that really gives me a lot of balance (okay), and I do my exercise and that's my balance for me, and I try to eat as healthy as possible, and that's my balance.

She then again reiterates the importance of a balanced life and the peace that comes with it as she describes the essence of a good quality of life while simultaneously living with a hectic schedule:

> I would have to say peace, which comes with the balance, peace, just being able to, well I don't know, I'm in my thirties and I already feel like I've done a whole lot (laughter), and I know I haven't, but I don't know, I just, peace. Like right now I feel relaxed, I feel fine, and come Monday it's a totally different thing because it's like you got to go to work, and you have to get this done, and this is where you need your balance; and when I do my exercise and when I talk to my God and all that, I feel really peaceful, it does help a lot, I don't know about others, but I find it helps a lot, and these guys (referring to her cats), they don't leave me alone but they're also good too.

This peace Jackie speaks of, which for her is brought about from what she experiences as a balanced lifestyle, is again presented as the quintessential marker of health for the women in this study. A common thread in this marker of health found among these women is a relaxed attitude where by one's mental state is clear, free from stress and worry. As Celina expresses some of the personal signs and indications of good health and well-being as she experiences, she depicts this theme, with again a balanced lifestyle being held in high esteem:

> For me, the sign of good health and well-being is again to have that balance… Physical, emotionally, the more you have packed on your plate the more your brain is just bogged down and that weight gets to you after awhile and the stress builds and stuff like that. So when I find that I'm in good health and well-being I'm laughing more, I'm relaxing more, I'm not as irritated, I can tolerate or I'm more understanding of people and where they're at, so your mind is more open… I believe also that when I'm in good health the quality of my work is also better, and my thought pattern is also clear and concise type of thing. So I think that all plays a part in good health and well-being…

As depicted through these quotes, indications and signs of good health for the women in this study have very little to do with the physical body, rather health here is perceived as a calmness which prevails in the heart and mind. This peace the women speak of is an essential marker they use to determine the level and quality of their well-being. Whether it is attained by finding balance in life, living one day at a time, or as Victoria expressed, deliberately 'purposing in her mind that she's not going to let things stress her out', for these women, having this peace is an important part of what it means to be healthy.

The Helping Community

The women in this study take great joy and satisfaction in their efforts to help others no matter the scale. When asked 'what are some of the things they do well for their well-being?' a common response was related to helping those in need. The type of help these women offer take on various forms including but not limited to volunteering in the community and in the church, sponsoring children from developing countries, and supporting various organizations with monthly donations. These women also expressed joy in taking advantage of everyday opportunities to help such as aiding an elderly woman down a flight of stairs, offering their home as a place to stay for someone until they're able to support themselves, or helping out a graduate student by participating in her research study.

Though the women in this study also described facing financial challenges and a desire to have a greater degree of financial liberation, a concept which will be further developed below, their monetary dreams were in part born out of a yearning to be able to reach out and help more people. Not only do these women find satisfaction in giving, but they also give freely, expecting nothing in return. Many participants expressed that it is far better to give than it is to receive. Grace makes this clear as she describes to the researcher what it is that she does well for her well-being: "I think helping each other, helping people, for me that's me, I like to help people as much as I can, for me I'd rather give than receive type of thing, and I like to just do things for people". For Grace, helping people is not something that she does in addition to her regular routine, rather her service towards others is a fundamental part of who she is as a person inherent in her everyday life. As she describes her typical day, she lists off in an almost subconscious manner her

routine of work, thanking God for each day that she has, and helping people in need, particularly her family and even more so her mother who is ill. Again, as she describes the elements that make a balanced lifestyle for her, Grace nonchalantly lists these components "you know, just work, going home, taking good care of my home, and you know, help people that need my help basically".

The natural manner in which philanthropic gestures are presented as standard day-to-day routine is not unique to Grace, but instead represents a consistency found among the other participants in this study. Mary also expressed her preference for giving as opposed to receiving, "as long as someone needs my help, and I can do something to help that person, I don't want repayment because I'm doing it from my heart, you know… that makes me happy". Contrary to this happiness that Mary derives from helping others, which she also describes as contributing to her health, she grieves over her inability to do more charitable work due to the debilitating illnesses she faces: "To me, I think to be healthy I would say not much sickness and disease in my life, I wouldn't have too many aches and pains, I could go out there and help others, rather than sitting here and knowing I could help someone else but can't do it, you know, that bugs me…I like to help people". Mary is unique from the other women in this study in that the illnesses she lives with has given her a magnified awareness of her physical body and the pain and diseases that it is fraught with; however, her perceptions on health still are not limited in this domain. She reminisces over the time when she felt at her healthiest, a time when she enjoyed visiting hospitals, walking through the corridors meeting and spending time with people who did not have visitors: "I used to like to go to the hospital and just walk around and meet people who don't have visitors; I used to like to do that". Now sadly, due to her inability

to stand or walk for extended periods of time, she can no longer engage in this benevolent health promoting behaviour.

However, as for the other women in this study who do have the physical ability to be active in the community, by and large choose to do so. These women experience a source of joy by engaging in the various volunteer programs which contributes to their well-being. Unsurprisingly, the church is a common place of humanitarian service in which these women offer their aid. Sandra, a woman who feels "called" to work with children, not only works for pay as a full-time babysitter, but also donates her free time working in the children's ministry at her church: "I'm in the children's ministry, so the entire children's ministry, the nursery, Sunday school and helping with the teachers". The depth of her involvement in this ministry is clearly significant in her church, as the researcher witnessed numerous women approaching her for directions regarding the functioning and carrying out of Sunday school and nursery duties, and the children approaching her for hugs, jellybeans, or simply popping their heads into the Sunday school classroom, where the interview took place, or stopping her in the hallways just to say hello. Celina, who also enjoys a passion for children, like Sandra, extends her full-time position as an Early Childhood Educator to taking charge of her church's Sunday night children's program. Again, her charitable efforts provide her with a sense of life satisfaction that also contributes to her well-being. In response to the question what are some of the things that she does well for her well-being and health, she answers:

> "I guess I would say it's volunteering. Right now I'm in charge of our Sunday nights children program at church, I believe I do that well. I enjoy getting out there and coming up with new games for them and challenging them... It's a kids program combined with Bible lesson type of thing, half of the night would be in the gym doing sports and stuff

> like that and the other half would be in a Sunday school class setting, so they're getting both the Word and it's coupled with for example, when you're at school and you come into this situation, this is how you can handle it and stuff like that, so I believe I do that well.

Yet in spite of the volunteer work Celina takes part in at her church, she still believes that it is not enough and could further improve her well-being by doing more. She aspires to join a committee or association that gives back to the community and makes a difference. With the recent sprawl of shootings and murders in Toronto, she wishes to engage in a type of volunteer work that will present a positive message to youths:

> One of the things that I would like to do is to join an association that I have a sense of belonging to something and that I'm giving back within my community… with all the latest shootings right now, well I was thinking the Children's Aid Society, but with just what happened up in Jane and Finch with the Crypts and stuff like that, they started a mentor program up there, and I thought, you know that's something I would like to do, to get into a mentorship type program, or maybe get on the police board where they're working with youths and stuff like that and just be a part of a professional organization that is making a difference.

Contributing to humanitarian services and making a difference in society is not only a popular theme among these women, there is also a consistent desire to do more despite the contributions that they already make and extend their humanitarian efforts to reach out to more people. However, similar to Mary, who as mentioned above expresses grievances over the limitations her illnesses places on her ability to help out in the community, many of the other women also expressed disappointment due to their financial limitations hindering their ability to give more. Deedra, a woman who acknowledges the vast contributions she already makes states:

> I do a lot of contributions to projects, you know, those causes and stuff like that, and I would like to do more, I can't do it every time every month, I make sure at least twice a month I do some, but there are about six of them that I do on a monthly basis, but I would like to do more because some of those programs they're for a very good cause, and if you could help people in anyway… I like to give because it's important, because they do good work and basically most of the time the help goes towards children, and it's important for children to have the opportunity, even though some of them they might be sick, but still that doesn't mean that we can't help them to enjoy life. So I would like to have more money to do more causes that will help people.

As Deedra explains here, her desire for greater financial freedom is in part born out of her desire to give more, she is not alone in her thinking, as many of the other women have also reported to have such dreams to give more than they already do if only they had the monetary resources to do so.

Nevertheless, the voluntary contributions that these women already make to society are in actuality quite generous; not only do their efforts penetrate their local communities and churches, but these women have also shown an interest in providing charitable funds and materials across transnational borders. Supporting children in developing countries was another sub-theme which arose in interviews with two of the participants. Jackie, a woman with five sponsored children from around the world, who donates through the charitable organization the Christian Children Fund, states that "wherever they need help, I'm there". April also expresses a heartfelt desire to reach out internationally and not only support the children around the globe who are living in disadvantaged conditions, but to also extend her efforts to support the missionaries who travel abroad to help those in need and spread the Gospel:

> I want to be in that position that I can be able to help others, that's my real great desire, it's a determination in my heart; I want to help people. You see the children in like Nicaragua, Africa, and all those sorts of things, sometimes when I see them my heart goes out a lot for them. But in the month on the fifteenth, let's say I get one thousand five hundred come in, bills come out, you could save and be able to send money for missions, it's a real joy when I am able to send money overseas for missions to help the children, and even missions when people go out to spread the Gospel, I really have a thing for that.

The joy that these women attain from the act of giving is central to their sense of well-being, they are glad when they are able to give, and grieved when they are not. Their giving takes on the form of participating in both organized charities as well as everyday gestures of unprompted generosity. When the opportunity comes around to help, these women have a tendency to strike. April explains how she loves to welcome people into her home, and if they do not have a place to stay, then she will gladly offer hers: "I love to entertain, to welcome people in to my home; like I may see someone that doesn't have a place to stay, I like to help them until they can build up themselves and get going". When Deedra was asked about the things she does well that contributes to her health and well-being, her response, similar to many of the other women was "Well, I love to help people, so that is my best quality of life… Yup, that's my number one, I love to do that; oh, I shouldn't forget this too, and loving people". For her, the deepest and best values contributing to her overall health are helping people and showing respect to everyone. The spirit of giving which these women so strongly possess as an intrinsic part of their daily lifestyle can be summed up by Hannah as such: "If I can help one person through the day, in whatever way possible, even help them down the stairs, no matter what it is, if

I can reach out to one person because I know I'm capable of doing it, that to me it makes my day… reaching out, that's part of being in a healthy environment".

Family Relationships and Friendships

Intimate relationships and social support showed to be another valuable aspect of having a healthy lifestyle for the women in this study. When asked 'how important is it to have a balanced lifestyle?' nearly all the participants in the study, with the exception of one, responded that it is very important. Then, when asked with the follow-up question 'what does it mean for you to have a balanced lifestyle?' the answers varied, but the common denominator proved to be spending time with family and friends.

Two out of the three married women in this study expressed the desire to have their husbands be more involved and participate more actively in the home. Of the women who were single, some expressed a desire to have the intimate companionship that having a spouse is supposed to offer. Spending quality time with children, nieces, nephews and other family members was another sub-theme which arose from this general theme of intimate relationships and social support. In addition, the women also frequently described time with friends as providing that breakaway needed at the end of a hectic workday or week.

Only Mary stated that having a balanced lifestyle was not so important for her, due to her aging and ailing body; she now wishes to place her focus on God and engaging in spiritual activities. However, she reminisces over the pleasure she got from visiting family and friends when she had the mobility to be more active and do things for herself: "Before when I could do things for myself I would like to go visit friends and family";

she later again nostalgically recalls the things she enjoyed doing when she had the physical capacity to do so, among these acts of pleasure spending time with family was again listed as one of her enjoyments, “When I was healthy I would visit family often…. and also going out taking my niece out, my nephew, I can’t do anything like that now”; she then goes on to explain the ordeal she must go through to visit her sister who lives in a neighbouring city by taking multiple flawed transportation systems designed for people with disabilities.

Though Mary has forfeited her interest in engaging in familial and friendship based affairs, and has redirected her energy to her spiritual practices, it is clear that she is reminiscent of the family relationships and friendships she once used to foster. However, she does derive companionship, a sense of community and social support from her church community where she now spends a great deal of her time.

For the rest of the women in this study, none of whom displayed physical disadvantages, a balanced lifestyle is very important, as was already stated, and actively engaging in activities with friends and family is part of this balance. Here Celina describes the value she places on having such relationships:

> I believe that family too is very important, where you’re spending time with your family and just getting in touch with them and doing things that you enjoy to promote healthy communications and stuff like that, and then you have your friends or your groups that you’re affiliated with, that type of thing, I believe that keeping in touch with those groups and those friends on a regular basis makes a big difference….

Though church life is an intricate part of these women’s realities, they also value time spent outside the church to keep in touch with family and friends; they acknowledge

that their relationship with God is their utmost priority, however they feel healthiest when they have a balance, and that balance in part comes from bonding with loved ones:

> It's the most important thing (referring to having a balanced lifestyle), even with a relationship with God, and I know I keep coming back to this, but there has to be a balance. I can't be so religious that I think this is the only thing… yes God has to be number one, but He gave us a balanced way, I can go to the movie if I choose to, some people don't but to each their own, if I choose to go and spend a relaxing movie with my son as long as it's clean, than to me that's a breakdown, that's a balance from everything. Really who is in church all week? It could overtake you in such a way that you become dissocialized from people and you don't know how to function (Hannah).

Sandra, who also acknowledges the dominant role of church in her life like Hannah, also identifies a need to spend time with her friends and involve herself in extracurricular activities outside of church activities:

> I'm a fun person, I do things, I'm not just church, church, church, church, even though like three, four days of the week I have church, I still find time to do things for myself, me and my girlfriends we go shopping, we'll just hang out, we'll just pop off at one's house, from work I'll go to the hardware store, we'll go buy whatever we need to buy there, we'll just sit, eat, drink, laugh, talk nonsense or sometimes positive stuff, depends on, you know, and then we go home. So for me I know that I'm pretty balanced, and I'm a sociable person so I always find time to socialize with people, so I'm balanced.

Balancing life with intimate relationships provides these women with a break from regular routines, as well as an avenue of intimate and personal social support which they may or may not receive from the larger church community. Having a confidante to share different issues with and depend on for support is also important to these women's sense of well-being. Jackie explains that though she does not have many friends the ones

she does have are quality friendships with people in whom she can place her trust, and as a result this makes her happy.

> Having good friends, people who you can talk to, people who just, you know, like Rachel (referring to her neighbour sitting with us), we don't talk a lot, but when we see each other we're happy to see each other, we're okay, you know… somebody you can talk to, not tell everything to, but you know, just some things. I don't have very many friends but the one's I do have they're really, really supportive, like people I can trust my own life with…

In addition to seeking social support from friends and family, many of these women also expressed the desire to have the intimate bond and partnership of marriage. This yearning however, came from two different perspectives: one from those who are already married but dissatisfied with the lack of involvement of their husbands; and the other from those who are single but longing to be married. Hannah, one of the single women in this study stated that she knew God would bless her with a husband; she believes that her bad habits such as poor listening skills and lack of patience are a training ground for her in which the Lord is preparing her for when her husband comes:

> … I haven't been in a relationship for so long, I don't have the patience, when a guy comes up to me and wants to have a conversation, sometimes it's general, it's like 'okay already, are you finished?'… God is teaching me in that area… and that could be because I don't have a husband now so I'm not use to that area, so I have to practice now because he's going to come, so I can't do that to him.

She also refers to a need to change her poor eating habits of skipping meals and not eating enough, because when her husband comes "who is coming soon", she will have to sit with him and make time for breakfast.

The optimism and confidence that Hannah shows is born out of her faith that God will bless her with a life partner just as she desires. April also holds on to faith that God

will bring her and her ex-husband back together, she believes that the companionship she hopes to share with him would bring an increased sense of healthiness into her life: “When you have a companion, you’re together, you can exchange ideas together… and I pray that if it is God’s will for me to get back with my husband it would bring such healthiness and everything”.

Paradoxically, Rachel and Bernice, two of the three women in the study who reported being presently married, had a different story to tell about married life. Indeed they desired to have the companionship and partnership that marriage is often associated with, however, they expressed great dissatisfaction because they lacked this with their partners. As they acknowledged their married status they also both followed it up by claims that though they are married, “everything, most of the things I do for myself” (Rachel). As Rachel also states, “I’m married yes, but I have nobody to do anything”. Bernice is able to relate to Rachel in this area as she similarly states “my husband is like, he’s there but he’s not there (laughter)”, she continues on to say that “he’s like another baby himself, I’m sorry, but it’s like having another child in the house… sometimes he should do a little bit more around the house to help out, to be more involved; so I don’t have that help from him so it’s very stressful that way, very stressful”.

The lack of partnership Rachel and Bernice find with their husbands is something they lament; they desire to have the support that a spouse is supposed to bring but rather they experience additional stress due to the lack of it. Nevertheless, like the rest of the women in this study, they still maintain a deep sense of value for intimate relationships with both family and friends. The social support, companionship and diversion from

everyday routines, which these women desire from their intimate relationships is another significant factor contributing to what health means to these group of women.

Shopping, Hair, Nails and Other Regimes of Self-Care

Another dimension in the way the participants in this study perceive health and well-being is related to their personal self-care regimens consisting of beautifying rituals to enhance their outer appearance. When asked by the researcher "What are some of the other ways you care for yourself or things you do for self-care that promote a sense of well-being and overall health?" the most common response was based on beauty enhancing practices such as going shopping, getting one's hair done, and performing manicures and pedicures. These acts of personal self-care were often explained by the women as simply making them feel good.

Bernice clearly states this here as she explains to the researcher her methods of self-care: "Maybe going shopping (laughter), it makes you feel good, getting my hair done, or my nails, my eyebrows, you know… taking care of the outer appearance, that makes you feel real good (laughter), makes you feel special". The "special feel good" emotions that Bernice and some of other participants experience through caring for themselves in this manner stem in part from the little time they have to focus on themselves and place their needs and wants as paramount. Not only do these acts of self-interest benefit their physical appearance, but they also provide these women with a much needed time out from their busy schedules to spend on themselves:

> I like to get my nails done, scrub my feet, I don't go to do pedicures but I try to do those things for myself, although sometimes you feel so busy and you don't have the time, and I feel something is missing, so I have to sit down and

> say for now it's enough, I have to do something about myself. I want myself to look beautiful, healthy, because Jesus wants us to look so beautiful, He wants us to look good; looking just up to date (April).

Such actions are not necessarily to gain the interest of men; rather their acts of personal self-care are indeed personal and pleasing to the self. Hannah makes a brief note of this as she describes some of the ways she cares for herself: "I like to take a nice long soak in the bath, do a manicure, a pedicure, do my hair up, look good, look pleasing with myself, it doesn't have to be for a man, just be happy for me…". Along these lines, Victoria cautions against assuming that setting time out for personal self-care symbolizes acts of selfishness; she justifies such acts of physical self-enhancement by referring to the large quantity of time spent by women like herself caring for others. Based on this, for Victoria, and others, it is therefore necessary to have personal time out to focus on the self, putting all others aside and rejuvenating for continued works. Her quote below is a testament to this perspective and value she places in health enhancing self-care practices:

> I love to take care of myself, I feel when I take care of myself, I love to dress, I love to dress, every month or so I would go get a pedicure done, every two weeks I get my nails done, and sometimes I would go to some of the makeup places and get my facial, yeah, I love to take care of me. Yes, so you know, those things they make you feel good; and if I might feel a little bit down or whatever I'd just look and be like oh maybe I need to go get a facial, maybe I need to go do this or whatever. And I think that's a lot of us as women we tend to forget ourselves, we think about oh the children have to get this, husband has to get this, and mommy has to get this and we forget about us. But as I said, it's not that we are being selfish but there are times when you have to think about you; okay, I'm thinking about me, making myself look good, remaining healthy, then I would be of more use to them. If I'm not healthy, I'm not thinking about me, I'm sick, I'm of no use to them.

Taking time out for personal self-care is a significant aspect of maintaining a good sense of well-being and health. The women in this study acknowledged this and found that by engaging in pampering treatments that enhanced their self-image, also enhanced their well-being by simply making them feel good, giving them a break from daily work routines and a sense of restoration to continue the work ahead.

Diet and Exercise Strategies and Apologies

Not surprisingly, given the nature of this research topic, physical activity and nutrition were popular topics among participants. Each woman interviewed accepted the importance of physical activity and nutrition; however their present experiences of physical activity varied from actively engaging in purposeful physical activity, to passive engagement through work activities, to simply having the desire to participate and giving voice to apologetic expressions for their lack of action. The women also varied in the degree to which they practiced healthy nutrition. The majority of the women expressed that they enjoyed eating healthily and were very conscious of this aspect of health, however they wanted to improve in this area. When asked "What are some of the things in your life that you would like to improve in order to have a healthier lifestyle?" nutrition and exercise were among the most common of responses.

With respect to nutrition, two recurring themes were not eating enough and not having the time to eat when they should. Hannah explains her problem with lack of nutrition, however in addition to acknowledging this she also expresses that it is a problem which she is working on:

> I don't feed myself properly, I should eat breakfast, I don't,
> I only eat when I'm really extremely hungry and I really

> should make the effort to eat breakfast. I skip lunch most of the time because I know it doesn't bother me, but I know eventually it's going to come back and hit me, because when the body is deprived it closes up, so when I really want to stuff myself the space wouldn't be there and it's going to cause problems. So I have to really take time out to sit down and not be in a rush so much… but I'm working on that.

Needing to take the time to sit down and eat proper meals is something Bernice can relate to. She too desires to find time to sit down as a family and eat a healthy meal together, but instead she places the duties of caring for the household by herself as a greater priority: "I still don't think I eat properly enough because there is not enough time, family time, to sit down and have a proper meal, I kind of miss that, you know…there is no time for that, you have a house and it's like taking care of the kids, and you come from work…". She again later states that "not eating on time and having a balanced meal" is something which she associates with poor health for herself, however when she is able to eat a meal which she feels is nutritious she feels good "When I go to the store, come back and I cook, and I eat lots of vegetables and salad, even though I don't have meat, I just eat that thing and I feel good you know..". For Bernice, like many of the other women, the desire and knowledge to eat healthily is there, however, what they see as lacking is the time to eat enough and to eat in a balanced way. Deedra indicates this in her statement "I make sure I eat a healthy diet, good food that has nutrients for the body…" hence the knowledge, however she then stated "sometimes I don't eat when I should, like if I come home and I feel tired, I don't eat, so tomorrow when I get up, it's either that my stomach doesn't feel right, or I get up in the middle of the night and I'm eating things that I shouldn't because it's too late…"

When it comes to nutrition, these women are not ignorant of what it means to eat healthily, in fact, they highly value nutritious eating and consider it to be an important aspect of their health and well-being; they speak about different strategies and methods they use to maintain a healthy diet such as steaming and baking foods as opposed to frying foods: "oh yeah, the way you cook makes a big difference too on your health; not too much frying of stuff, instead baking stuff, steaming stuff, and if you go out for dinner at a restaurant, no matter how classy the restaurant is or whatever, you still should maintain your quality of eating" (Jackie). They are also aware of marketing exploits in the diet and nutrition industry: "I used to take Centrum but then I realized that fruits and vegetables have the same vitamins, all the stuff that is good for your body because it's natural, so I tend to eat a lot of fruits now…" (Jackie). Their knowledge also extends to nutritional doctrine such as that from the Canadian Food Guide, though at times they fall short of complete compliance: "to eat from the food groups that is required, that's really poor, like that is 'P' a lot of 'Os', not two, a lot of 'Os', poooooooor, so that I have to work on that but I'm aware of it" (Sandra). Simply put, for these women, eating healthy is part of what it means to be healthy, as Grace summarizes here:

> Just eat right, take care of your body that you have, because if you don't take care of your body and do what you have to do, the Bible says your body is the temple, so you have to focus on taking care of what you have, because if you don't, you start falling apart, you start developing all kinds of sicknesses and disease, diabetes, cholesterol, so just eating right, exercise, doing everything that would contribute to good health.

As mentioned by Grace, and acknowledged by the other participants, physical activity is another contributor to good health. The type of physical activity these women engaged in can be divided into two groups: those who actively engage in physical activity

routines through scheduled workouts such as time spent in the gym or going jogging, and those who passively engage in physical activity through their places of employment and household duties. There was a moderate theme found among the two women who worked in office settings in jobs which involved a lot of sitting to have active participation in formalized physical activity, compared to those working in childcare, elderly care or factory settings, who tended to be more passive in their engagement of physical activity. Though all the women in this study did acknowledge physical activity and exercise, only two women, Grace and Victoria, placed more than moderate emphasis on its relevance to their health and well-being with respect to the entire interview on a whole; these women were also the only two women whose work involved a great deal of sitting.

For Victoria, who enjoys going for jogs in the morning and to the gym in the evening, exercise became an important aspect of her well-being after being on medication for high blood pressure, and given an ultimatum by her doctor to either lose weight or also go on medication for high cholesterol: “He said ‘it’s either you start on the medication, or you lose weight’, and with that I think a light bulb went off in my head, and I joined the gym, I bought some Tai-bo tapes and I started exercising”. Victoria is unique among the other women in this study in respects to the high regard she places on exercise. Grace, who also places an emphasis on the role of exercise as related to her health and well-being, though not to the same extent as Victoria, explains how working-out enhances her energy level and empowers her to face the world: “So for me working out and going to the gym also helps, and it also gives you more energy and stimulates you and you feel like you’re going to conquer the world when you’re active in whatever your doing and being active in other stuff. And like I said, I think people do need to have a

little bit of activity in their life, when I wasn't working-out at the gym I was so sluggish, it kind of gives me a boost me up a little bit…".

Contrary to Grace and Victoria's experience of exercise, the majority of the women in this study acknowledged being physically active, however, through passive means of work and household duties. These women commonly described such means of physical activity as being sufficient, yet at the same time it was also common for some of these women to apologetically express that they should engage in more formal means of exercise. As Rachel explains some of her daily activities that promote a sense of well-being and health for her, she puts herself down for not engaging in formal exercise while in the same sentence explaining how she is quite active in the home: "I do a lot of movement, I'm lousy, I don't exercise, I don't do exercise, but I do a lot of movement, gardening, I changed my kitchen…And I do a lot of stuff inside the house, cleaning too, and I always take the bus, sometimes I walk from Dufferin home, and I run through the park at night to get to the bus". Though the participants were never asked if they exercise, their responses at times indicated that this was what was expected by them. Here Celina communicates her regrets for not making formal exercise a part of her regular routine: "unfortunately I never did put in time for exercise, which is also important…" However, she neglected to state here that her work activities as an Early Childhood Educator, which involved looking after several young children, likely kept her quite active.

Though some women expressed their regrets for their lack of formal participation in physical activity, there was also a group of women who acknowledged their daily incidental activity as being sufficient and were therefore satisfied with it, not feeling a need to designate periods for exercise. "Health wise I like to be moving, active, I'm

always active so I really don't have a special time when I'm going into exercise because I'm active all during the week anyway" (Hannah). Sandra also explains getting a good level of exercise through her workday activities; "I walk a lot, like the programs where I take the kids they're not like right here, sometimes a half-an-hour walk both ways, twenty minutes, fifteen minutes, and I think it's very good for me…"

The common denominator between those who passionately engage in formal exercise routines, those who desire to but rather are engaged in informal incidental forms of physical activity and those who are satisfied with the level of incidental activity they get through their standard everyday routines, is that all of these women acknowledge physical activity as being a valuable health contributing component to their multidimensional conception of what it means to be healthy. Bernice explains this component of health as a part of this multidimensional ideology as she describes some of the signs and indications of good health:

> I think maybe exercise because you need that; your body needs to sweat, so when I see somebody doing that and they're eating right they look like they're healthy. But sometimes people aren't healthy, they do that but they're not, they be doing all that but they have other stress, I don't know how you call that, other problems, they're always depressed or something, they're depressed because they don't have God you know, because you have to have a balance right, I'm talking about spiritual things. Because you need a balance, you need the Word, and you need God, and you need to exercise because our body is the temple of the Holy Ghost, so you need all that just to have a balance in your life…

Job Dis/Satisfaction and Dreams of Financial Freedom

The final major theme which was prevalent among the participants of this study was their job-related experiences and financial needs. With respect to their health and well-being, the women were divided in their experience of paid work as either being beneficial or detrimental to their overall health. The desire for financial security was widespread among the women; financial instability and monetary lack were generally seen as hindrances to health.

Those women who spoke positively of their job experiences perceived employment to be a part of having a balanced lifestyle and contributing to their general sense of well-being. Grace explains the important role paid work plays in her life: “For me it’s important that you have a job and a career in your lifestyle so that you could work… you don’t have to worry about what tomorrow is going to look like or where you will get your next pay-check… so having a job and career is important to having a good balance”. Grace, also mentions at another point in the interview that she loves her job, however her situation is somewhat unique relative to the other women in this study in that she is one of two women who work in an office setting and the only woman with a professional job title (Dental Assistant). Furthermore, she is also just one of two women in this study who do not have children. Nonetheless, other women in this study have also emphasized paid work as an important attribute to their health and quality of life, “I’ve always had a job for the last nineteen years, so that’s healthy for me…”(Deedra). On the other hand, some participants have made a very clear distinction between their current place of work, which they do not find to be healthful, and one which they long for that would grant them personal and financial peace and self-esteem. There were also women

who mentioned that they would rather not work at all in an occupation but instead spend their time as a stay at home mom, taking care of themselves, or being more active in reaching out to others and engaging in community services.

Hannah, one of the women who expressed dissatisfaction with her job and a desire to work at a place which would provide greater stimulation and better pay expresses her discontent in this aspect of her well-being:

> Job wise, I wish there were more jobs with more creativity, instead of just taking something that you have to take to make a living, I wish that you just didn't have to settle. I've been to school and I'm still in the process because it really comes down to money, and in the mean time I have to settle for something that really is a bondage until I finish going through the whole process of schooling. So I want to get something that I could say okay, this could provide for me in case I don't get to finish… because we all need a job in the bucket, but to be scrapping where there is more months than pay it could be frustrating and it could be a big turn-off…

Despite her discontentment with her current job, Hannah still has the will to work, albeit in a more amenable environment. Her desire is consistent with her spiritual beliefs; "in the Word of God he talks about the sluggard, being lazy, if you don't work, you don't eat…" (Hannah). Similarly, April also shares her dream to move from her current place of employment to a prominent position that offers good pay:

> … and most of all my desire is to have a good job, not a job that makes you tired, though I like to do the health care, but you go and do a day work here, one hour here, one hour here, another hour another place, it really makes you very, very tired. So the thing that would make me really happy is that I have a prominent job, and then working for a certain amount of money that would be able to keep me, my bills, and since my bills could be paid off you could buy the things that you want, you have everything, but when you have that struggle in your life, it's not easy.

Dissatisfaction in the workplace was more common than contentment. Even Grace who asserts that she loves her job acknowledges that it is worthwhile to seek better employment if one is dissatisfied due to the negative impact it could have on one's well-being: "I find that if you're not happy in any job you should try to find another place where you can be happy, because you need that, I feel that also helps with your well-being, with your health, because that would really, really put you down, go home everyday complaining this and that".

Some women appeared to be so dissatisfied by their places of employment that they seemed utterly turned-off by working and would prefer not to work at all if it were not for their financial needs. Bernice, who works on an assembly line at an automotive factory, describes her experience with her job as being overworked, overly physical and leaving her too tired at the end of the day to spend the quality time caring for her children the way she would like to. She wishes she did not have to work so that she could be a full-time stay at home mother: "Yeah my work, yeah my work definitely [referring to an obstacle to her health and well-being], it gets in the way a lot because they push you so much that when you get home your whole body aches, I feel tingling in my shoulder, you know in my body, because it's physical, it's too much, your body hurts"; she again states at another point "So by the time I get home in the evening, it's like I'm really tired because my job is not white collar, I'm on the floor all day, on my feet all day, hurting, I have to tell you, I'm not enjoying it right now". For Bernice, like many other women in this study, their place of work is seen as a hindrance to their health and overall well-being, "I wish I didn't have to work, it would improve my health a lot" (Rachel). This distaste that some participants exhibited towards work can be attributed to their particular

places of employment, where they work very hard for little pay, leaving them with little time and energy to take care of themselves and other things that are important to them: "Right now all I'm doing is work, work, work all the time, not much time for myself" (Rachel). Participants held varied opinions about the impact of work on health, partly dependent on the degree of manual labour and general work conditions of the positions they held. Not surprisingly, dreams of financial freedom was a collective theme.

Financial security was one aspect of having a healthier lifestyle that participants wanted to improve. Money was frequently cited as being connected to a lot of things and with financial security would come a greater degree of control and freedom to make more choices. Hannah explains here how her life would improve given greater financial standing:

> Money would help, that could help bring me into all the good food instead of buying second hand things. Like it or not money covers a lot of areas. To me that is the only thing I can see, all I need is some money and I'll be fine. The living environment is good right now, I just need the money, give me the money and I will show you what I could do to improve my overall health… everything is money, money, money, so that. Put me in there for money, put me down for money, that would be a big help for me right now, and I believe God is going to send it, if you come back to me this time next year I will tell you I got the money, because that is where the limit is right now, money. So when you're in prayer pray for me for financial blessings.

In addition to having their personal needs and wants met through greater financial security, part of these women's desire to be more financially stable is to also be a greater help to others; this sub-theme which stems from the idea of financial freedom is represented here by April:

> You know when you have everything that you want, you're all wonderful, but when you don't, especially when you want to buy something, or somebody ask you for something and you don't have it to give, it bothers you, so I would like to have some money, you have this money and you can do what you want, you can help people, because there are so many people out there that are in need, and when you're able to help them that is a joy (April).

Not surprisingly, sufficient finances to meet living expenses and freedom from worry of how one will make ends meet is an important factor in the way these women experience health and well-being. Their desire to improve this aspect of their lives is born out of a hope to help themselves live a life where they have the freedom to make more choices, as well as to be of greater service to others. Again, like all the major themes which have arisen out of this study, the issue of financial security is also informed in part by these women's Christian faith; the following quote by Celina is an expression of this faith:

> I dream to be rich (laughter), well no, to be financially stable. I mean when you say to be rich, like I mean rich in what sense, because you can be rich spiritually and that is above anything, because once you have that spiritual richness in you, you can accomplish anything, you don't have to worry because faith goes along with it and stuff like that. But yeah, I would like to be financially stable.

CHAPTER SIX -DISCUSSION

Health is a concept which has often been taken for granted as having a standard and generalizable meaning that is applicable to all. Health promoters fervently develop and promote strategies and interventions intended for diverse populations, but are repeatedly left discontent when such programs are not eagerly embraced by those whom they try to help. This may be due in part to the fact that expressions and perceptions of health represent a diversity that is not always taken into account. For the participants in this study, perceptions and experiences of health greatly differed from the dominant biomedical theme of bodily control through exercise and diet, but rather was embraced as a dynamic concept with multiple dimensions and themes.

Summary of Findings and New Insights

The major health themes which arose from this study include having a sense of peace in one's life, helping others, fostering familial relationships and friendships, taking time out for self-care and pampering, workplace satisfaction, financial freedom, and—perhaps to the comfort of health promoters—physical activity and diet. The underlying theme which informed these multiple conceptions of what it means to be healthy is a strong Christian faith which for these women forms the basis of how they live their lives and perceive the world around them. The tenets of their faith are directly tied to the various concepts of health which they described. This is made evident in part through the Christian references and viewpoints which permeated nearly every aspect of the interviews, as well as the numerous scriptural quotes they often quoted in explaining what health means to them. In fact the underlying theme of Christian faith was based on

the foundational premise of putting God first as stated here by Hannah " it's about putting the Creator first, once you know what is first in your life, I believe everything else is taken care of".

In short, the meaning of health and the way it is experienced for this group of women is an amalgamation of spiritual principles which holistically touches the various domains of these women's lives. In this regard, health, well-being and quality of life are seen by them as emotional, social, communal, personal, physical, material and above all spiritual concepts.

Underlying Influences

Gender, Race and Class: The Unspoken Variables

The position from which these women speak is highly multifaceted as they represent various social identities including, but not limited to their gender, race and class. Interestingly enough however, the social identities of being gendered and raced, with the exception of socioeconomic class, were never directly indicated by these women as being a significant part of their personal self-schemas or experiences with health. One may think that when doing an investigation of this nature, that is, in the context of gendered, raced and classed participants, that these three socially constructed phenomena would show themselves as highly relevant, if not even shape the very identities of groups and individuals. However, it appears that, at least in this case, these social constructs are identities which are ascribed to individuals by social researchers who remind them of their race and gender, as opposed to being a daily and conscious awareness that these women walk around with. In other words, the participants in this study, with the

exception of one woman who made a brief comment about racism, showed no indication of consciously going through life understanding their circumstances and experiences through these social lenses—at least in their understandings of health and well-being.

Of course, gender, race and class are of great significance at the societal level. In addition, the experiences of these women, such as single parenthood, low-incomes and even their church activities, whether acknowledged or not, are highly patterned along racial and gendered lines. Though the participants did not show signs of identifying themselves or perceiving their lives in these terms, they indirectly have a role in shaping these women's experiences, and dare I say perceptions of what it means to be healthy.

Economic class stood out as unique from this social trinity of gender, race and class as it was the only construct which was explicitly discussed by the women. As they were asked what were some of the things they would like to improve on in order to have a healthier lifestyle, they often responded with a desire for greater financial freedom and stability. Unlike gender and race, which are generally fixed variables throughout ones life, income has the ability to change throughout the lifespan and is subjected to a certain degree of human control. Perhaps this is why it was presented as an aspect of health, and well-being that the participants desired to improve.

Gender, race and class can be related to spiritual beliefs and practices (Lee & Newberg, 2005; Mattis, 2000; Clark & Schellenberg, 2006; Statistics Canada, 2006) as is evident by the disproportionate number of church-going Black women and immigrant women with low levels of formal education (Larson & Larson, 2003; Miller & Thoresen, 2003; Clark & Schellenberg, 2006). Researchers have often tried to understand this relationship as a response to the low social positioning these women hold in the social

stratification system. This overrepresentation of visible minority women with low levels of education in the church have been explained by concepts of church as an institution and as a body of people being a safe haven in a discriminatory world, a place offering social support and fellowship with like minded brothers and sisters of faith, and a coping resource to depend on in times of need (Marks, Nesteruk, Swanson, Garrison, & Davis, 2005). However, the focus of this discussion will not be on understanding why such an overrepresentation in the church exists, though such a topic might make for interesting discussion and theorizing. The purpose here is rather to understand how and why these women use Christianity, the overarching theme found in the interviews, to inform their health beliefs and practices.

Spiritual Exercise

As previously mentioned, active Christian faith and church participation has the potential to offer many positive attributes to those who are believers and attend church on a regular basis. The institution as well as the faith can be seen as a haven in the midst of a cruel and chaotic world (even the very name of the place of worship is called the *sanctuary* is indicative of this). The church also offers fellowship and provides a sense of community and belonging. Faith provides a frame of reference in which to understand and cope gracefully with life challenges; it establishes purpose in life and direction for the future; and it can grant one a strong sense of security and serenity in the knowledge that God is omnipotent, omnipresent and omniscient. These are just a few of the affirming attributes outlining participants' faith which are elements to a much larger vision of how the women live in and perceive the world around them as a whole.

By societal standards, these women may be labeled as second class citizens and placed at the bottom of the social hierarchy because of their race, class and gender; however, their faith, which they value as the most important aspect of their lives, gives them a different impression of who they are. They have an established sense of self-worth based on the knowledge that they are children of God with a divine destiny and an ultimate goal of eternal life. Their health and well-being is holistically shaped by their spirituality which also provides them with a sense of balance in life.

Though they generally may not place a great emphasis on physical activity, particularly when it comes to leisure time physical activity, they do hold reverence for the physical body as "the temple of the Holy Spirit". Instead, participants emphasized *spiritual* exercise, which is much more relevant for them, and which they understand to be fundamental to their health and well-being. Their spiritual exercise involves various activities such as daily morning devotions characterized by praise, worship, prayer and reading of the Bible; participating in mid-week church meetings such as prayer meetings, followed by both corporate and individual prayer and Bible studies; and of course Sunday church services, which frequently involves both morning and evening attendance.

These are just a few of the spiritual exercises which these women of faith practice on a daily and weekly basis. Special events, such as Holy Spirit Crusades, guest speakers and pastors, retreats and spiritual encounters, call for additional spiritual exercise, keeping these women exceptionally active and spiritually fit. Through their Christian faith, along with the accompanying spiritual activities, these women portray a sense of fulfillment and life satisfaction which makes them feel healthy.

Spiritual Teachings and Literal Interpretations

Their spiritual faith calls them to conceive of health in ways which not only include the physical body but even more so extend beyond it. They speak of health in terms of reaching out to the greater global community and loving their neighbours as they love themselves, while also nurturing intimate relationships. They speak of health in terms of coming into greater financial freedom so that not only may life become easier for them with that ability to make more choices, but that they may also be able to give more generously than they already do. They also speak of health as having a sense of peace even in the face of a storm. These characteristics of health participants speak of are all contextualized within biblical principles. For instance, the peace of mind which participants described as one of the many attributes to their overall health can be attributed to their belief that God is in control of all their circumstances and will not allow them to go through more than they can bear. They acknowledged that being a Christian does not exempt them from trials and tribulations, but it is also known among these women that if trials should come, they will never be abandoned or forsaken for they have a sure foundation in which they stand upon. As stated by April in direct reference to the Bible "we are more than conquerors through Him that loved us".

Having the sincere belief and confidence that they are truly more than conquerors in all things as stated by April elicits a great sense of empowerment for these women because they know in their hearts that they cannot be defeated, that their God is on their side to fight their battles and see them through. The literal interpretation that these women hold of the Bible is one of the fundamental factors explaining both how and why these Christian women use their faith to inform their health beliefs and practices. For

them, the Bible is not just a mere book from which to get the occasional inspiring quote. Rather to them it is deemed holy and divine and is revered as the true inspirational word of God in which they base their life. As a result, these women of faith hold on to each scriptural passage as the ultimate truth, using the Bible as a direct road map as to how to go about living their lives. They stand on the word of God which they see as being filled with instructive words of wisdom, warnings and promises and claim these messages as their own.

The instructions these women take from the Bible is applicable to their understandings of health and well-being as can be seen by each major concept of health which they brought forth. For instance, the value they place on helping others, which they expressed as contributing to their overall sense of health, is imbued with biblical references that teach that it is better to give than it is to receive. The women are able to grasp this concept and attain great joy and satisfaction for their obedience to this biblical principle. Consequently, they keep their eyes open looking for opportunities to help others in need and feel a sense of sadness when they are unable to do so due to limited resources.

By perceiving the Bible in literal terms, these women also submit themselves obediently and gladly to its doctrines and teachings. Through their conscious obedience of obeying the words of God, they experience a sense of contentment, self-fulfillment and life satisfaction which again, gives them reason to perceive their health and well-being in positive terms. They do not see themselves as fairing poorly in dominant health standards, nor do they perceive themselves to be second class citizens or even low social

class, though they acknowledge their low incomes, because their confidence in who they are as children of God is not moved as they proudly profess their faith.

This literal interpretation of the Bible provides participants with a great reason for hope in this life and even more so in the afterlife. They have found purpose and direction based on what they see as the eternal will of God, everlasting and never changing. The Bible tells them that their body is the temple of the Holy Ghost, so they respect their bodies and show it care by staying away from harmful chemicals and drugs. They try to improve their nutrition and accept the concept of physical activity as being a part of important health practice though they may seldom engage in leisure activity. However, many of the women expressed feeling content with the level of incidental physical activity they attained throughout the day through household chores and daily work activities. The Bible also tells them that they should love their neighbours as themselves, so they therefore not only embrace a helping spirit, but a desire to develop and nurture relationships with friends and family. Even their workplace experiences can be understood in biblical terms, as Hannah has stated, "in the Word of God He talks about the sluggard, being lazy, if you don't work, you don't eat. By submitting themselves to these "sacred scriptures" and perceiving them to be a roadmap of life, these women can be seen as having a distinct perspective of what it means to be healthy.

Physical Exercise

Given the great degree of personal fulfillment and life satisfaction these women attain through their Christian faith, I question how open they would be to accepting conventional health practices which places a greater emphasis on physical exercise and

biomedical outcomes of health. As previously stated, the participants are aware of the social value placed on physical exercise, and apologetically acknowledge it as something that they should do for their health. However, only three out of the thirteen women interviewed actively participate in leisure time physical activity, while the others either feel content with the incidental levels of activity they achieve through the day, or passively express exercise as something that they *should* improve on.

The impression given by those who do not actively engage in this form of exercise is a negotiation between societal imperatives and their own true personal self-interests. This is indicated by their acknowledgement of the importance it has for health, which they often express as something that they are suppose to or are expected to say; "unfortunately I never did put in time for exercise, which is also important…" (Celina). Though they perceive exercise to be relevant to their health, their mention of it was exceptionally brief relative to the other concepts of health discussed, with the exception of Victoria and Grace who placed a greater emphasis on its role in their health.

However, whether the women interviewed wish to adhere to it or not, the reality is that physical activity can indeed have some real implications on one's overall health outcomes. The impact it can have in preventing different diseases which could ultimately effect one's quality of life have been found to be significant. Such diseases include diabetes, which has the potential to lead to blindness and numerous other complications as both Mary and Rachel know all too well, heart disease, which is again all too familiar with Mary and Rachel; osteoporosis and other physical ailments which can impact one's mobility, independence and ultimately quality of life (Warburton, Nicol & Bredin, 2006).

The significance of these physiological health outcomes which are in part associated with levels of physical activity are found to be even more pronounced among Black women who experience higher rates of cardiovascular disease (Young, Miller, Wilder, Yanek & Becker, 1998). However, these findings on morbidity and "race" are not as clear as they may appear, as it has also been consistently found that those who are religiously active, that is, who engage in regular spiritual exercise among which Black women are more likely relative to national standards, experience lower rates of both morbidity and mortality. In fact, African Americans who attend worship services more than once a week have been found to have an extended life expectancy of up to 13.7 years compared to those who never attend (Hummer, Robert, Rogers, Nam & Ellison, 1999). Given these complex findings, it would be interesting to know whether or not a greater emphasis placed on physical activity, coupled with participants' spiritual activities, would further enhance or reduce feelings of health and well-being.

To effectively respond to such a question, it is important to understand the value that this group of women, and perhaps women like them place on deliberate forms of physical activity. These women's attitudes towards focused exercise is in part a reflection of their cultural upbringing and values; all but one of the women interviewed in this study immigrated to Canada from the Caribbean, with the exception being one woman who immigrated from Nigeria. These women all came to Canada in their adult years, with again another exception of one woman who came to Canada as child. The biomedical emphasis on leisure time physical activity is far less prevalent and is of far less value in these regions of the world. To see someone jogging along the roadside in a Canadian

context may be perceived as an admirable activity, however, the same act in a Caribbean country would likely be viewed as obscure and even impractical behaviour.

There are practical impediments to physical activity in many parts of the Caribbean and Africa, such as inadequate infrastructure and quality roads to use for jogs or leisurely walks. Gyms are not readily available in local neighbourhoods and even if they were, to spend money on going to one would likely not be a priority for many local residents. There is also the factor of the elements, to engage in such deliberate forms physical activity in the tropical heat would also not be wise. Furthermore, people living in non-industrialized parts of the world such as the Caribbean and Africa are often highly active on a daily basis to begin with due to the amount of manual labour they must do just to maintain. Above all, the obsession with controlling, refining and altering the physical body which is prevalent among Anglo-American and European nations is not a universal value, but rather can be partly understood in light of a unique set of circumstances relating to affluence, overabundance, consumeristic strategies and materialistic identities that calls for a need to self-compensate for such indulgences through acts of bodily discipline and self-control.

In other words, my impressions are that active engagement in physical activity is not culturally encouraged among this group of women and thereby holds little significance in their lives. Further, the greater tendency they have to fellowship with other Black women compared to the amount of time spent in fellowship with White women provides additional reinforcement of cultural values and propensities. Though three women stated engaging in leisure time physical activity, only two of them actually placed emphasis on this aspect of their health. I do not perceive these two women as

“outliers”, but rather their lifestyle behaviour can also be understood in this notion of sociocultural values and influences. Both Grace and Victoria are unique from the rest of the participants in that they are the only two women who work in an office setting, both likely characterized by a greater exposure to Eurocentric values and culture, which I observed at the dental office where Grace works at and where her interview took place. In addition, unlike the other women of this study who work in either healthcare, care giving, or factory settings which involves a lot of physical activity, Grace and Victoria’s jobs consists of little physical movement and involve a lot of sitting. This perspective runs in contrast to the approach of barriers and hindrances to physical activity that is often used to understand what has been termed by researchers as physical activity “under-participation”.

Such barriers frequently cited by researchers include time, cost, motivation, care-giving and other familial responsibilities. However, I contend that the true hindrance keeping Black women, particularly the participants of this study, from a greater involvement in leisure time physical activity is that it simply is not a priority in their lives, and this is in part again due to the lack of cultural value placed on it. Contrarily, strong spiritual faith and active participation in the church is not only a cultural norm in the Caribbean and in Africa, but it is also a significant part of the very culture itself that is highly valued from a tender age. For this reason (though by no means the sole reason), spiritual beliefs and practices, are held as top priority for the women in this study. Because of the great value they place on their faith, they are willing to invest the time, money and put familial duties as second place next to their relationship with God. As stated earlier in this paper by Bernice “prayer life and spending time with the Lord is the

most important…with my prayer life and everything that has to be the top priority, my husband and family come second". For these women, motivation to be spiritually active is by no means any problem.

As already demonstrated, the time these women invest in going to church for various church programs and activities is extensive. On top of this, the women interviewed also described being very active in different volunteer activities both inside and outside the church. With respects to their finances, despite these women's low-incomes, they also make significant investment into their faith by faithfully paying their tithes[1], and generously donating to fundraisers and various charitable organizations. Therefore, as can be seen, the issue of participation, whether it is in regard to physical activity or spiritual activity, is not so much a matter of barriers as it is of priorities, values and interests.

These women of faith are dedicated to what they see as promoting health, and well-being for them, that is, their Christian faith. Based on the extensive literature on religion, spirituality and health, the health outcomes of such strong faith and the associated spiritual activities are not only real but are also significant (Hummer et al., 1999; Zullig, Ward & Horn, 2006; WHOQOL SRPB Group, 2006; Lee & Newberg, 2005; Marks, Nesteruk, Swanson, Garrison & Davis 2005; Larson & Larson, 2003; Kimble, 2001; Maselko & Kubzansky, 2005; Ellison, 1991; Mattis, 2000; Thoresen & Harris, 2002; Miller & Thoresen, 2003). Although physical activity also does have real and significant health benefits, particularly pertaining to the physiological and biological

[1] Tithes are a Biblical principle which involves giving a tenth of one's income as a means to help support the church.

aspects of health, lifestyle behaviours are in part socially and culturally influenced. To simply impose *shoulds* on either side without meaningful substantiation for intended populations would likely result in ineffective health promoting tactics.

Misleading Myths and Misconceptions

The passionate Christian faith found among these women specifically, and among low-income Black women in general may be prone to tendencies to rationalize and theorize it, by trying to reduce it to such notions as escapism, psychological coping tactics, compensatory behaviour, folk traditions and customs as well as gullibility due to low levels of formal education. However, I caution against such intellectual tendencies of over-theorization, as the participants' spirituality can only be truly understood in light of their lived experiences.

Such supernatural phenomena understandably is difficult to conceive, even for the women themselves who practice and live by and for this faith, however, it is in part this unknown factor which characterizes their faith as is explained in the Bible which they hold so dear, "now faith is the substance of things hoped for, the evidence of things not seen" (Hebrews 11:1), or in secular terms by the Merriam-Webster's Online Dictionary, faith is a "firm belief in something for which there is no proof". Yet to minimize or disparage such population's belief system due to lack of understanding, absence of tangible evidence, or an insignificance found in dominant cultural ideologies is problematic on a number of grounds. For one, such an approach replicates the historical tendency of silencing minority groups' lived realities and experiences, while imposing devaluing explanations based on Eurocentric understandings. Hence, the reason for the

objectives of this research project to gain an understanding of the meanings, experiences and perspective of health among Black women with low-incomes. Another reason for the problematic nature of this approach is that it hinders the development and dynamism of new research that could potentially provide new insights and windows into diverse phenomena.

Yet despite this potential for dynamic growth in the realm of research and the expressions of diverse voices and stories representative of the land which we proudly claim to be multicultural, there still remains a great tendency to limit such nuanced expressions within a one-sided dominant frame of reference. Subsequently, spiritual beliefs and practices, which have been found to be an essential aspect in the lives of so many "poor" Black women around the globe, framing the way they see the world and understand their personal experiences, has been diminished to such concepts as a buffer against social discrimination in order to fit into the understanding of a Eurocentric framework. However, though the world around these women may see them through racialized, classed and gendered lens and perceive them to be second class citizens, it is my strong impression based on the time I have spent with these particular women, and the countless times I have spent with women like them, that they do not see themselves in such belittling terms as an inferior class of people, rather they exude great confidence in who they are in the sight of their God.

Confessions and Reflections of a Qualitative Interviewer

The first confession I will present is my own spiritual faith as a Christian, next follows my reflections of both the bias and insiders' privilege this entails. However, despite my personal faith system as mentioned in the introduction of this thesis, it was by no means my intent nor my expectation to explore conceptions of health within such a strong spiritual framework; on the other hand, it was my great delight when the project, through no push of my own, took on a new route in this direction.

I reflect on the issue of bias not so much in regards to the analysis, because as I will soon discuss below I perceive the analysis to be enhanced by my privileged understanding of participants' perspectives. Rather the bias I speak of became an acknowledged concern for me during the interviewing process. As the women spoke about their faith freely without any probing or spiritually related questioning, which can be seen in the interview guide found in appendix 'D', I had to really ensure that I maintained my role as the listener and learner and not a fellow sister of the faith. Perhaps this caution led me to go too far in the other direction of objectivity as I was frequently hesitant to probe further into responses and make comments though the desire to do so was there. While I usually left the interviews feeling uplifted and content, with the exception of the two initial pilot interviews I conducted which I felt dissatisfied with, my only discontent with the other interviews was that I wish I was able to speak more freely and openly with participants about our shared passion and not be bound by the structure and impartiality that even the semi-structured interview holds. Nevertheless, for the sake of sound research, I held my peace during the interviewing process, took the risk of

saying too little rather than too much, and allowed the women to share their thoughts and experiences uninfluenced and uninterrupted.

It was not until the review of the verbatim transcripts and the analysis of the interviews that I truly realized the extent participants' conceptions and experiences of health were shaped by their spirituality. However, it was through my own spiritual faith that enabled me to fully grasp this Christian outlook participants hold and understand the lens in which they use to view the world. As they often referred to scriptural passages throughout their discussions, I was able to recognize familiar quotes and references and realize that it was the Bible they were using as a frame of reference. Further, just as a woman may have additional insight and understanding in interviewing another woman relative to the degree of understanding a man might attain, the same could also be said in interviewing one of like faith, particularly when they are highly devoted. This may not only be the case with respect to the practicality of it, that is the expression of certain concepts, terms and ideologies that are unique to a particular faith system, but even more so the experiential side of the faith which simply does not compare to the observation of the faith.

Additionally, being an insider also provides the advantage of comparing how findings resonate with other knowledge and experience that may not be published in the academic literature. Though I have made no prior attempts to connect perceptions of health with spiritual beliefs, the stories and insights presented by these women of faith is familiar to me through my encounters with other church-going women of similar demographical characteristics. By this I mean the Christian worldview that permeates nearly every aspect of these women's lives is not completely unique to this specific group

of thirteen women, but rather is a common phenomenon among other regular church-going women of the faith. The time has now come to make room for their stories to also be told and heard.

Implications for Health Promotion and Health Care

Spirituality and religious affiliation has been found to be highly valued by Canadians as 44% of Canadians place a great degree of importance on religion in their life (Clark & Schellenberg, 2006). With the exception of East Asia, this emphasis on religion is even stronger among Canada's growing immigrant population, over half of whom are from non-White regions of the world (Clark & Schellenberg, 2006). For some of these people, who have strong religious and spiritual ties, it is plausible that like the women in this study, their spirituality and religious standpoint does not only shape their general worldview, but permeates into the way they perceive and experience health and well-being.

Having a diversified understanding of what health means among a heterogeneous Canadian population would not only be an asset to the professions of health care and health promotion, but additionally, such insight could also provide greater health benefits and services to those whom such professionals aim to help. Collaborative work between spiritual leaders and mainstream health professionals could facilitate progressive health policies that would be more inclusive, attractive and representative of the growing diversity found in Canada. Such initiatives might include a greater immersion and amalgamation of pastoral care and chaplaincy with dominant health care, as well as faith-based referral systems for health counseling from a spiritual framework, guidance, and

corporate prayer offered to those who express interest. These agendas could potentially provide a more holistic well-rounded approach to health with added effectiveness.

Limitations

Because of the qualitative nature of this study, findings are not intended to be generalizable nor representative. Rather a deliberate approach was taken to investigate a small purposive sample as a starting base to build upon in the exploration of diverse perspectives of health.

Directions for Future Research

As a preliminary explorative research project, there still remain many questions to be asked and much to be explored. For example, the women interviewed in this study are members of a charismatic Christian sect, therefore, some of their spiritual experiences such as worship services and other church meetings differ significantly than those of other Christian sects such as Roman Catholics, Anglicans etc. Based on the many divisions of Christianity, not to mention the other world religions, people have different spiritual experiences that may also uniquely shape their worldviews and ultimately the way they understand and experience health. A further look into the connections between health and diverse spiritualities will not only provide a more inclusive and thorough account on the diverse conceptions of health, but also on the connections found between spirituality and improved rates morbidity and mortality.

In line with this and as mentioned above in the discussion on implications, collaborative partnerships made between spiritual leaders and mainstream health

professionals will need to be evaluated for their effectiveness and impact they have on its users. Different techniques would need to be devised, tested and evaluated for this process. Participatory Action Research might show to be a fruitful methodology for going about this.

Another area of research pertaining to this study that is worth further investigation into is not so much directly related to the issue of spirituality, rather it relates to the terminology of concepts of health and well-being. As found in the initial pilot interviews performed in this study, using the term ‘health’ to ask participants about their perspectives and experiences of it, compared to using the terms ‘health and well-being’ either in conjunction or interchangeably yielded quite different responses. I found that the term ‘health’ alone was affiliated more with biomedical conceptions, while well-being and health used together yielded greater dynamism. A further exploration into the usage of such terminology, particularly in research involving lay perspectives of health might yield significantly different outcomes depending on choice of language usage.

Furthermore, attempts to gain a greater understanding of health and well-being among diverse populations can be further facilitated with the development of inclusive quantitative measurement tools. Findings from this study and other explorative research which investigates the various perspectives and experiences of health in diverse societies can be used in the development of such tools which are intended to reach large populations and subsequently also hold the potential for making generalizations.

Above all, this research touches on two very distinct areas of study, health and spirituality/religion. As humans we do not live in vacuums but rather are highly dynamic and interdisciplinary by nature. It is time to have a greater representation of this quality

reflect in our research. Through this we hold the promise of new heights, dimensions and colour in our investigative findings.

CONCLUSION

Health as multidimensional is not a new concept nor is it unique to this particular group of women. Since 1946 the World Health Organization has publicly recognized health as multifaceted (World Health Organization, 2007). However, despite this awareness of the dynamic nature of health, this concept continues to be marginalized by the hegemonic biomedical model (Hewa & Hetherington, 1995) leaving the voices that represent this view often silenced or placed on the margins.

It is my hope that I have been able to present to readers the stories of this group of women in a way which is representative of their own voices. This is important since such voices have traditionally been silenced within the Canadian context, yet at the same time present a valuable message on plurality and inclusivity, not only in the domain of health research, but in Canadian society at large. These women bring to light a distinct and multifaceted conception of what it means to be healthy, a reflection of the diversity that is represented in the many faces of Canada.

In light of this growing diversity, there is a need to move beyond dominant impositions of what health should mean and how it should be experienced. There is a need to embrace a more pluralistic approach where an amalgamation of different voices are able to listen and value one another; only then will diverse realities be represented in public conceptions of what it means to be healthy.

REFERENCES

Agyemang, C., Bhopal, R., Bruijnzeels, M., (2005). Negro, Black, Black African, African Caribbean, African American or what? Labelling African origin populations in the health arena in the 21st century. *Journal of Epidemiology and Community Health, 59*, 1014-1018.

Banks-Wallace, J. (2000). Staggering under the weight of responsibility: The impact of culture on physical activity among African American women. *The Journal of Multicultural Nursing and Health*, *6* (3), 24-30.

Banks-Wallace, J. (2000). Womanist ways of knowing: Theoretical considerations for research with African American women. *Advances in Nursing Science, 22* (3), 33-45.

Banks-Wallace, J., & Conn,V. 2002. Interventions to promote physical activity among African American women. *Public Health Nursing, 19* (5), 321-335.

Barksdale, C., Willis, S., Davidson, K., van Roosmalen, E., Loppie, C., Kirkland, S. Unruh, A., Stewart, M., & Williams, D. (2001, June). Women's definitions and priorities of health. *Moving Towards Women's Health*, No. 20. Maritime Centre of Excellence for Women's Health.

Bhopal, R., (1997). Is research into ethnicity and health racist, unsound, or important science? *British Medical Journal*, *314*, 1751.

Bhopal, R., & Donaldson, L. (1998). White, European, Western, Caucasian, or what? Inappropriate labeling in research on race, ethnicity, and health. *American Journal of Public Health*, *88,* (9).

Brady, B., Nies, M.A., (1999). Health-promoting lifestyles and exercise: A comparison of older African American women above and below poverty level. *Journal of Holistic Nursing*, *17*, (2), 197-207.

Clark, D.O., (1995). Racial and educational differences in physical activity among older adults. *The Gerontologist*, *35*, (4), 472.

Clark, W. & Schellenberg, G. (2006). Canadian Social Trend No. 81. *Statistics Canada.* Retrieved November 14, 2006, from www.statcan.ca/english/freepub/11-008-XIE/11-008-XIE2006001.pdf

Ellison, C.G. (1991). Religious involvement and subjective well-being. *Journal of Health and Social Behaviour,* 32, 80-99.

Enang, J., Edmonds, S., Amaratunga, C., & Atwell, Y. (2001). Black women's health: A Synthesis of health research relevant to Black Nova Scotians. *Maritime Centre of Excellene for Women's Health.*

Entwistle, V.A., Renfrew, M.J., Yearley, S., Forrester, J., Lamont, T. (1998). Lay perspectives: Advantages for health research. *British Medical Journal,* 316, 463-466.

Eyler, A.A., Baker, E., Cromer, L., King, A.C., Brownson, R.C., & Donatelle, R.J. (1998). Physical activity and minority women: A qualitative study. *Health Education and Behavior, 25* (5), 640-652.

Fine, M., Weis, L., Wessen, S., & Wong, L. (2000). For whom? Qualitative research, representations, and social responsibilities. In N.K. Denzin, & Y.S. Lincoln (Eds.), Handbook of qualitative research (pp. 107-131). Thousand Oaks, CA: Sage Publications.

Floyd, M.F., Shinew, K.J,, McGuire, F. A., & Noe, F.P. (1994). Race, class and leisure activity preferences: Marginality and ethnicity revisited. *Journal of Leisure Research. 26* (2).

Floyd, M. F., (1998). Getting beyond marginality and ethnicity: The challenge for race and ethnic studies in leisure research. *Journal of Leisure Research. 30* (1), 3-22.

Health Canada. (2001). Healthy policy working paper series: Immigration and health. Hyman, I.

Heesch, K.C., Brown, D.R., Blanton, C. J., (2000). Perceived barriers to exercise and stage of exercise adoption in older women of different racial/ethnic groups. *Women and Health*, *30*, (4), 61-76.

Henderson, K.A., (1998). Researching diverse populations. *Journal of Leisure Reseasrh 30* (1), 157-171.

Henderson, K. A., & Ainsworth, B.E. (2000). Sociocultural perspectives on physical activity in the lives of older African American and American Indian women: A cross cultural activity participation study. *Women and Health. 31* (1), 1-20.

Hewa, S. & Hetherington, R.W. (1995). Specialists without spirit: Limitations of the mechanistic biomedical model. *Theoretical Medicine 16*, 129-139.

Hughner, R.S., Kleine, S.S. (2004). Views of health in the lay sector: A compilation and review of how individuals think about health. *Health,* 8, 395-422.

Hummer, Robert, A., Rogers, R.G., Nam, C.B., Ellison, C.G., (1999). Religious involvement and U.S. adult mortality. *Demography, 36*, 273-285.

Kimble, M.A. (2001). The search for health and the role of the faith community. *Journal of Religious Gerontology*, 13 (2), 3-15.

Larson, D.B. & Larson, S.S. (2003). Spirituality's potential relevance to physical and emotional health: A brief review of quantitative data. *Journal of Psychology and Theology,* 31 (1), 37-51.

Lawton, J. (2003). Lay experiences of health and illness: Past research and future agendas. *Sociology of Health and Illness,* 25, 23-40.

Lee, B.Y. and Newberg, A.B. (2005). Religion and health: A review and critical analysis. *Zygon,* 40 (2), 443-468.

Lee, S. M., (2005). Physical activity among minority populations: What health promotion practitioners should know – A commentary. *Health Promotion Practice*. *6* (4), 447-452.

Lillie-Blanton, M., Parsons, P. E., Gayle, H., & Dievler, A. (1996). Racial differences in health: Not just black and white but shades of gray. *Annual Review Public Health. 17*, 411-448.

Marks, L., Nesteruk, O., Swanson, M., Garrison, B., & Davis, T. (2005). Religion and health among African Americans: A qualitative examination. *Research on Aging,* 27 (4), 447-474.

Maselko, J. & Kubzansky, L.D. (2005). Gender differences in religious practices, spiritual experiences and health: Results from the US General Social Survey. *Social Science and Medicine,* 62, pp 2848-2860.

Mattis, J.S. (2000). African American women's definitions of spirituality and religiosity. *Journal of Black Psychology,* 26 (1), 101-122.

McKague, M., Verhoef, M. (2003). Understandings of health and its determinants among clients and providers at an urban community health centre. *Qualitative Health Research,*13 (5), 703-717.

Miller, W.R. & Thoresen, C.F. (2003). Spirituality, religion and health: An emerging research field. *American Psychologist,* 58(1), 24-35.

Nazroo, J.Y. (1998). Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health. *Sociology of Health and Illness, 20* (5), 710-730.

Warburton, D.E.R., Nicol, C.W. & Bredin, S.S.D. (2006). Health benefits of physical activity. *Canadian Medical Association Journal, 174* (6), 801-809.

Ritchie, J. & Lewis, J. (ed.) (2003). *Qualitative Research Practice: A Guide for Social Science Students.* London: Sage Publications.

Spencer, L. Ritchie, J., & Dillon,L. (2003). Quality in qualitative research: A framework for assessing research evidence. Retrieved January 27, 2007, from http://www.policyhub.gov.uk/docs/qqe_rep.pdf

Statistics Canada. (2006). Women in Canada Fifth Edition – A Gender Based Analysis.

Taylor, J.Y. (1998). Womanism: A methodological framework for African American women. *Advances in Nursing Science, 21,* (1), 53-64.

Thoresen, C.E. & Harris, H.S. (2002). Spirituality and health: What's the evidence and what's needed? *Annals of Behavioral Medicine*, 24(1), 3-13.

Walcott-McQuigg, J.A., Sullivan, J., Dan, A., Logan, B., (1995). Psychosocial factors influencing weight control behaviour of African American women. *Western Journal of Nursing Research*. *17* (5), 302-520.

World Health Organization frequently asked question. Retrieved November 3, 2007, from http://www.who.int/suggestions/faq/en

WHOQOL SRPB Group. (2006). A cross-cultural study of spirituality, religion and personal beliefs as components of quality of life. Social Science and Medicine, 62, 1486-1497.

Williams, D.R. (1997). Race and health: Basic questions, emerging directions. *Annals of Epidemiology*, *7*, 322-333.

Young, D.R., Miller, K.W., Wilder, L. Yanek, L.R., & Becker, D.M. (1998). Physical activity patterns of urban African Americans. *Journal of Community Health, 23* (2), 99-112.

Zullig, K. J., Ward, R.M., Horn, T. (2006). The association between perceived spirituality, religiosity, and life satisfaction: The mediating role of self-rated health. *Social Indicators Research*, 79, 255-274.

APPENDIX A – LETTER OF INFORMATION

(on Queen's letterhead)

Project Title:
Listen Up! Marginalized Voices on the Experiences, Perceptions and Meanings of Health

Investigator:
Nike Ashabo, School of Kinesiology and Health Studies, Queen's University, Kingston, ON

The purpose of this study is to explore the meanings, experiences and perceptions of health among Black women who are living on low-incomes in the Greater Toronto Area. In order to understand these perspectives, I would interview you to find out what you think about your health, being healthy, and what makes you feel healthy. During the interview you have the right to not to answer any question that makes you feel uncomfortable or you do not want to answer, for any reason. The interview will last approximately ninety minutes, it will be audio taped with your consent and transcribed.

Your privacy and confidentiality is highly valued and will be respected. Your name will not appear on any document and neither will the name of the Community Health Centre you attend. All tapes, notes and data with identifying information will be kept in a locked and secure location that only the researcher conducting this interview will have access to; this data will be destroyed five years after the completion of this study. Some of the data may be shared with my supervisor or other researchers on this project; in this case you will still remain anonymous. Any publications, presentations or reports that may result from this study will use a code name to protect your identity; the name of the Community Health Centre you attended will not be revealed.

There are no known risks to participation in this study. Participation is voluntary and you may feel free to withdraw from the study at anytime, whether during the interview or after. You may request a copy of the final report from the researcher conducting the study.

If you have any questions, concerns or complaints regarding this research please do not hesitate to contact me, Nike Ashabo, at (647) 801-3703 or my supervisor Dr. Elaine Power at (613) 533-6000 ext. 74690. If you wish to speak to an authority that is not directly related to this research project about the ethical procedures you may contact the Acting Chair of the Queen's University General Research Ethics Board, Dr. Steve Leighton, (613) 533 2182, email steve.leighton@queensu.ca.

Sincerely,

Nike Ashabo

APPENDIX B – CONSENT FORM

Project Title:
Listen Up! Marginalized Voices on the Experiences, Perceptions and Meanings of Health

Investigator:
Nike Ashabo, School of Kinesiology and Health Studies, Queen's University, Kingston, ON

I have read and retained a copy of the letter of information concerning the study *Listen Up! Marginalized Voices on the Experiences, Perceptions and Meanings of Health*, and all questions have been sufficiently answered. I am aware that the purpose of this study is to gain an understanding of perceptions, experiences and meanings of health. I understand the procedures of this study.

I am aware of the measures that will be taken to ensure confidentiality and understand that participation in this study is voluntary and that I may withdraw at anytime. I am also aware that I may request to have part or all of my data removed from the study without any consequence to myself.

I am aware that if I have any questions, concerns or comments pertaining to this study I can contact Nike Ashabo at (647) 801-3703 or her supervisor Dr. Elaine Power at (613) 533-6000 ext. 74690. I understand that for questions, concerns or complaints concerning the ethical procedures of this study I may contact the Acting Chair of the Queen's University General Research Ethics Board, Dr. Steve Leighton, (613) 533 2182, email steve.leighton@queensu.ca.

Signature: ____

Printed Name: _____________________________________

Date: ________________________________

I also hereby consent to having my interview audio recorded by the researcher.

Signature: ____

APPENDIX C – PILOT INTERVIEW GUIDE

- Can you tell me about yourself (demographical information)?
- What is a typical day like for you in your life?
- Can you describe a typical day in your life?
- What does it mean to you to have good health?
- What does it mean to you to have poor health?
- How would you personally define wellbeing? (This may be the same as health)
- Are there any other domains of health and wellbeing that are fundamental to you?
- What factors in your life do you find have a positive impact on your health (and/or wellbeing)?
- What factors in your life do you find have a negative impact your health (and/or wellbeing)?
- How do you cope with the factors that have a negative impact on your health?
- What are factors in your everyday life that you feel keep you healthy?

APPENDIX D – MAIN INTERVIEW GUIDE

-Can you tell me about your background? (family, married, work…)

-What is a typical day in your life like for you?

- How important is it for you to have a balanced lifestyle? - What will it mean for you to have a balanced lifestyle?

- Can you tell me some of your daily activities that you feel promote health and well-being?

- What are some of the other ways you care for yourself or things you do for self-care and to promote well-being and health?

- What then would you say are some of the indications or signs of good health and well-being for you?

- What are some of the areas in your life that you would like to improve on in order to have a healthy lifestyle? - How would your life change as a result if this area was to be improved?

- Can you give any other examples of some of the things that can get in the way of promoting good health and well-being?

- How do you cope with these hindrances to your health and well-being?

-Can you sum up for me some of the characteristics that you associate with poor health for yourself?

- Can you identify some key characteristics that you associate with being at your healthiest?

- How important is it for you to have these characteristics consistently in your life and to feel at your healthiest?

-When do you feel at your healthiest?

- What are things you do well for your well-being?

- What are things you do poorly for your health? What do you need to improve on if you so desire?

- Is there anything that you would like to learn to do well to enhance your health and well-being?

- What are some of the dreams or wishes you have that you believe will enhance your health and well-being?

-What are some barriers, constraints, obstacles you see possibly in the way of your potential for enjoying your ideal health and well-being?

- What deep values in living do you believe are important to your health and overall well-being?

- Is there anything else you would like to add about what health means to you or how you experience well-being?

APPENDIX E - REFLECTION QUESTIONS

(Questions adapted from Fine, Weis, Wessen, & Wong, 2000)

-Have I connected the "voices" and "stories" of individuals back to the set of historic, structural and economic relations in which they are situated?

-Have I described the mundane?

-Have I worked to understand my contribution to the narrations provided and those silenced?

-Have I worked to explain to the reader the position from which informants speak?

-Have I considered how these data could be used for progressive or repressive social policies?

-How might data be heard and misread? Do I need to add a warning in the introduction about potential misuse?

-Who am I afraid will see these analyses? Why?

-To what extent has my analysis offered an alternative to the dominant discourse? What challenges might very different audiences pose to the analyses presented?

Biographical Notes on Participants

April

April is a woman in her forties. She was born in Grenada and came to Canada ten years ago. She lives in Toronto Ontario. She has and adult daughter and another daughter who passed away. She is divorced but hopes to be reunited with her husband. At the time of the interview she was working as a personal support worker.

Bernice

Bernice is a woman in her forties. She was born in Grenada and came to Canada seventeen years ago. She lives in Toronto Ontario. She has four children, two whom are adults, one who is elementary age and one who is a toddler. She is also married. She values quality family time and aspires for her family to have more of this. At the time of the interview she was working at an automotive manufacturing company on an assembly line.

Celina

Celina is a woman in her thirties. She was born in the West Indies (did not specify which country). She came to Canada as a very young child. She lives in Toronto Ontario. She has no children and is single. She was working as an Early Childhood Educator before she was forced to stop work due to a back injury from a prior accident unrelated to her job.

Deedra

Deedra is a woman in her fifties. She was born in Jamaica and came to Canada thirty-one years ago. She lives in Toronto Ontario. She has one adult daughter. She is also single.

She enjoys baking. At the time of the interview she was working at an aircraft manufacturing company.

Grace

Grace is a woman in her forties. She was born in Jamaica and has been in Canada for over thirty years. She lives in Toronto Ontario. She has no children and is single. She is learning to play the saxophone as she has wanted to for many years. At the time of the interview she was working as a Dental Assistant.

Hannah

Hannah is a woman in her forties. She was born in St. Vincent de Grenadines, she has been in Canada for over ten years. She lives in Toronto Ontario. She has one son who is a teenager. She is single but is confident that she will soon get married. Her occupation was not stated.

Jackie

Jackie is a woman in her thirties. She was born in Jamaica and now lives in Toronto Ontario. She has one adult son and is also married. She works as a secretary and also with seniors at a nursing home. She enjoys listening to music and hanging out with her cats.

Mary

Mary is a woman in her sixties. She was born in Trinidad and then moved to the U.K. where she lived for twenty-four years. While living in the U.K. she was married and had a daughter. After her time in there she moved to Canada where she has now been for seventeen years. She faces a number of health issues but still tries to maintain her

independence as much as possible. However, due to her illnesses she is unable to work and is therefore on disability.

Rachel

Rachel is a woman in her forties. She was born in Guyana and then moved Trinidad and then to the United States for a short time before coming to Canada where she has now been for seventeen years. She has two adult children and is also married. She enjoys her solitude. She works at a nursing home.

Sandra

Sandra is a woman in her forties. She was born in Grenada and has been in Canada for twenty-one years. She has three adult children. She is single. She enjoys working with children. At the time of the interview she was working as a nanny.

Victoria

Victoria is a woman in her forties. She was born in Grenada and has been in Canada for over twenty years. She has one adult son who has a medical problem called spinal bifida. She is divorced. She enjoys engaging in leisure time physical activity. At the time of the interview she was working at a call centre.