"At-risk? Really? I think anyone can get it": Bio-pedagogy, sexual health discourses, and African newcomer youth in Winnipeg, Canada

by

Allison Odger

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfilment of the requirements of the degree of

MASTER OF ARTS

Department of Anthropology

University of Manitoba

Winnipeg

Abstract

In my thesis, I focus on the role that sexual health messages play in the lives of African newcomer teen girls and young women living in Winnipeg. The research question I ask is: How have sexual health discourses shaped my interlocutors' experiences and perceptions of sex and sexuality upon settling in Canada? My work seeks to address the complexities of sexual health discourses through a feminist-poststructuralist framework that reveals the taken-for-granted and emphasizes how looking at the heterogeneity of these young women's experiences of sex and sexuality can challenge universalizing public health discourses. Specifically, I utilize the concepts of risk, bio-pedagogy, and biological citizenship to better understand how health has become bound up with idea of being a "bio-citizen." I conducted 13 ethnographic interviews with ten participants and utilized participant observation in the field. My research will allow us to question not only the importance placed on being "sexually healthy," but also how these narrowly defined discourses effectively obfuscate other ways of thinking about sexual health.

Acknowledgements

I would like to thank my advisor Dr. Susan Frohlick, for all of her words of encouragement and the time she has spent helping me to cultivate my ethnographic voice. She was always there for me to articulate any ideas or concerns I had throughout this process, providing insightful commentary which contributed to my growth as an anthropologist, a graduate student, and a person.

I would also like to thank my wonderful committee members Dr. Francisco Ibáñez-Carrasco and Dr. Deborah McPhail for their continued support.

To Francisco, thank you for your ever thought-provoking questions.

To Deborah, thank you for sharing my love of theory and continually pushing me to think critically.

I want to thank Dr. Laura Bisaillon and Dr. Rob Lorway for sharing their insights into community-based research with African communities.

To Estella Marmah, my fellow student-trainee and wonderful friend, I am so grateful for having been able to share this unique experience with you. You helped me move outside of my comfort zone and supported me in both times of elation and panic.

I am especially thankful for the hard work and dedication of Selam Ghebreyohannes and Huruy Michael. You both always brought strong perspectives to the table and helped me to understand the diversity of African communities living in Winnipeg.

I also want to thank Adey Mohamed. Even though she did not join our research team until I was writing my thesis, her insight, encouragement, and resourcefulness helped me in these final stages.

I want to acknowledge the insightful and invaluable perspectives the peer-researchers provided throughout this process. Thank you to Winta, Weyni, Yoko, Arsi, and Oiza.

I would like to thank all of the fantastic staff at IRCOM (Immigrant and Refugee Community Organization of Manitoba), including but not limited to Shereen, Surafel, Nadia, Marko, Vanessa, Amal, and Thomas, for supporting the project and providing honest feedback on my research.

I would also like to acknowledge that my thesis research was funded by a Canadian Institutes of Health Research HIV/AIDS Community-Based Research Program Operating Grant.

Table of Contents

Introduction: Recognizing Heterogeneity

Over the course of my fieldwork in the inner city of Winnipeg, Manitoba, I came into contact with a number of organizations that serve youth and, in particular, newcomer youth. I explain these partnerships in more detail in a moment but for now I want to tell an important story that unfolded while I was spending time in such places. There I met Nagan.[1]

Nagan is a 16-year-old African newcomer teen girl who attends high school. She comes from a Muslim background and, whenever I saw her, she wore a hijab, in a number of colours and ornate designs. Our informal discussions moved in a number of directions that I did not anticipate. During my volunteer placement at this particular organization, I came to look forward to seeing and speaking with Nagan; every conversation I had with her revealed a new aspect of her life, and I was excited to learn more.

Early on in our conversations, she expressed an interest in makeup. Nagan inevitably commented on my eyeshadow every time I saw her, asking questions about what brands I used and how I put it on. When I asked if she liked to wear makeup, she revealed that she kept all of her makeup at school in her locker. She would put on her makeup there but had to take it off when she got home. Her father did not like her wearing it, and he especially disliked when she wore red lipstick, her favourite.

As time passed, Nagan seemed to feel more comfortable sharing pieces of her life with me. On one occasion we were discussing movies playing in the theatres and I asked her who she was going with. She revealed that she had a double date with her boyfriend—an exciting and unexpected development, for a number of reasons. I was elated that she had shared with me what

was happening in her personal life. Hearing such personal information was a valuable learning experience for me because it caused me to reflect on my own assumptions about African young women and, in particular, Muslim women. Many questions raced through my mind but I did not want to bombard her with all of them too quickly. I found out that her boyfriend went to the same high school and he was two years older than her. When I asked if he was also from her country, she laughed and exclaimed *"No! He's Canadian."*[2]

She went on to explain that she was not interested in dating guys who shared her ethnic or national background. She met her boyfriend through a friend via Facebook and began dating him after they met in person at a birthday party, where they kissed for the first time. Every time Nagan spoke about him, her face would light up. When I asked her how they communicated with each other outside of school she told me that they text every day, expressing how much she enjoyed receiving messages from him because they made her smile.

As my time in the field was coming to an end, I continued to look forward to my discussions with Nagan. One day, I asked her if she had enjoyed her spring break. She explained that she had been going through a lot recently and had needed the week off to get away from it all. When I asked her if she was having any problems at school, she sighed and said *"sort of."* I initially did not pry into what was going on but later in the evening she said, "*Me and my baby broke up.*" The last time I had spoken with her, things had been going so well between them. I asked her what happened. She said that on the Friday before spring break, they were having lunch together in the cafeteria at school. He was being very quiet and then said, *"I have some bad news."* She had never heard him say the word "bad" before, so she knew what he was about to say would not be good. He had paused for a long time and then told her that they had to break up, but wouldn't give her a reason why. She was still hurting when I spoke with her but was glad

that she had some time away from school and him. However, since they broke up he had been trying to get in contact with her, posting multiple messages on her Facebook wall and staring at her in the hallways at school. Nagan assumed that he was acting this way because he regretted the break up and wanted to get back together. She had told her brother that her ex-boyfriend had been bothering her. Apparently her brother had then informed Nagan that he would "*take care of it.*" Soon afterwards, her ex-boyfriend would not even look at her. When I asked her if she wanted to stay single or be in another relationship, she expressed that she wanted to be single for as long as she could. For Nagan, it had been fun to be in a relationship and to receive loving text messages but the heartbreak was unbearable.

This narrative serves to introduce some of the central themes I will be exploring in my thesis. One theme is the heterogeneity of African newcomer young women and their diverse experiences. By teasing out the particularities of Nagan's life in this story, I am recognizing that not all young women who are both African and newcomers will have the same experiences upon settling in Canada, nor will they come with identical backgrounds. I wish to emphasize this point because public health literature and agencies have used broad labels in their assertion of "riskiness" via membership, and therefore have universalized these particular women into distinct categories. I chose her narrative also because it piqued my curiosity; I cannot help but wonder how her coming to Canada has shaped her experiences of dating, sexuality and sex.

These particular conversations with Nagan were also selected to spur a critical examination of my own positionality and the assumptions and notions I held upon entering the field. As a white Euro-Canadian woman who grew up without knowing any Muslim women personally, I was uninformed in many ways about their experiences: In my mind, a young African Muslim woman would not openly talk about dating a Canadian boy and would not be

intimate in public or defy her father's rules about makeup. I was also naively surprised that she involved her brother as a mediator in her romantic relationships because I thought she would have kept her relationships a secret from him.

I believe that my own ideas upon entering the field of what it means to be African or Muslim demonstrate the power of universalizing discourses, and the subsequent need for acknowledging and critically reflecting upon them. By exploring the particularities of my interlocutors' experiences in contrast to the broad categorizations that are discursively produced in the context of sexual health (for example, Public Health Agency of Canada documents and the literature on youth's sexual health) and through the young women's narratives, as I will show in the thesis, I hope to tease out some of the nuances and tensions between official discourses and their subsequent negotiation. Their differing experiences will help challenge dominant stereotypes of African newcomer teen girls and young women and thereby serve to trouble homogenizing discourses.

At the same time, I recognize that the ways in which I framed my research questions, in the context of sexual health messages, may have served to reproduce dominant discourses. However, throughout the interviews I conducted I was conscious of this. I tried to find ways of asking my interlocutors about sexual health and sexual health messaging that would not only allow for a critical discussion but also contextualize sexual health in a broader Canadian context. I emphasized that I was seeking their perspectives, so that with their insight we can produce a form of messaging that resonates with their lives, needs, and wants.

The following chapters will explore various issues and themes that developed through an analysis of the ethnographic interviews I conducted with a focus on 6 youth participants between

15 and 25 years of age, from Ethiopia, Eritrea, Kenya, Mauritius, and Rwanda, the sexual health messages I collected, and the insights I obtained through my experiences in the field. The main question that I am exploring is: How have sexual health discourses shaped my interlocutors' experiences and perceptions of sex[3] and sexuality upon settling in Canada?

The argument that I want to make, based on my research, is that sexual health discourses have shaped these youths' experiences in a number of ways, including how they think about their own sexual health and sexuality, which is intimately connected to how they listen to, accept and make sense of these messages in their everyday lives. My specific argument rests on my interpretation of my participants' words and stories, such that I believe that these young women have come to understand sex (as in sexual relations and practices) as a biological, but ultimately manageable, risk. This interpretation is ultimately my own, although it was derived at after multiple conversations with team members including peer-researchers and research coordinators, who are community members.

A parallel argument, which demonstrates the differences between official discourses and what occurs at the everyday level, questions the usefulness of "at-risk" categories; black youth immigrants and refugees from African countries where HIV is endemic are labelled as "at-risk" in Canadian public health literature, yet no community-based and targeted messaging campaigns exist, at least not in Winnipeg. None of the African newcomer young women I spoke with had encountered any messages that were tailored specifically to them. What this leads me to conclude is that the circulation and dissemination of sexual health messages in a "one-size-fits-all" approach reflects a "national health project," which thereby produces universalized "sexually healthy" bio-citizens. I approach the role of sexual health education in this production with a critical lens, as a universalizing and homogenizing discourse. Through this research process, I

have come to question whether sexual education in schools are effectively promoting a singular and narrow approach to thinking and talking about sexual health, focusing on the negative consequences of having sex, as will be represented in these young women's narratives in the following chapters. In the conclusion, I address the question, then, of how the bio-medical language and an appearance of "objectivity" in sexual health messaging in Canada obfuscate the moral undertones of public health.

After I have provided the background to my research and research question, I move on to my research findings. In Chapter 3, I focus on how these particular young women define sexual health and the subsequent importance they have placed on it, in their own experiences of sex and sexuality by utilizing the idea of sexual health subjectivity. In Chapter 4, I examine what I call the complex landscapes of sexual health discourses, and how my interlocutors have navigated them upon settlement in Canada. Finally, in Chapter 5, I reveal the importance of not only looking at the content of said messages but also examining how they are circulated. This be done specifically by looking at how the dissemination of said messages has resonated with my interlocutors; I analyze the ways in which their dissemination (how these messages are communicated via media, word-of-mouth, internet, and educational institutions) can be seen as contributing to the production of "sexually healthy bio-citizens."

These six youths' ability to provide engaged and thoughtful discussions is critical to my thesis. I would not have been able to formulate these themes and explore these issues without the meaningful conversations with them. The role and value of qualitative research, both ethnographic and community-based, is an asset to the task of challenging essentializing discourses. By showing how larger public health agencies and health promotion literature have labelled sub-populations as "at-risk" in the context of sexual health do not necessarily align with

the personal experiences of the African newcomer teen girls and young women I spoke with in Winnipeg, I reveal the disconnect between official discourses and everyday practice.

Chapter 1 – Why Bio-pedagogy and What Has Been Said about African Newcomer Youth in Canada and Sexual Health

My theoretical framework involves both critical medical anthropology (Singer and Baer 1995) and feminist post-structuralism (Mascia-Lees 2010). This means articulating the taken-for-granted and using the concept of discourse to explore the relationship between language, subjecthood, and power. Similarly it will also involve questioning how bodies become a central site for regulation and how the female body in particular is subject to, and produced via, normalizing discourses (Bordo 2003). Normalizing discourses are not repressive, but rather constitutive, "of the mechanisms that shape and proliferate – rather than repress – desire, generate and focus our energies, construct out conceptions of normalcy and deviance (Bordo 2003: 167), as they define and actively produce what is "normal", and therefore what is not.

The concept of "intersectionality" (Phoenix and Pattynama 2006; Gunnarsson 2015) (axes of identity including age, sex, gender, race, class, and sexuality) allows me to tease out the particularities of these young women's experiences and subsequently combat universalizing discourses. This framework informs my research question and how to answer it. Specifically it is useful in analyzing the power of Canadian health discourses to shape my interlocutors' experiences and perceptions of sex and sexuality. I will be using three major concepts in my thesis which will be explained in the following pages, including bio-pedagogy, biological citizenship, and risk. Before I move onto these theoretical concepts, I will first explore what has been said about the social construction of sex, gender, race and heterosexuality, as they pertain to my emphasis on the intersectionality and heterogeneity of these young women's experiences.

Social construction involves both social structure and cultural representation (Glen 1999: 11). According to Butler, both the materiality of the body and the performativity of gender can be found in the category of sex, constructed via discursive practices (1993: 1). In this context, performativity is not a conscious and deliberate action but rather is produced through these discursive practices (Butler 1993: 2). Subsequently, sex has become a "cultural norm which governs the materialization of bodies" (Butler 1993: 3). In this context sex does not refer to the physical act but rather a form of identification (for example, woman). We must also recognize that the social construction of such categories operate through a reiteration of these norms in which they become naturalized (Butler 1993: 10).

By uniting feminist theory and poststructuralism, a pointed question is asked: "if everything is discourse, what happens to the body?" (Butler 1993: 28). Butler emphasizes that bodies (and their subsequent materialization) are produced through regulatory norms, and similarly work to construct a form of heterosexual hegemony (1993: 16). These ideas are useful for thinking about the construction of the "sexually healthy" body and how it is constituted in a particular normative framework. In this context, the fixed (or fluid) nature of sexual identity is couched in a normative framework of "compulsory heterosexuality" (Butler 1993: 93). Butler emphasizes the role of denaturalizing sex in an effort to work against this framework (1993: 93). Ultimately we are told that "there is no sexuality outside of power" (Butler 1993: 95).

In alignment with the role of intersectionality, we need to acknowledge that every subject is multiply constituted and constructed, therefore we cannot focus on one aspect of identity but rather we need to emphasize how these axes of identity are inextricably interwoven (Butler 1993: 116). Race has also been theorized and "exposed as a social creation" and therefore racial categories must be examined as both historically constructed and maintained (Glen 1999: 6),

both transformable and malleable (Frakenberg 2001: 73). However, when arguing that race is a socially constructed identity of being, we must still recognize "the potency of race as an organizing framework in the relations of oppression and exploitation", and as processual (Frakenberg 2001: 72). In addition, Frakenberg pointedly states that race has come to be an "awe-ful fiction" including the construction of gender and compulsory heterosexuality (2001: 72).

In the context of sexual health, language of risk is frequently evoked in an effort to emphasize the dangers, or potential negative outcomes, of engaging in sexual activity. I am utilizing the concepts of bio-pedagogy and biological citizenship in particular to theorize the ways in which sexual health discourses in Canada have shaped African newcomer young women's experiences of sex and sexuality, how particular individuals approached sex as a (manageable) risk, and the importance they placed on being maintaining one's sexual health. The theoretical concept of bio-pedagogy allows me to explore how specific sexual health messages, and the wider discourses in which they are entangled, encouraged young women to self-regulate and manage their sexual lives and bodies in accordance to these messages. By exploring the connections between sexual health messaging and women's sexual subjectivities utilizing the concept of bio-pedagogy, I am suggesting that bio-pedagogy produces a "sexually healthy nation" and "bio-citizens" by placing an overriding importance on a particular kind of sexual health achieved in a specific manner. Bio-pedagogy is also a useful concept because it allows an examination of pedagogical sites in a broader sense, beyond a teacher-student relationship, and in turn a way to theorize the explicit and implicit messages young women came across. Similarly, the concept of biological citizenship is used to explore how sexual health discourses can be realized not only as a right, but a responsibility. Biological citizenship will also allow me

to theorize how homogenizing and universalizing discourses can work to erase or minimize other ways of being "sexually healthy" in the production "bio-citizens."

However, I argue that the heterogeneity of African newcomer young women's experiences gives good reason for understanding that the concepts of bio-pedagogy and biological citizenship cannot be applied wholesale and for paying attention to the particularities of how sexual health discourses are taken up by individuals within immigrant or newcomer communities. By utilizing the concepts of bio-pedagogy, biological citizenship, and risk within a critical medical anthropology and feminist-poststructuralist framework, I aim to explore taken-for-granted concepts in sexual health through analyzing the power that underpins discourses. Similarly, I aim to examine the ways in which normative frameworks shape young women's experiences.

Bio-pedagogy

Bio-pedagogy is comprised of two theoretical concepts; Foucault's bio-power and pedagogy (Wright 2008). The former was coined in his book, *The History of Sexuality* (1998) and was later re-worked in the context of health education (Gastaldo 1997). Bio-power constructs the body as a site of self-management and involves the "production of scientific knowledge which results in a discourse of norms and normality, to which individuals desire to conform" (Pylypa 1998: 22), reflecting regulatory over coercive forms of power.

According to Gastaldo, Foucault saw all biological life as a political event, involving the management of reproduction and disease. In this context, health has become a point of contact between the government and the imagined population of citizens (1997: 113). However, this requires the construction of more subtle forms of power, as "with the establishment of a net of

human rights and citizenship practices, the art of government has had to develop more refined strategies in order to maintain control over the population while avoiding coercive actions" (Gastaldo 1997: 113). In her perspective, health education can be realized as contributing to the exercise of biopower by its very definition, as involving the promotion of "healthy" behaviour norms and the discipline required to attain them, along with its pedagogical nature (1997: 113).

The pedagogy aspect refers to the ways in which bodies are involved in processes of meaning-making, shaping how individuals see themselves and subsequently act (Wright 2008: 7). This involves what Wright calls "pedagogical sites," which can operate in a deliberate manner or can be more subtle. For example, public health campaigns would represent the former, as they attempt to change individuals' behaviour, whereas more nuanced messages can implicitly be found in other forms of media, such as television shows (2008: 8).

The concept of bio-pedagogy can serve as an analytic tool for investigating the entanglement of being healthy and being a "good citizen." Health is "the result of complex assemblages, of health knowledge, practices and representations" (Fitzpatrick and Tinning 2014: 135), wherein particular "truths" are constructed and this allows for the possibility of (self) regulation (Wright 2008: 9). I contend that ideas of being "sexually healthy" and being a "good citizen" have become entangled through complex discourses, emotions and perceptions.

Biological citizenship

According to Rose, biological citizenship represents a move away from defining individuals through national or cultural characteristics, instead looking to frame citizenship through biology (2007: 132). However, I would argue that we cannot disentangle race/ethnicity or any other identities of importance from the equation, especially in the context of immigration. I will utilize

this tension to examine how African newcomer women have been met with a system that seeks to produce a singular idea of what a "healthy citizen" looks like. The production of bio-citizens involves specific responsibilities that are "embodied in contemporary norms of health and practices of health education" (Rose 2007: 133). Information and "expert" knowledges play a role in the way in which individuals actively engage in their biological citizenship (Rose 2007:140).

This is particularly relevant to my own research examining how sexual health discourses have come to play an important role in how my interlocutors assess and maintain their sexual health; how the values communicated in said discourses shape how these particular young women take up, reproduce, or resist these values. Bio-citizenship both individualizes and totalizes and therefore "languages and aspirations of citizenship have shaped the ways in which individuals understand themselves and relate to themselves and others" (Rose 2007: 133).These discourses speak to individuals and their behaviours, maintaining that the production of "sexually healthy" individuals will subsequently lead to a "sexually healthy nation."

Defining Sexual Health

From a critical medical theory perspective, "sexual health is a complex, multidimensional construct" (Lewis 2004: 223) that has been defined in innumerable ways to reflect specific contexts and perspectives. Lewis points to the impossibility of developing an objective and socially-divorced definition of sexual health (2004:224). I believe this is due in part to the realization that sexual health is not a universal concept, and that it cannot be applied wholesale to any given context. While *The Canadian Guidelines for Sexual Health Education* (2008) encourage defining sexual health in broad terms by recognizing that a singular definition of

sexual health is not practical, and by incorporating its subjective nature, I believe that the messages my interlocutors' encountered did not always reflect this position.

By looking at the discursive practices in sexual health, I am able to examine how the complexities of language operate to shape how these young women have embodied the values embedded in these discourses. Discourses refer to the process of meaning-making through language and, in this case, there are "multiple systems of meaning to be found within sexual health discourses" (Lewis 2004: 224), defining what can and cannot be said about a subject (Foucault 1982/2010). Due to the fact that my research will explore the role of specific institutions in the dissemination of sexual health messages, I need to emphasize how power comes into the equation. Discursive knowledges are "reliant upon institutional support and distribution, [which] tends to exercise a sort of pressure, a power of constraint upon other forms of discourse" (Foucault 1982: 219), and thus privileges (and presents) itself as "expert."

The preventive discourse is starkly contrasted with other discourses that emphasize the role of sexual pleasure. The former focuses on disease prevention and sexual health promotion by placing importance on the role of individual behaviour and the subsequent negative consequences which can arise as a result (Lewis 2004: 225). As some of my interlocutors' narrative will reveal, young people's sexual health has largely been promoted in bio-medical terms, through the construction of "healthy" norms in "expert" language and has subsequently positioned particular groups as "at-risk subjects" (Wong et. Al 2012: 76). Furthermore the "labelling of youth subpopulations as at-risk and problematic" not only discounts the role of intersectionality and socio-structural factors they encounter (Wong et. Al 2012: 76) but also homogenizes their experiences through the blanket-statement that all young people are "at-risk."

Sexual Risks

Ideas surrounding risk, being labelled "at-risk," and "risky" behaviours/mindsets will be integral to answering my research question, in examining how sexual health discourses have shaped young women's perceptions of sex and sexuality upon settling in Canada. The definition of risk is often taken-for-granted (Lupton 2013) and utilized in an objective manner when talking about particular groups, such as youth (PHAC 2012). Specifically, youth have been positioned as being "at-risk," both more broadly (Besley 2010; Kelly 2000; Kelly 2001) and particularly in the context of sexual health (Spencer 2013, Wong et. Al 2012; Shoveller and Johnson 2006). I examine the concept of risk from a social constructionist perspective, which emphasizes that risk is "never fully objective or knowable outside of belief systems and moral positions: what we measure, identify and manage as risks are always constituted via pre-existing knowledges and discourses" (Lupton 2013: 43). This idea is in contrast to how public health and sexual education speak to risk-related issues. Public health and sexual education discourses generally operate from the top down, labelling particular sub-populations as being "risky." While I acknowledge that there can be practical reasons for labelling particular groups at-risk in the context of public health, such as in order to facilitate responses to epidemiological concerns, as an anthropologist I cannot help but wonder what it means to individuals to be labelled "at-risk."

Subsequently I felt it was pertinent to ask my participants what risk meant to them, and what they thought about some groups/individuals being categorized as more "at-risk" than others. In their narratives, I found that risk was seen as something negative, with the power to affect their lives. However, risk was not a topic that was spoke about outright, rather the emphasis was placed on how education and information can prevent (and protect them from)

negative consequences, reflecting the implicit ways in which risk discourses operate on the context of sexual health.

This emphasis on education and information is reinforced through the value placed on "expert" knowledge (Kelly 2000; Wong et. Al 2012; Leahy 2014; Ayo 2012; Gastaldo 1997). It is under the guise of scientific expertise that youth are positioned as "risky" and these discourses universalize their experiences. These messages also tend to "pathologize and problematize young people and their behaviour" (Spencer 2013: 458). In the context of sexual health, this labelling operates as a disciplinary regime by normalizing particular attributes (responsibility, self-regulation, risk-management) and inciting the desire to conform to them (Wong et. Al 2012: 76). Along this line of inquiry, there is a need to examine "the assumptions that underpin public health approaches to youth sexual health" (Shoveller and Johnson 2006: 48) or, in other words, the idea that increased knowledge will inevitably lead to better health. This approach to prevention largely ignores the heterogeneity and complexities of young people's lives and positions them as in need of guidance. In particular, African newcomer young women have been positioned as "at-risk" in the context of sexual health in Canada (PHAC 2012).

What has been said about African newcomer youth and sexual health in Canada?

Particular populations have been signalled as "risky" and targeted for increased prevention efforts in the context of sexual health and HIV. Public health agencies have focused their preventive efforts on particular sub-populations and this has been reflected in the literature on health promotion. The Public Health Agency of Canada has labelled such groups as particularly vulnerable to contracting HIV/AIDS; the most crucial of these categories to my own research are youth, women, and people emigrating from Caribbean and sub-Saharan African countries where

HIV is endemic (explicitly associated with people who self-identify as Black) (2012). These "key populations" were created using HIV/AIDS infection statistics, connecting a high rate of infection with an increased risk for other members of these sub-populations (PHAC 2012). Their website offers a number of statistics to bolster their perspective that all persons in these populations are subsequently more "at-risk" than others. The fact sheets on youth provide a particularly interesting deviation, namely that while "young people constitute a very small proportion of the total number of HIV cases in Canada, the literature reports on specific groups of youth as being at increased risk" (2012), such as the racialized and marginalized. What does this mean for African newcomer teen girls and young women? The labelling particular of groups as "at-risk" in the context of sexual health implies that intervention will lessen this risk.

Racialized youth in Canada have become a targeted population for sexual health research focusing on HIV and STI prevention, but in different ways. Minority ethnic groups have been associated with increased risk and vulnerability to these negative consequences while an increase in infection among young people has been particularly attributed to their "risk-related sexual behaviour," such as engaging in unprotected sex, in a Canadian context (Omorodion et al 2007). By linking particular sub-populations with disease, without explanation or context, this perceived "riskiness" comes across as "inherent" and "natural" (Larkin and Mitchell 2002: 78). Therefore, it has been pointed out by Lupton that there is a need to "acknowledge the differentiation of the targeting and effects of risk discourses on specific groups" (2013: 172) and ask what does it mean to be labelled "at-risk"? What are the hidden implications of labelling African newcomer young women as "at-risk" for HIV/AIDS?

An exploratory study was conducted in Windsor, Ontario, Canada, focusing on the sexual behaviour of African youth (Omorodion et al 2007). They examine the roles of sexual behaviour,

cultural norms, belief systems and exposure to infections, to better understand "risk factors" that will increase youths' vulnerability to HIV and STIs (Omorodion et. Al 2007: 430). In their findings, they focus on empowerment, counselling and education as a way to decrease these particular youths' vulnerability to infection. In particular, young African women were positioned as being especially vulnerable due to cultural norms and power relations. An emphasis was placed on negotiating safe sex, relaying that "discussion[s] about STIs and HIV/AIDS [were] not part of the everyday experiences of participants," and this was attributed to the taboo of talking about sex in "African culture" (Omorodion et al 2007: 433). This silence extended to conversations about talking with their parents about sex and sexual health (Omorodion et al 2007: 434). The ultimate conclusion they drew was that these youth, and young women in particular, are in "need" of sexual and health education in order for them to be empowered enough to negotiate safe sex and therefore reduce their vulnerability (Omorodion et. Al 2007: 435).

However, I would argue that this can only be considered a "need" under a specific Canadian public health paradigm which places the upmost importance on being informed and always practicing "safe sex." Similarly the idea of empowerment is often used in sexual health promotion literature and needs to be problematized (Ibáñez-Carrasco 1997/1998: 24) for it inherently involves a particular understanding of what should be done (or not done) to be "empowered." In the context of sexual health, empowerment also invokes a sense of condescension by implying that young people, and in this case young African newcomer women, *need* to be "empowered" with the help of larger institutions. Discourses of "safer sex" provide a rigid template of rights and responsibilities in the context of sexual health (Ibáñez-Carrasco 1997/1998: 8) through a "step-by-step design of how to predict risk and how to have sex"

(Ibáñez-Carrasco 1997/1998: 15). How does this effectively erase (or hide) other ways of thinking about sexual health and what it means to be "sexually healthy, through the promotion of a clinical approach to sex?"

I will explore the ways in which risk is not as straightforward a concept as public health agencies and sexual health literature may present. In a theoretical sense, risks are "always virtual, in the process of becoming: they are potentialities, both 'constructed realities' and 'real constructions' that are comprised of complex networks of materialities, procedures, regulations, discourses and strategies – and emotions" (Lupton 2013b: 638). This statement reflects the subjective nature of risk in contrast to the normative understanding of risk as calculated and objective. Is an objective approach to risk a reproduction of institutional discourses in the Canadian sexual education system that position youth as "risky," impulsive and in need of intervention?

Chapter 2 – Methodology: Why Winnipeg, Why African Youth, and Why Ethnography?

The research I conducted took place in Winnipeg, Manitoba, Canada. I chose this setting for two interrelated reasons. Firstly, I became a student trainee on a project, "What Risk? Whose Voices?: An Intervention of "Risk" of HIV/AIDS Through a Participatory Ethnographic Project with African Immigrant and Refugee Youth in Winnipeg, Canada" led by my advisor Dr. Susan Frohlick that was situated in Winnipeg. This research team was developed through this project funded by the Canadian Institutes of Health Research, Community-based Research and HIV/AIDS Program and includes myself and one other M.A. student trainee, two research coordinators, and multiple peer-researchers. Secondly, I was intrigued by both the theoretical framework, critical medical anthropology, being used in the project along with its community-based and participatory nature. My involvement in this project would allow me conduct ethnography "at-home," which I elaborate on shortly.

Canada has become a top immigrant receiving country and Manitoba in particular has seen rapidly accelerated immigration numbers over the past decade due to recent policy changes by the provincial government (Citizenship and Immigration Canada 2013). Statistics reveal that African newcomers in Manitoba skew to the younger side of the spectrum in comparison to other immigrant groups.[4] I focused on the downtown core of Winnipeg for a number of reasons, including the range of organizations located in this area that serve and target newcomer youth as well as this being a space where my potential participants either live or spend time. Additionally, I predominantly asked my interlocutors to meet me downtown and conducted the majority of my participant observation in centrally located venues, not only to gain a sense of the space as it pertains to their lives but also to avoid the formality and inconvenience of asking participants to come across the city to the University of Manitoba.

The research setting of Winnipeg means that I was conducting ethnography "at home." I was born, raised, and have lived in Winnipeg for my entire life. At first I found myself reflecting on what impact this would have on my research, since at its core, anthropology and ethnography seek to explore particularities and articulate the taken-for-granted. However, upon entering the field, I soon realized that even though I had been living in Winnipeg for 25 years, this did not mean that I was familiar with its every aspect. I had not spent a substantial amount of time in the downtown core, nor had I had much, if any, occasion or opportunity to interact with African or with newcomer communities. As I began to conduct participant observation at organizations located downtown and held ethnographic interviews in the downtown core, I realized that I could have been in any major city in Canada because these spaces felt novel to me. Additionally, even though at the end of my fieldwork stint I was able to "exit" the field every day and return to my house, I still felt that I was able to immerse myself in the research and gain a sense of my participants' lives.

My research used ethnographic and community-based and participatory methodology. Community-based participatory research (CBPR) is a methodology that "involves community members and other stakeholders throughout the research process, including its culmination in education and action for social change" (Minkler and Wallerstein 2010: 2); CBPR has become a valuable (and collaborative) approach to health research. After ethics approval from the University of Manitoba Research Ethics Board, the research began. Between January and June 2015, I interviewed ten newcomer teen girls and young women from Eritrea, Ethiopia, Kenya, Sudan, Rwanda, and Mauritius between the ages of fifteen and twenty-five, and various backgrounds in terms of class, race, and religion. I would be amiss to not mention the presumed heterosexuality of these young women, to the extent that non-heterosexual

sexualities/identities/orientations were not brought up by any of them, although I did not ask either

Ethnographic interviewing was critical to exploring my main research question, which is to examine how sexual health discourses have come to shape these young women's experiences and perceptions of sex and sexuality upon settling in Canada. The art of ethnographic interviewing will be elaborated on shortly. I met my participants through social connections made by our team research coordinators and community members, Selam Ghebreyohannes and Huruy Michael, as well as a peer-researcher, Winta Michael. The role of the research coordinators was to facilitate relationships between the research team and the African newcomer community in downtown Winnipeg. For the majority of my fieldwork, Selam acted as a liaison between myself and potential participants; she helped set up meetings and made arrangements to have a room available at the public library. Both the research coordinators and peer-researchers held important roles in the project as a form of cultural intermediaries. For my thesis research, working with Winta offered insight into the everyday experiences of African newcomer women living in Winnipeg. The peer-researchers did not have access to confidential data except in the cases where acted they as translators. I only had one participant, Dehab, who requested a translator for all of her interviews. It is importance to acknowledge what can be lost (or altered) through translation. During my interviews with Dehab I wrote extensive notes while constantly checking with the peer-researcher that I was getting at Dehab's own perspectives.

At this point, I would like to speak to my experience of completing a thesis within a larger research project. My position as a student trainee afforded a valuable learning experience. I was able to get in the field training, feedback and support. It also provided a unique experience for a graduate student to complete their research, by working so closely with one's advisor.

However, this relationship developed over time. I was approached by Dr. Susan Frohlick about the possibility of joining her research team at the beginning of my graduate studies; as a result I took a directed readings course on the anthropology of risk. As a result, my interest grew in the social construction and the usage of the concept or risk and how it might be explored in the "What Risk? Whose Voices?" project. While being a part of a larger project, to some extent, directed my research interest (in what subjects needed to be addressed in both my fieldwork and my thesis) I did not feel constrained by this at any point. This experience also provided critical access to African newcomer communities, which I would not ordinarily be able to work with, in such a short amount of time. There was also a sense of community in the team itself, which lent much support throughout the research process.

The research team, including four peer-researchers, designed recruitment posters that were put up in the downtown core of Winnipeg. However, none of my own participants were found through this method. The criteria for participation included being in Canada six years or less, from an African country, between the ages of fifteen and twenty-five, female, currently living in Winnipeg, and open to discussing sexual health. I did not ask about their status as immigrants, refugees, permanent residents, citizens, or international students. In the context of this research, in dialogue with the community members (research coordinators and peer researchers) we defined "newcomer" as someone residing most of the time in Canada for no longer than six years because we wanted to capture these participant's initial experiences of arriving in Canada, and this would be harder to do the longer they have been residing here. The reasons for focusing my research on girls and women are three-fold. Firstly, in the context of HIV, girls and women are a growing epidemiological concern (PHAC 2012; Larkin and Mitchell 2002). Secondly, I felt more comfortable working with teen girls and young women rather than

teen boys and young men because of the nature of the research topic. Lastly, after discussions with my thesis supervisor Dr. Susan Frohlick, I believed that teen girls and young women would be more receptive than young men to my research topic and methodologies.

Although I conducted interviews with ten participants, in my thesis I focus on six young women selected out of the larger sample. Central to ethnographic methodology, my rationale to feature these particular women as key participants in my thesis is because I was able to meet with them multiple times over an extended period of time and, therefore, was able to establish a sense of continuity between interviews, in both the questions I asked and the subjects we spoke to. This was done in order to understand the similarities and dissimilarities between their experiences. I was unable to meet with the other participants a second time for different reasons. Two participants did not wish to participate beyond the preliminary interview. I was unable to get in contact with the other two after our initial meeting(s). This is understandable, as I needed to remind myself over the course of my fieldwork. My interlocutors have lives of their own and my research is not going to be as high a priority for them as it is to me.

Because the six participants' experiences are central to my thesis and in order to emphasis the heterogeneity that is obfuscated in the category "African youth," which includes differences in age, ethnic background, country of origin, age of emigration, individual cultural values, past experiences with sexual health/sexual education, current experiences in Canada, living arrangements, and family dynamics, I provide a brief sketch of each key participant below. Throughout the thesis, readers will gain further glimpses into their lives as well. Before I provide this sketch, I would like to clarify that I use pseudonyms to protect their anonymity but I have not changed any other identifiable features, such as country of origin or the age at which they

came to Canada, because these factors play an important role in understanding their individual experiences. Now, let me introduce my key participants:

Candace is a 16-year old[5] Ethiopian teen girl who has been living in Winnipeg for approximately four years. She immigrated to Winnipeg with her older brother to live with her mother, who she had not seen for several years. When I first met Candace, she came across as shy but social. She was initially quiet but soon felt comfortable chatting and joking around with me. She attends high school and is currently finishing grade ten. She works part-time on the weekends and enjoys playing soccer. She enjoys spending time with her mother and brother, especially because her mother works long hours.

Semira is a 15-year old Eritrean teen girl born and raised in Kenya. She immigrated to Winnipeg with her parents and siblings around the same time as Candace. My first impression of Semira was that she was shy but assertive, and not afraid to voice her opinion. She attends high school and is about to complete her ninth grade. The Orthodox Christian church she attends with her family plays a role in her everyday life and she participates in a youth group on the weekends. Her father has moved to Alberta for work and she helps her mother take care of her siblings.

Dehab is 18 years old and from Eritrea. She moved to Winnipeg with her parents and sister less than one year before my first meeting with her in early 2015. She spent two years in Sudan (when she was 15 and 16 years old) before coming to Canada. When I first met Dehab, she was quiet but very polite. However, I came to realize over the course of our conversations that she was able to articulate nuanced responses to my questions. She had a good understanding of English but felt more comfortable speaking in Tigrinya, so Eritrean native-Tigrinya-speakers

who were peer-researchers on the project translated during my meetings with her. She enjoys math and science, hoping to go into nursing once she has completed high school.

Feven is 25 years old, born and raised in Kenya and Eritrean. She immigrated to Winnipeg with her mother and brother approximately 6 years ago, when she was 19 years old. My first impression of Feven was that she was outgoing and extremely candid. She is enrolled in university full-time and also has a job as a support worker. She hopes to go into finance once she completes her bachelor's degree and likes to hang out in the downtown of Winnipeg with friends.

Cheyenne is a 22-year-old international student from Mauritius. She moved to Canada three years ago, initially living in Toronto and attending college there before coming to Winnipeg; one of the reasons for this move was the lower cost of living and the university programs offered. When I first met Cheyenne, I found her to be warm and deliberate in her word choice, taking time to express her thoughts. She hopes to obtain a degree in architecture. She lives with her brother and a roommate.

Gretah is a 21-year old woman from Rwanda who has been living in Winnipeg for two years as an international student. She came to Canada on her own when she was 19 years old after completing an International Baccalaureate diploma. My first impression of Gretah was that she was very comfortable in her own skin, relaxed and confident. She is interested in gender issues and feminist studies. When she initially arrived, she spent most of her time near campus because she had been exposed to a barrage of discourses that constructed downtown Winnipeg as a dangerous taboo place. However she has since resisted such discourses and has come to love spending time downtown and meeting people from different backgrounds.

Haben is an 18-year old Eritrean woman who was born in the Sudan. She has been living in Winnipeg for about seven years since she was approximately 11 or 12 years of age. She lives with her mother and her four younger siblings (two brothers and two sisters). When I first met Haben, she was very curious and assertive in her opinions. She would like obtain a degree in nursing but revealed that she frequently changes her mind when it comes to careers. Haben recently obtained her driver's license and her father has left her the family vehicle to drive because he moved to Alberta for a job.

Methodology: fieldnotes, ethnographic interviewing and participant observation

Over the course of several months, I conducted ethnographic interviews and participant observation. I kept detailed fieldnotes of virtually everything that happened "in the field," including interviews, volunteer work, and meetings with the participants, the peer-researchers, and the research coordinators. This was done with urgency, as I did not want to lose the immediacy of my recollections. My process of writing ethnographic fieldnotes was two-fold; I would make extensive jottings in a small notebook as soon as I exited the field and within twenty-four hours I would use these jottings to create a narrative. For every hour I spent in the field, I would spend close to two hours writing it up afterwards.

Fieldnotes are a vital component to ethnographic research and involve "firsthand participation in some initially unfamiliar social world and the production of written accounts of that world that draw upon such participation" (Emerson et al 2011: 1). Participant observation and ethnographic fieldnotes are inextricably linked. The construction of ethnographic fieldnotes is a complex process wherein one inevitably filters description and reflection, "a process of

interpretation and sense-making that frame or structure not only what is written but also how it is written" (Emerson et al 2011: 9).

I conducted ethnographic interviews, wherein I sought to obtain a kind of oral history from each participant. An ethnographic interview "is not as simple as asking a series of direct questions and getting unproblematic answers [and] is a complicated exchange that while obviously instrumental in character, still relies on many conversational norms and patterns to help it to flow and be productive" (Madden 2010: 69). While I prepared interview schedules (see Appendices A, C, and D) and scripts (see Appendix B), which coincided with a particular conversational progression and were developed through a dialogic process, in conversation with my thesis supervisor Dr. Susan Frohlick, the project's research coordinators Selam Ghebreyohannes and Huruy Michael, and peer-researchers. The construction of open-ended ethnographic questions is a balancing act, wanting to avoid ambiguity while at the same allow the participant to "explore their answer as an act of conversation" (Madden 2010:69). My conversations with Susan, Selam, Huruy and Winta helped shape how I approached the ethnographic questions. This meant that I was conscious of the fact that I should not rigidly adhere to my prepared documents but rather use them as a tool to guide the interviews while still being open to other routes our individual conversations took. Ultimately, a good ethnographic interview "will give the ethnographer insight into how a participant sees the world in analytical, typological, and relational ways, and such information helps to create insight into the participant's worldview" (Madden 2010: 73).

Interviewing should be understood as a subjective practice and the "complexity of human talk" should be recognized, involving gestures, translation, emic vocabularies, silence, expressions and much more (Devault and Gross 2007: 173). Furthermore, individual's social

realities are "historically situated and constituted through people's activities" and experiences (DeVault and Gross 2007: 173). Additionally, I need to explore the power dynamics involved in conducting ethnographic interviews, between the young women who participated in my thesis research and myself, as a researcher. In alignment with a feminist-poststructuralist framework, I will unpack my own subjectivities and the role of privilege in my positionality. As a young, white, Euro-Canadian, third generation, heterosexual woman, I need to grapple with my own privileges in an ethnographic research setting. I need to reflect on these identities and how they can represent "unmarked norm[s]" (Frankenberg 2001: 81) in order to obtain a form of "race cognizance" (Frankenberg 20001: 92).

Throughout the research process, I contend that it was pertinent to express to these young women that I was seeking their emic (or "insider") perspectives, strongly emphasizing that I was not there to test them, instruct them, or "empower" them, for this would come across as condescending and paternalistic. In providing a venue for participants to voice their opinions, I also emphasized that I wanted to challenge homogenizing discourses and labels that target young African newcomer women. A community-based and participatory approach to research played a critical role in addressing my subjectivities and privileges. Specifically, I consulted African newcomer young women and community members in designing my research activity, for feedback on my analysis, as well as feedback on the conclusions I had drawn. The nature of the interviews, being ethnographic, also helped to address power dynamics. I tried to make our conversations dialogic rather than simply asking questions and getting responses. I encouraged participants to ask any questions they had about my own experience and offered candid answers; I felt this was important because of the sensitive nature of the topics we were discussing. It seemed unfair to ask them to reveal so much about themselves and not offer anything in return.

My background as a white woman may have also shaped the openness of their responses. Specifically, before I began my fieldwork, I had a conversation with my advisor about how my whiteness and outside status can work as an advantage, as she shared that there had been research that suggested these young women would feel more comfortable talking about a sensitive subject such as sexual health and sex with someone outside their community, and thus encourage them to share their personal stories.

I met with each of the participants for multiple interviews (excluding Gretah who had to leave Winnipeg on short notice, but who I chose to include because the time I did spend with her evoked interesting thoughts) over the course of several weeks to several months. I set up a comfortable private place for the ethnographic interviews at a centrally located library, where meeting rooms were available upon appointment. It was important that I develop a sense of rapport (see Dewalt and Dewalt 2011) with each of my interlocutors in order to build trust between us and ensure that they felt at ease during our conversations, especially due to the sensitive nature of some of the topics I wished to discuss. This was done through initial meetings for coffee or through other volunteer activities. I emphasized that I was not there to teach them about sexual health or test their know ledge, that there is no right or wrong answer, and that I wanted to hear their perspective and experiences.

As a student trainee, I received interviewing advice during a "training day" workshop in November 2014. In addition, Dr. Susan Frohlick was present for two of my interviews. This was done with the participant's permission. This provided a valuable learning experience and additional training in the art of ethnographic interviewing. Before these interviews, she provided feedback on the schedules I had written and I saw how she conducts her own interviews, offering valuable first-hand experience. Before conducting the interviews, I went through the informed

consent or, where necessary, assent paperwork with each participant. This process included explaining that some of the topics we will discuss may bring up negative feelings or traumatic past experiences. As such, they were provided with a list of counselling services since we as anthropologists are not trained to provide counselling.

For the two teen girls under the age of 18, the team's research coordinator, Selam, spoke with their parents and explained what their participation would entail before asking for their permission. However, we also deemed it necessary to obtain the informed consent from the minors. I went over the informed consent directly with the participants who were 18 years of age or older. I kept a record of this process and filed the appropriate paperwork with Dr. Frohlick. At the end of the interview, each of these young women received twenty-five dollars in cash and two bus tickets for their participation in order to show our appreciation of their time.

The schedule for the initial interview was developed to first gain an understanding of the backgrounds of young women from African countries and newcomers to Canada and their life in Winnipeg and then to draw out their perspectives on more sensitive subjects, such as dating, sexual health, and HIV; obtaining background information was critical to contextualizing their experiences in Canada and to particularizing these young women's experiences. With some participants, we dealt with these potentially sensitive discussions the first time we met, while with others these topics were not broached until a second interview. The pace of the interviews had to do with my own assessment of how the interview was progressing and the level of rapport that had been developed (and how comfortable they seemed to be with speaking to me).

In the early months of the research, I scheduled second meetings with new participants to discuss with my research topic with them and then a follow-up meeting to explain the research

activity. However, towards the end of my fieldwork, this was no longer the case, and instead I discussed this information together. This was due to time constraints but also that separate meetings were not needed. In the latter months of my research after an initial meeting, participants were given enough time to conduct the research activity, which I will explain, and then I met with them a second time to discuss the messages they had come across.

An important research strategy that informed my methodology was the "sexual health discourse biography," a research strategy that was initially created by Dr. Susan Frohlick in the grant proposal, which proposed to illuminate how and where and through which people sexual health knowledge or discourses are circulated. For example, this research strategy would allow us to see how sexual health discourses have been pertinent in their lives, migration paths, and settlement experiences.

I adapted this tool to my research activity because I was interested in getting them to see the material in their regular lives, as per ethnographic methodology. Rather than a biography, the strategy I utilized was more like an "everyday sexual health discourses activity". In a way, I was tasking them with being anthropologists of their own lives. What I elected to do instead of the biography, then, was to ask participants to spend approximately two weeks collecting sexual health messages that they encountered (see Appendix B), and then bringing them to a final interview for discussion (see Appendices C and D). In this sense, when I asked them to "collect" sexual health messages, I was asking them to write down/record where they saw the message, when they saw it, or who gave it to them; additionally I suggested they use their cell phones to capture an image that they could bring to the final interview. I wanted to hear what sexual health meant to them individually before speaking about sexual health messaging and also wanted to keep the idea of a "sexual health message" open to interpretation, defining it as any form of

communication that is trying to offer information/advice about sexual health. I provided a brief list of examples (see Appendix B) that included brochures, pamphlets, posters, films, television, advertisements, websites, friends, and family and so on. However, I did not want them to think this was an exhaustive list, so I emphasized that it was up to them to decide what constituted a sexual health message, and that it was up to them to decide what types of messages to bring.

For the final interview, I had prepared two slightly different interview schedules. One was constructed with the expectation that they had brought specific messages to the interview, while the other allowed for further conversation if they could not find any (or very many). In addition to seeing what kinds of messages they brought, I traced their experiences, both pre- and post-immigration, with sexual health messaging and sexual education, including their perspectives on dating, sex, and risk.

That I left the "everyday sexual health discourses activity" relatively open came with specific advantages and disadvantages. By letting the participants decide what constituted a sexual health message, I was able to get at their emic perspectives, although the looseness of these instructions may have left them feeling a little bit lost. After having several of these participants go through this process, it became apparent that the activity fell short of my expectations. In particular, the majority of participants did not bring in images or physical documents to the final interview but rather talked about messages they had come across. Some of these young women mentioned time constraints while others felt that there was a lack of "everyday sexual health discourses" in their lives. However, through our conversations I was able to indirectly hear about other sexual health messages, along with their perspectives on them. These issues will be explored later on in Ch. 5, and actually evoked an interesting analysis.

With this "everyday sexual health discourses activity," I am not trying to provide an objective account (or an efficacy evaluation) of the sexual health messages that can be found in Winnipeg. Rather I am exploring my interlocutors' experiences (and perspectives) on how these messages are communicated and where they were found in Winnipeg (and Canada in general). I should note that this approach became more than a research activity involving the collection of sexual health messages in everyday life, but also worked to trace my interlocutors' individual experiences with sexual health messaging, both pre- and post-immigration. I have met with five young women to discuss their findings from this activity, revealing different experiences and perspectives on how these types of information are talked about in Canada.

In addition to these ethnographic interviews, I conducted participant observation in various locales. In order to establish a sense of rapport and connect with the African newcomer community, particularly in the downtown core of Winnipeg, I was placed as a volunteer with different organizations as per the methodology of the larger project. Volunteer placement commenced after meetings with the organization partners to discuss the ethical considerations of conducting participant observation through volunteer placement. Partnerships with Immigrant and Refugee Community Organization of Winnipeg (IRCOM), Spence Neighbourhood Association (SNA), and Sexuality Education Resource Centre (SERC) were facilitated and developed by my advisor.

It was important to develop a relationship with these organizations for practical and ethical considerations which included to carefully and respectfully gain access to potential participants (African newcomer teen girls and young women) but also in alignment with the community-based and participatory nature and principles (Wallerstein and Duran 2006; Minkler and Wallerstein 2010; Israel et al 2003).

Data analysis and interpretation

Once the data was collected over a period of six months, I conducted thematic and discourse analyses by working with the material produced in meetings and interviews, including my fieldnotes and transcriptions. I transcribed the interviews that were recorded and, as mentioned above, wrote out detailed fieldnotes for everything I did in the field, including meetings with participants, members of organizations we are partnered with, peer-researchers, the research team, and volunteer work. As per Dr. Frohlick's advice, I first read through all of these materials without my research questions in mind. After completing this step, I highlighted sections that caught my attention and wrote notes in the margins; I noted such things as the language of bio-pedagogy reflected in these participants' responses, the impact of "Canadian culture," and the circulation of messages, to name a few. Afterwards, I utilized Post-Its to begin drawing out different themes that worked to answer my initial research question: What role do sexual health discourses play in the lives of African newcomer teen girls and young women in Winnipeg?

In my analysis I chose the following transcripts and fieldnotes from interviews with my six key participants: one with Gretah, one with Haben, two with Cheyenne and Feven (together), three with Candace and Semira (together), and four with Dehab. These interviews serve as my primary ethnographic data. The remainder of my fieldnotes served to inform my analyses and the conclusions I have drawn. As a result of my coding and analysis and in discussions with my advisor, my research question shifted slightly and became more specific, asking: How have sexual health discourses shaped my interlocutors' experiences and perceptions of sex and sexuality upon settling in Canada? This shift will be explained in the conclusion of my thesis.

After I had begun writing my thesis, we held a meeting in order to get community feedback on some of my conclusions. This meeting was attended by Dr. Frohlick, Selam, Estella Marmah, two peer-researchers,, and six African newcomer young women. This meeting was an opportunity to share some of my finding and to hear their perspectives on my analysis and interpretation, in alignment with community-based and participatory principles. The conversations that ensued offered some valuable insight into the assertions I was making, and will be elaborated on in Chapter 5.

Before I discuss what the participants said, it is integral to a feminist post-structural framework that I address my own perspective on the subject in order to illustrate that I am not only a researcher but an individual with personal attitudes and therefore I must make these clear. Do I think sexual education, sexual health messaging, and being a "good bio-citizen" are important? My initial reaction is to agree that they are important. But as a critical medical anthropologist I am questioning the power and authority of discourses that place an emphasis on neoliberal values and that have conflated health with being a good person (and bio-citizen). Why is it important to be represented as a "sexually healthy" and responsible citizen and what does this mean for those, like immigrants and especially immigrants and refugees "at risk" of HIV, who do not fall into a narrowly and morally defined category of citizenship? Does this importance to be a good citizen related to one's sexual health practices, beliefs, and knowledge, defined by public health and governmental agencies, have a particular meaning for young women? Safer sex inevitably "reminds everyone, especially for recent immigrants, that we should be 'good citizens'" and in this context, HIV becomes depicted as a danger to the security of the nation (Ibáñez-Carrasco 1997/1998: 31).

The literature has specifically investigated how health, risk, citizenship, and morality have come together in the context of sexual health and HIV/AIDS (Vander Schee and Baez 2009). There are multiple and conflicting HIV/AIDS discourses that are concerned with "what is to be done to individuals, and what individuals do to themselves, because of it" (Vander Schee and Baez 2009: 33). Specifically biomedical knowledge concerning the prevention of HIV/AIDS, and I would argue any sexually transmitted infection, involves particular moral and behavioural objectives (Vander Schee and Baez 2009: 41). These objectives involve health values that police the boundaries between good/bad, normal/abnormal, and moral/immoral (Vander Schee and Baez 2009: 41). This policing of boundaries can be examined within HIV/AIDS and sexual education curriculums that promote social responsibility in the production of good/bad citizens through risk-laden preventive language, wherein the "practice of citizenship involves not only care for the self but also protecting others' rights" (Vander Schee and Baez 2009: 41). Within the context of sexual health and sexual health education, behaviours, attitudes, and states of being are connected to deep moral undertones that proscribe what it good/normal/moral, and what is not.

Chapter 3 – Meanings of Sexual Health for African Youth in Winnipeg

"Sometimes I'll be like, 'I should have just stayed a virgin.'" (Feven)

I now turn to the ethnographic material that I collected that helps me to answer my research question, how did sexual health discourses shape the experiences of African newcomer teen girls and young women, especially experiences and perceptions of sex and sexuality? The first place I start is by showing what "sexual health" meant to my interlocutors, as it became apparent during fieldwork that sexual health is a complex and dynamic concept. That sexual health was a dynamic and ambiguous concept had implications for how people thought of themselves, or not, as "sexually healthy." While my participants gave sexual health and the idea of being "sexually healthy" different meanings, a predominant theme was to place a high degree of importance on being educated and taking an active role in their own sexual health, involving good communication, testing, negotiating "safer sex" and being prepared. As I will explain in greater detail in my analysis, I felt that this idea of sexual health was linked to risk discourses emphasizing the need to be informed in order to avoid the potential negative consequences associated with having sex. The main point of this chapter is to demonstrate how settling in Canada has shaped these particular young women's ideas of what sexual health means and how sex is being understood as a manageable biological risk.

Participants' understandings of "sexual health"

In order to explore my research question, I asked my interviewees to define "sexual health," an often taken-for-granted concept, and explain what it means to them in their own words. While each of the women I spoke with presented a slightly different take on the subject, I found a divide between the younger women who were still in high school, ages 15-18 (Dehab, Semira,

and Candace), and those who were already attending university (Cheyenne, Feven, and Gretah). For the teen girls they were not currently thinking about engaging in a sexual relationship, yet, as I explain further, knowing about their own sexual health and being informed was perceived as beneficial for future relationships as well as a part of growing up. For the university students, they expressed the importance of "maintaining" their sexual health, although in different ways. In this section I focus on the conversations I had in the ethnographic interviews with six participants. The predominant meanings that all of these women ascribed to sexual health were related to safety, open communication, responsibility and prevention; while such meanings directly fall in line with the "preventive" domain of discourse (Lewis 2004: 225), I will turn to that analysis shortly. For now, I want to demonstrate how their definitions entail subtle and not so subtle differences that I tease out here.

When I asked Candace, Semira, and Dehab to define sexual health, they initially could not describe what it meant to them and agreed it was a difficult task. However, their reactions were slightly different. Candace and Semira, who were interviewed together, exchanged nervous glances with each other while Dehab appeared to be giving the question deep thought. I emphasized, jokingly, that this was not a test and that I was simply interested in their perspectives. They knew what "sexual health" was but could not articulate it. I had prepared a general definition for the interview (in case this happened), emphasizing that sexual health will mean different things to different people. I confessed to them that I had also found it challenging to define what sexual health meant. I expressed that sexual health can be associated with many different subjects, including sexual well-being, prevention, reproduction, and sexuality. Semira instantly took a liking to my definition and agreed with it. Since Semira and Candace both attended high school health classes, I was curious if their teachers had ever defined sexual health.

To teach a class on health that involved STI/STD/HIV prevention, pregnancy, contraception, and other related topics, one would hope that a definition of sexual health would have been provided to the students, or at least have a discussion as to what it means. When I asked them about this, Semira expressed, *"We just like learn about things. They don't really define it."*

I believe that the lack of definition by the high school girls suggests two important points. It reflects sexual health education guidelines that will be elaborated on in Chapter 5, by not explicitly defining what sexual health is for the students. However, the lack of discussion of what sexual health means to these particular youth can be representative of the power relations between teachers and students. Do students feel comfortable in challenging dominant and institutionalized discourses? Is there any room for them to express issues they are interested in or ask questions? Of course, my questions assume that young women want to discuss sexual health in class. It became apparent throughout my conversations that sexual education in schools represented the predominant way in which they encountered sexual health messages in their daily lives. I did not have access to the specific documents used. Rather, I focused on the participant's narratives of the messages communicated to them in their respective health classes and workshops. Due to their institutional setting, the sexual health messages taught in classrooms represent sexual health discourses that have the power to shape not only how we think about sexual health but also how it comes to have meaning in our everyday lives. However, we need to acknowledge that these messages will be taken up, reproduced and resisted in different ways, in accordance with the heterogeneity of my interlocutors' experiences. Each young woman arrived in Canada with different experiences and they hold different perspectives from each other, so therefore they will take up messages in the different ways, or they might not pay attention to sexual health messaging.

After Semira revealed that the teachers or students had never talked about what sexual health means to them in the any of health classes she had taken, I again expressed interest in hearing their own opinions about sexual health. Semira paused, and then stated that she thought it was mainly to do with prevention and *"being safe;"* this emphasis on safety can be positioned in opposition to the dangerousness of "risky" behaviour. The Public Health Agency of Canada (PHAC) explains that sexual health should encompass "a state of physical, emotional, mental and social well-being in relation to sexuality…not merely the absence of disease, dysfunction or infirmity" (2008: 5). However, according to the experiences these particular young women had with the sexual education system and dominant discourses, it has largely been talked about in terms of the negative consequences of having sex, reflecting the before mentioned preventive model of sexual health.

Dehab also had some difficulty in describing the meanings of sexual health. She thought she knew what it was but could not explain it. However, she did speak about how in Canada people have *"freedom"* by describing how you can see young people kissing in the streets and doing different things. Her difficulty in defining sexual health can also be attributed to the fact that the term "sexual health" does not readily translate into a word in Tigrinya. I recognize that interpretation may very well play a role in how the interview progresses, including power dynamics between the researcher, interpreter and participant. Dehab was the only participant who requested an interpreter. Weyni, a young heterosexual newly-married Ethiopian woman, acted as the interpreter for the first two interviews while Winta, a young single heterosexual Eritrean woman, was the translator for the remaining two interviews. When discussing sexual education, Dehab expressed that it was important to know about prevention and protection. In her perspective, she may be separating sexual health and sexual education, framing the former in

terms of the freedom people have in expressing their sexuality while the latter deals with the clinical aspects of sex.

While the three high school students placed an emphasis on being "safe" through having the right kinds of information, the three university students offered something slightly different as far as what sexual health meant to them. Cheyenne and Feven were interviewed together, at their request. After thinking about the question I posed for a short period of time, they were able to come up with detailed and nuanced answers. Cheyenne, an international student from Mauritius, said,

> *"For me personally, it's like, I don't believe about no sex before marriage or anything like that. So it's more about maintaining your sexual health, getting checked, not having STIs, asking your partner if he's clean, and yeah. For me, that's sexual health. And not having too many sexual partners at a time…just because of like, the safety."*

Feven, an Eritrean woman from Kenya, saw sexual health in a slightly different light by stating,

> *"I would say it's being more aware of like the sexual diseases around, um I guess being true to your…like if you're true to your partner, and you're sleeping with that person, and that person is true to you. Unless one of you is, like has an STI or an STD, it wouldn't come to you right? So I guess it's being more open."*

Cheyenne spoke to the more to the clinical aspects of sexual health, such as getting tested and making sure you are not infected; this is representative of a particular definition of sexual health, one that "implies the absence of diseases, suggesting that health is an objective quality" (Sandfort and Ehrhardt 2004: 182). She also echoes the preventive discourse by expressing that

being disease/infection-free and making sure your partner is *"clean"* are both part of maintaining sexual health. "Cleanliness" has also been talked about in relation to trust in relationships and negotiating condom use; "clean" in this context refers to a negative STI test (Graffigna and Olson 2009: 796). Feven focused on the communication and trust aspect of relationship between partners. In her perspective, by being in a monogamous relationship, in which no one is infected, you significantly lower the chances of contracting an STI. The idea that having multiple partners or "sleeping around" as something one should avoid is a theme that I will explore later on. Both women expressed in their own way that being "sexually healthy" is intimately connected to a lack of disease or infection.

Gretah, explained how the meaning of sexual health has shifted since living in Canada. She clarified this by saying,

> *"So even though I never really got to have a conversation about sex and stuff, somehow because of the, my environment, I got to know that unprotected sex is not safe for me. So that was more like my sexual health. But now I feel that it's more than that. I would say now it has more to do with sexual subjectivity. More to do with women, cause well I'm a woman that's why I'm saying women, to uh be in charge of their bodies, to not be ashamed of their bodies. To take care of themselves and to care about how they feel, and just the way they want to without feeling ashamed, or feeling like they're tempting anyone. Like I'm not doing all of this, taking care of myself, for anyone else but myself."*

In this narrative, the Canadian context and feminist literature has had an impact on how Gretah thinks about sexual health, how it has taken on particular meaning in her life beyond the clinical aspects of sex, and how she saw this as having a positive effect on her sense of self.

While she does not simply define sexual health in bio-medical preventive terms, as was done with some of my other interlocutors, she still focuses on the idea of self-regulation. Gretah strongly associates being "sexually healthy" with "being happy with yourself," mentally and physically. This is representative of the "sex positive" approach particular sexual health organizations utilize. Literature that examines young people's perceptions of sexual health also shows how youth connect sexual health to happiness and pleasure (Spencer 2013: 454), beyond illness, reflecting that there are different ways of thinking about sexual health.

There may be a number of reasons for why the teen girls did not talk about what sexual health in as much breadth as the older women; nervousness, shyness, language, or even the fact of currently learning about sexual health in an formal setting (such as school or a workshop), can all play a role. The differences in young women's definitions of sexual health can also be attributed to the role that being "sexually active" plays in their lives currently. For the teen girls, they are not currently thinking about entering into a sexual (or romantic) relationship, so they may not have given this topic extensive thought. While taking an active stance in *"maintaining"* one's sexual health can be seen in the university students' narratives through discourses of responsibility, which place an emphasis on being informed, making good-decisions, and self-management (Fitzpatrick and Tinning 2014; Strebel and Lindegger 1998), the contingent experiences of each person I spoke will also play a role in how they enact this information in practice. A feminist post-structural framework is attentive to the role of intersectionality (axes of gender, race, age, sex, sexuality, etc.) as key context to their experiences. The circulation and dissemination of sexual health discourses is not linear, meaning there are negotiations (and re-negotiations), shaping how they understand sexual health as a concept and how it takes on meaning in their lives. While these young women have expressed that increased awareness and

maintaining your sexual health are important parts of being "sexually healthy," I recognize that these perspectives could reflect the official discourses circulated in their lives that "reinforce the discipline and control of the body and which ascribe personal responsibility for health and illness" (Fitzpatrick and Tinning 2014: 132).

To summarize what participants said, sexual health was presented as an objectively important part of life and my interlocutors felt that they should know what it means. Yet, in my conversations with newcomers and African team members I learnt that sexual health is not readily translatable, neither in the linguistic nor conceptual sense. For instance, there is no word in Tigrinya for sexual health. Understanding how sexual health is talked about, particularly in different contexts, can provide insights into how these discursive practices can work to shape the ways in which it takes on different meanings in the everyday lives of individuals, which I further explain in the next section.

The "correct" way to be informed about sexual health: "growing up"

In speaking with participants about sexual health meanings, an important theme emerged, which was the importance placed on being "correctly" informed on matters of sexual health. I have come to recognize that this was the case for their experiences before and after immigrating to Winnipeg. My participants explained to me that sexual health is a topic that is relevant in their families and communities in the context of planning to engage in a sexual relationship but, more broadly, as a part of "growing up."

My own perspective, as a young white woman growing up in Canada, was quite similar to those expressed by my interlocutors. Even though I did not have any formal sexual education beyond the age of 15, I still felt that in order to engage in a sexual relationship, I needed to have

all the "right" kinds of information and behave in a certain way. When I was in high school and decided that I wanted to have sex for the first time, with my boyfriend, I went to my mother to ask about taking oral contraceptives. In my mind, if a young person could not openly discuss the prospect of having sex and birth control with a family member, then they were not ready to have sex; this echoes the idea that one must be a "responsible self-regulating bio-citizen." Throughout my fieldwork, my conversations,, and through the process of interpreting and analyzing the data, I came to question how I felt so strongly about such things as a teenager; did this position on sexual health represent the power of sexual health discourses I encountered?

Candace and Semira first suggested the connection between "growing up" and sexual health to me when they explained how their parents had utilized Canadian television shows to indirectly communicate specific values to them about sex and relationships, in particular young people having romantic relationships. When I asked them whether television shows that depicted youth having "adult" experiences were common in Ethiopia and Kenya, they both laughed and said that it was very rare, even for persons over the age of 18. But since coming to Canada they had noticed that this is common on Canadian television. Candace's mother watched the show "Teen Mom" to use the theme of the show and the girls starring in it as a warning of the consequences of having sex, framed in a conversation about "those Canadian girls." I later asked Candace what kind of messages she thought television shows like "16 and Pregnant" and "Teen Mom" communicate to young people. Candace explained,

> *"Like they show you how they struggle with things, with that age having like a kid and stuff like that. So it's just like so, if you're going to do it, then you have to face this, so our age, most of us don't want to face the same thing as we seen. So it's just like, even if*

they're not saying right away don't do it, but like we think like I'm not going to do it. If we're gonna do, this will happen, our life is not gona be the same and stuff like that."

This quote demonstrates the ways in which parents' socialization in combination with popular culture can shape how African teenagers understood sex and the consequences associated with it, namely sex as reproduction and, more specifically, the consequences of reproductive sex being pregnant at an inappropriate age and in the shameful manner of Canadian teen girls.

There were other examples, too, that suggest how sexual health was understood to play an important role in maturation. Candace and Semira talked about a poster that they had found on a bulletin board at their high school. This poster is a part of the 'Heads up!? Use a condom" campaign created by the Winnipeg Regional Health Authority, and disseminated throughout the city. I remember being at the movie theatre and seeing one of these ads running before the previews. The campaign encourages youth to use condoms in order to prevent the spread of sexually transmitted infections, specifically syphilis. When talking about the poster, I asked Semira and Candace about the role that such sexual health messages play in their lives, specifically in the context of future relationships since both girls had expressed that they were not interested in dating until after high school; in particular, would they seek out messages? As Semira explained, she had been influenced to do so since migrating to Canada,

"I feel like before this [before I came to Canada and took part in the sexual education system], I probably wouldn't..but like realizing that it can be a long term thing if you do have HIV or AIDS, I could probably start looking into it, and like being more careful."

This is a significant statement because it demonstrates the power of sexual health discourses that are disseminated to youth in the context of sexual education, to shape how they think not only about sexual health in general but their own future as a sexually active individual.

Dehab said that regardless of whether she was going to be in a relationship or not, she wanted to know about these things, to have a general knowledge about them; being informed about sexual health issues, including your body, was for her a part of growing up. When I asked her where she would look for these messages, she spoke about how the internet was useful in some ways but that on the internet you cannot always get the answers to your exact question. Dehab spoke about how you can ask your parents, *"If they can help you, if they have the knowledge,"* and she went on to say that if they did not have the answer to your question, *"Then you can go to a clinic [which can be the] best option."*

This kind of importance placed on "expert" knowledge was seen, too, with Candace when she discussed HIV-related stigma. When asked why she thought HIV had so much stigma surrounding it, Candace drew a link between increased education and a decrease in stigma. She contextualized this link through a story about the first time she went back to Ethiopia after moving to Canada. She had been visiting a village with her grandfather and when they found out that someone there had HIV, her grandfather immediately wanted to leave. Candace attributed his fear to his lack of information about HIV and how it is transmitted. She explained that things are changing in Ethiopia now, *"It's like the more information they have, like more they will know, and they wouldn't be as they were before."*

Following their cultural norms and their parents' advice, Candace, Semira, and Dehab wanted to wait until they had finished their schooling before beginning a romantic relationship.

Dehab's parents had given her direct advice when it came to dating, such as how to spot a "good" man, while Semira emphasized that her parents were not likely to ever speak to her about dating or sex. Nevertheless, they were exposed to a public sexual education as high school students that emphasized the urgency in being informed before making any decisions about sexual practices. In the youths' perspective such education aims to give youth the tools to engage in sexual relationships (such as the location of and where to get free condoms, etc.). These three young women negotiated and re-negotiated the different messages they came across, that is, those of their parents and those of the school. As a result, Candace, Semira, and Dehab placed value on having the "proper sexual health information" that helps them prepare for a sexual relationship but also, because they were not planning to become sexually active for a while, that was an integral part of maturing. In this context, they are able to conform to Canadian public health discourses on sexual health that encourage obtaining the "right" kinds of information, while maintaining their own cultural and familial beliefs and values about delaying dating and sexual relationships. I did not want to assume that in order to have sex, these young women must be in a romantic relationship, so I chose the phrasing of my questions carefully..

"Sexy" clothing and the condom machine: sexual health linked to identity and difference

Sexual health, to the participants, had to be talked about correctly and also was related to growing up, especially as a part of growing up in Canada. Related to these meanings was the way in which sexual health knowledge was linked to performances[1] of race, ethnicity, culture,

[1] According to Butler, performativity "must be understood not as a singular or deliberate "act" but, rather, as the reiterative and citational practice by which discourse produces the effect that it names" (1993: xii), meaning that it is not a conscious performance of her sexuality but rather her perspectives have been shaped through feminist discourses of empowerment.

sex, gender, age and sexuality. Gretah illustrated this especially well when she explained how learning about the concept of sexual health as a university student in Canada has shaped how she feels about expressing her sexuality. She used clothing as an example. She explained that back home in Rwanda, she would feel self-conscious if she wore a "sexy" outfit, which she described as clothes that would make her feel good about herself and desirable. But in Canada she did not feel this way. In her words,

> *"I was made to think that I'm not entitled to that, because if I do that, I'm gonna tempt another man to see, you know, someone will be lookin' at me and maybe desire me. And I would, I felt like I shouldn't be desiring people. Because it's not the right time yet. Now I feel like, yeah I'm entitled to that. I'm entitled to not feel guilty about my desires and my needs."*

In this narrative, her newly formed definition of sexual health—feeling good about yourself and not being ashamed of your female body—has shaped how she thinks about her sexuality as a young Rwandan woman living in Winnipeg.

Throughout other conversations I had with my interlocutors it became apparent that the sexual health discourses they encountered were not simply taken in and reproduced without negotiating other aspects of their identity and experiences, so that sexual health was entangled with age, gender, race, ethnicity, class, etc. A conversation with Candace and Semira regarding a condom dispenser in the girl's bathroom at school illustrates this point. When Semira brought up that *"they also like sell condoms in the bathroom"* while discussing the sexual health messages they collected, I clarified whether they mean the metal dispensers that sell both condoms and feminine hygiene products. After we established this was the case, Susan asked the girls if they

had seen anyone using it. Initially Semira hesitated but after Susan assured her that she didn't have to be specific about who has purchased them, Semira said that she has seen a couple of girls using it. I wanted to know if these other girls who were purchasing condoms were nonchalant or secretive about the process and Semira revealed that they didn't seem to care who saw them. Candace and Semira expressed that while they had no qualms about looking for sexual health information, they did find condoms for sale in the girl's bathroom in their high school to be a bit awkward.

In this sense the condom dispenser can be seen as a symbol of a stigmatized sexual health message that cannot be separated from the girls' cultural backgrounds, where pre-marital sex was forbidden. There is tension between a system that encourages youth to take an active role in maintaining their sexual health and the messages about abstinence they have received from their families about sex. It is clear from this narrative we cannot simply disentangle the different axes of identity upon receiving particular types of sexual health information and each of these young women will understand and respond to these messages in their own ways.

Constructions of youth: sexual health and "riskiness"

Now that I have provided examples of how different meanings of sexual health were expressed by the participants, namely, that sexual health knowledge must be proper or "correct" information (coming from authoritative sources such as sexual education in schools, public health funded documents and sexual health organizations), is a part of growing up in Canada, and cannot be separated from their identities, I want to show how sexual health discourses tended to construct youth (all youth) as risky subjects. On the one hand, as my interlocutors' narratives suggest there are particular, contested, and culturally embedded meanings attached to sexual

health messaging while, on the other hand, sexual health discourses categorize and universalize. While African youth I spoke with did not see themselves as "at-risk" for poor sexual health, they did see youth as a category where risks of pregnancy and disease were very high. In this section I show how this idea of sexually active youth as "at-risk" is one that my interlocutors completely accepted except that they distanced themselves from that discourse – it was other (Canadian-born, non-African) youth who fit the construction.

First I explain how I stumbled across this positioning of young people as "at-risk" in my fieldwork. As I began my volunteer work with newcomer youth and interacted with other volunteers, I learnt that young people, particularly those living in the downtown core, were increasing framed in terms of being "at-risk" and needing positive role models. At one organization, I noticed that the majority of volunteers were white university students in their early to mid-twenties; it was explained to us before we began volunteering that education students at the University of Winnipeg are given a choice of either taking an additional course or volunteering at one of the organizations located in the downtown core. I recognize that all of us have our own reasons for volunteering at these particular locales, and this includes my own rationale as a researcher. One of the volunteers spoke about how she had originally been teaching at the elementary level but recently had been switched to an alternative school, working with "at-risk" youth (grades 10 through 12). While she did not specifically mention the nationalities or cultural backgrounds of these youth to be African or newcomer, I believe that this further stigmatizes young people who attend school and/or live in the downtown core and therefore is reflective of dominant discourses that label them as "at-risk" and in need of help or guidance.

What I saw for myself while in the field was not surprising given what sexual health literature says about youth. Youth have been positioned as "biologically more vulnerable to

infections, more susceptible to peer pressure, developmentally more disposed to risk taking, and behaviourally often lack[ing] the skills and confidence to negotiate safer sex" (Flicker et. Al 2010: 112). Young people are also seen paradoxically as both risky (and in need of intervention) and also able to make "good decisions" if properly informed. An important insight from my research is that the participants did not specifically associate risk to their subjectivities as young newcomer women who have emigrated from various African countries, but they did to other youths' behaviours. I turn to some examples from my fieldwork and interviews.

The term "risk" was not one that they raised themselves; they framed their perspectives in terms of the potential for negative outcomes associated with having sex.. However, some of the young women I spoke with agreed when I asked them whether they thought particular groups were being signalled as "risky" in the context of sexual health education. In particular, Candace and Semira saw young people as being more "at-risk" for the negative consequences associated with sex. Candace described how she understood young people to react poorly to peer pressure and to be impulsive,

> *"A lot of the time, people see things on social media or like youtube or whatever. And then but like they want to try it. And then they don't care about what the risks are. So like the thing that they care about, like if someone tries, they have to too. It's like everyone, if one person tries, the other person has to try. Have to be like them, so they don't care what the risks are. Like they just want to do it and be equal like that."*

While Candace and Semira had not used the word "risk" until it was brought up in the interview, risk could be found implicitly in our conversations of sexual education, when they discussed the potential for negative consequences associated with having sex.

One way in which risk is implicit could be seen in how the participants talked about youthhood (adolescence) as a time for many changes. Dehab talked about the right age to begin educating young people about sexual health. She felt that having sexual education classes for youth in junior high was a good thing; she said that at this age, their surroundings and bodies are changing, they are in the process of growing up, and therefore this type of information will be important and help them in the future. She clarified that youth are not children, but not yet adults.

Several other participants, too, mentioned that youth are prone to making poor decisions. Yet always implied was that once they became adults and were educated this would change (and they would presumably make better decisions). Candace and Semira thought young people are "at-risk" in the context of sexual education because of the choices they make. They also described 'un-educated adults' as being "at-risk." In the context, we can draw from Semira's comments that people were not inherently risky but rather were in need of being informed about sexual health issues in order to "be safe." While they never explicitly described newcomers as being "at-risk," Semira expressed that she thought that it was helpful that there are programs in Winnipeg that educate newcomers on sexual health and HIV/AIDS because they might not have access to these types of information back home.

A discussion of how groups are labelled as "at-risk," in particular how some of the young women I spoke with saw young people and the un-educated, prompted a conversation about how having correct information could implicitly lessen a person's risk. This is representative of the sexual health messages circulating in Canada, which emphasize how "youth [are] expected to *apply* facts, knowledge and attitudes about risky behaviour within their everyday practices" (Shoveller and Johnson 2006: 51). An assumed linear pathway between knowledge and behaviour change has been prominent in the literature on sexual health and sexual education

(Kendall 2012). Semira implied that sex is something that one must plan and prepare for, namely by gathering all the information available on prevention, contraception, and consequences before entering a sexual relationship; she spoke about sex in the terms of preparedness and planning.

When discussing who could be seen as being "at-risk," Semira and Candace both felt that this predominantly included young people. As previously mentioned, they discussed the behaviour of non-African Canadian-born students who were engaging in sexual relationships, implicitly labelling them as impulsive and vulnerable to peer-pressure. Do the ways in which these particular girls received information on "risky" groups shape the way they see other young people as "at-risk" in the context of sexual health? Do they think about the risky, uneducated young person as the "Other?" Is this representative of how moral discourses creep into public health and sexual education? This line of analysis has been explored in the literature, specifically by Spencer who saw that when discussing risk, youth implicitly utilized Othering language, "serving to distance the Self from the risky Other" (Spencer 2013: 451). This process of Othering was shaped by the sexual health messages they received and led to their identification of risks associated with other young people's behaviour (Spencer 2013: 458).

"The sexually un-healthy and the not yet sexually un-healthy"

In the previous section, I showed how participants accepted the universalizing notion of youth as sexual actors who are impulsive and not capable of good choices with respect to sexual practices/ behaviours unless they have the proper information but also distanced themselves from such a notion. It was interesting, then, that while they did not see themselves at risk the same way as other groups of youth, they disagreed with the idea that some particular groups were more "at-risk" than others. What became apparent to me was how they saw sexual health as a relative

capacity, or on a continuum, rather than as one group at risk and other groups completely not at risk.

Dehab implicitly expressed that everyone can be considered "at-risk."[6] I asked Dehab to picture two people; one is "sexually healthy" and one is not. I then asked her to describe how these two people are different/similar in their behaviour, attitudes, or otherwise. After taking a moment to think about her answer, Dehab responded with a reversal of the question.. She asked me to picture a person who is HIV positive and a person who does not have HIV. In her explanation, the person who is living with HIV will be stressed, worried about spreading the infection and will have less freedom. Dehab clarified that the person who does not have HIV, while having more freedom, will still be conscious of the risk of contracting it and thinking about how they can protect themselves.

I believe that this narrative expresses the idea that while some people may be labelled as more "risky" than others, everyone is "at-risk" of the negative consequences of a sexual encounter. It is not so much that only some people are "at-risk," it is that some people are perceived as being *more* "at-risk." I think this idea is important because it hints at the pervasiveness of sexual health discourses concerning risk and, more importantly, the potential formation of a sexual health subjectivity that the youth were formulating. By sexual health subjectivity I refer to specific behaviours, attitudes emotions and anxieties surrounding the potential for the negative consequences associated with being sexually active and as a part of maintaining your sexual health, which I further expand on in the conclusion.

Here, I use the term "sexual health subjectivity" to think about how the idea of always being "at-risk" led to emotions and feelings that coincide with this new form of subjectivity. For

example, when talking about the kinds of messaging she would seek out if she were going to be sexually active, university student Cheyenne talked about how her mindset about sex changed after being in Canada. When she was living back home in Mauritius, young people talked about having sex. But when they talked about having sex there was no mention of disease prevention, testing, or the possibility of HIV/AIDS or STIs. As she explained, *"It's not even like, you don't think about diseases, but here you have to think about diseases."* Specifically, she spoke to the fact that when she came to Winnipeg and was living on residence, a common topic among Canadian students was sex. Cheyenne described how Canadian students all talked about different STIs, contracting certain infections and then getting treated; these conversations thus shaped her understanding of the prevalence of STIs in Canada, and subsequently led her to think about her own sexual health and the importance of getting tested for STIs and protecting herself from getting any STIs. She wanted to avoid becoming a "sexually un-healthy person."

While a dominant discourse of disease prevention in Canadian universities shaped Cheyenne's subjectivity, discourses around condoms as the key to "safer" sex were also influential. Feven and Cheyenne both felt it critical to use a condom the first time with a new partner, if they have not had an open conversation about their partner's sexual health history. However, Feven expressed that she probably would not have sex with that person if they did not have good communication; there was a pause after she stated this and then laughter. What our shared laughter points to is how having conversations with sexual partners about condom use were not always a given. Negotiation of sexual health discourses was not automatic because it demanded open communication and trust, power-laded social relations that are often left out of the equation in public health messages that stress condom use with all sexual contact. Again, a distinction was made between sexually healthy (able to communicate openly) and un-healthy

(not able to negotiate condom use through open communication). This distinction was even more apparent when Feven and Cheyenne offered reasons as to why young people might engage in a sexual act with another person even if there is a lack of communication. Cheyenne mentioned the possibility of being *"drunk"* while Feven implied that you might just *"need"* to have sex. However, she explained that if this happened, you would have a lot of stress and would feel the need to get tested. When I asked if this was something they thought about a lot, she replied, *"I always think about it. Even sometimes when I haven't done it [had sex], I'll still be like 'oh I should get tested just in case,' like you know. Just to check."* Cheyenne echoed this sentiment by emphasizing that it was something that was always on their minds, expressing, *"I think once you're sexually active you have to be, to check all the time."*

These last two quotes resonated with me. As a young Euro-Canadian heterosexual woman who has been in a monogamous relationship for six years, and having been sexually active since high school, what does it mean that I do not have this same mindset? I have surely encountered discourses that emphasize the importance placed on getting tested and practicing "safe sex" but I have not taken up these messages in a similar fashion, as I have never been tested at a clinic and have not even thought about getting tested in the past several years. Has my being in a long-term monogamous relationship affected how I think about sexual health and being "sexually healthy?" Similarly, since I am situated outside of the immigrant and newcomer networks, I may have not been exposed to the same sexual health discourses.

Another issue that bears some attention is the dominance of heterosexual sex within my discussions with these young women. While they only spoke about sex, relationships, and partners in terms of "boyfriends" and "guys," the majority of the messages that they came across in Canada concerned heterosexual sex in terms of reproduction and male condom usage. In the

context of sexual education and public health, how does this conflate being "sexually healthy" with being heterosexual? In a similar vein, how does this erase (or obscure) other forms of sexuality within a normative framework that constructs and constitutes "heterosexual privilege?" (Butler 1993: 126).

I started this chapter by raising the question, how do sexual health discourses shape the meanings of sex and sexuality for African newcomer teen girls and young women. What I hope is now clear is that one of the main messages they have received from their exposure to safer sex campaigns in the city, to sex education in the high schools, and conversations with fellow university students in a Canadian university is the ever-present warning about being "sexually healthy." The overwhelming emphasis on prevention, testing, and disease, produced anxiety and particular emotions around thoughts of sexual lives and of being sexual subjects, suggesting to me that pleasure and desire were not authorized and therefore sexual subjectivity was centered on biological disease-free healthiness.

Sexual health subjectivity

To conclude Chapter 3, I believe that through the conversations I had with my interlocutors I am able to discern an emergent sexual health subjectivity. Subjectivity is a term that has been contested and debated in the literature, however aligned with Sherry Ortner's definition, as encompassing "the ensemble of modes of perception, affect, thought, desire, and fear that animate acting subjects…as well [as] the cultural and social formations that shape, organize, and provoke those modes" of thought (2006: 107). It is in this context that I believe sexual health discourses (and the value these youth placed on them) work to shape how they see themselves as

sexual health subjects. Similarly, the idea that everyone is "at-risk" played a factor in how they understood and accepted these discourses.

Sexual health subjectivity can refer to the ways in which these particular women thought about and felt that maintaining their sexual health was an important part of their lives and the "right" thing to do, in accordance with bio-medical perspectives of sexual health. However, I do not wish to apply this concept wholesale, which would serve to homogenize my interlocutors' experiences and perspectives by reinforcing the idea that all African newcomer women would feel the same way about this subject. I also do not want to diminish the agency and choice they exercise in their lives.

In reflecting on my own experiences as a young Euro-Canadian woman, I realized that before I began this research many of my opinions on sex, sexual health, and sexual education were very similar to these young women.. When I was fresh out of high school, I believed that all young women needed to be in charge of their bodies, be "correctly" informed, get yearly physical exams, and embody the behaviours proscribed in "safer sex" discourses; all in alignment with neoliberal tenets of individualization and self-management. In my mind, in order to be "sexually healthy," I had to follow all the rules and guidelines. Now looking back on this time, I question how I came to hold such a strong position, and what did this position dismiss? How does a narrow vision of what being "sexually healthy" entails erase other ways of thinking about sexual health and sex?

Chapter 4 – A Landscape of Sexual Health Discourses in Canada: Sexual Freedom, Teen Sex, and Teen Pregnancies

Through conversations with my interlocutors, participant observation, and the messages shown to me by the participants, it became clear that sexual health messaging is not a simple and singular discourse but rather a complex landscape, within a diverse set of contexts and involving innumerable actors. As I described in the previous chapter, the participants encountered messages in formal settings including high school health classes and university orientations, as well as through informal conversations with friends and relatives. As they brought particular messages to my attention (through their participation in ethnographic interviews as well as their "everyday sexual health discourses activity"), in conversation with them I found out that some discourses were empowering, others served to Other, and still others were implicit or explicit, in other words, a myriad of discourses rather than a singular message.

My methodology included engagement with community members where I discussed my provisional interpretations and analysis with them and they had opportunities to add theirs. This methodology allowed me to learn that the influence of sexual health messages on African youth was not a straight-forward process that operates from the top-down: Each of my participants had encountered sexual health messaging, both pre- and post-immigration, in various spaces and contexts. What became clear was how Canadian culture was understood through a framework of freedom, and this sense of freedom was thoroughly entangled in emergent ideas about dating, gender and (human) rights. The main purpose of this chapter is to show, through their perspectives, how these entangled ideas about freedom, dating, gender, and rights, fit into a complex landscape of sexual health discourses, a landscape that included lessons from home as well as education and workshops in Canada. Also, I show that teen sex and teen pregnancies

were related discourses that were salient in African contexts compared to the STI and HIV messages in Canadian contexts.

Perceptions of "Canadian culture:" encountering messages from all angles

It became apparent through the multiple discussions I had with these young women that their perceptions of "Canadian culture" and Canada as a nation have come to shape how they understand their own sexual health in the context of rights, responsibilities, gender, expression and "freedom." This has caused me to question, how do they understand Canadian culture? The teen girls and young women expressed how the idea of "Canadian culture" has become inextricably linked in their minds with freedom/s; freedom of expression, spatial freedom, and sexual freedom. While I do not want to minimize their agency, I am reminded of how Butler discusses the ways in which all choices are structured by discourse, namely by providing a cultural context that makes particular choices possible (1993: 2). Even in the context of sexual health, which has been couched in the tenets of neoliberalism (individualization, responsiblization, self-management), this proliferation of messages does not intend for a sexual free for all, but rather "specify which forms of sexual behaviour among young people will be considered as ideal" (Shoveller and Johnson 2006: 57).

To gain an understanding of how these young women understood "Canadian culture" in comparison to their own cultural background, I asked them to think back to when they first arrived in Canada, to remember what it was like, and whether they noticed any major differences or similarities, and if anything surprised them. Dehab expressed that her Eritrean culture was *"very, very different"* from what she thought of as Canadian culture. "Canadian students," in her view, exercise considerable freedom. People are free to publicly express affection and intimacy.

She was shocked to see young people engaged in open displays of affection, such as kissing and hugging, in the streets. When I asked her what she thought about this, she explained that while having freedom in general was good, young people might have *"too much freedom"* and they did not focus on their studies enough. "Too much freedom," in the context of romantic/sexual relationships, can lead to negative outcomes; this was reiterated in more than one discussion, specifically the idea that engaging in these kinds of relationships would become a distraction. Candace expressed that her mother took up this position and would like her to wait until she has at least completed high school before she begins dating. She said,

> *"It's like, like most of the time when she was back home, if you were dating someone, you were probably going to get married. But she might think that it's going to stop me from doing my school stuff. So like, you have to finish high school."*

Another poignant example of the perception that Canadian culture is defined by freedom, and in particular sexual freedom comes from an early interview in my fieldwork with Haben, an 18-year-old Eritrean woman who has been living in Canada for several years.[7] During our interview, her mother had called a few times, causing her to have to exit the room to take the phone call. When she came back after the last phone call, Haben explained that her mother is constantly asking her questions and calling her many times a day, wanting to know where she was and who was with. She explained that her mother worries a lot about her and sometimes she went out without telling her. Haben juxtaposed this story with how she will always call her father, who is living and working in Alberta, to ask permission to go out with her friends. She explained that she had not gone out to any clubs in Winnipeg and was not allowed to go to "Habasha places" at night.[8] Haben explained that her mother thought she would get into trouble if she went out all the time.

Haben linked "Canadian culture" with the idea of sexual and spatial freedom. By spatial freedom, I mean the ability to move freely throughout the city without limitations or consequences. During a discussion of the differences in how her parents think of dating and relationships compared to what the younger generation thought, she explained,

> *"Our parents have changed too, cause they can see we can do whatever we want especially in this country, they do let us do whatever we want. But uhh I'm just talking about maturity. No offense, but kids in Canada, in this age, they're crazy. All of them, or most of them I can say aren't even virgin or anything."*

Yet, although Haben criticized Canadian youth for their sexual practices, she also sometimes wished she was part of "Canadian culture" so that she would be able to *"do a lot of stuff."* The ways in which Haben thinks about the possibility of dating, or having a sexual relationship at a young age, have been influenced by her settlement in Canada.

Many of the participants' narratives point to the idea that how "Canadian culture" is understood and presented to newcomer families affects them differently; some felt that their parents had changed since they had been living in Canada while others saw their parent(s) holding onto their cultural/ethnic values. Feven made a point of emphasizing multiple times throughout our meetings that she thought her mother had become "more open" since they came to Canada.

However, when discussing the relative "openness" of Canadian culture, I would also point out that there are many families in Canada who would not fit into this category. While I would consider my own family background to be fairly open to ideas of gender equality, rights, sexual freedom, there are still many issues that I would not speak to my parents about, either due

to the uncomfortable nature of the subject or because I know it will initiate an argument. I have also been reflecting on the idea of "openness" and whether these discourses simply represent an ideal notion of what society should be like: What does this say about nations that are not considered "open" by these standards?

Openness and sexual relations

The perception that Canada and Canadians were relatively "open" translated to contested ideas and rules about sexual relations, such as the appropriate age to begin dating or sexual relationship, number of partners, and race and ethnicity of permissible partners (see Frohlick 2011). Heterosexuality was the implicit norm. Some expressed that they did not want to engage in any form of relationship until they were finished high school or university. Haben stated that while she was open to dating now, she drew the line at a sexual relationship. She would only have sex (and by this she specifically referred to "losing her virginity") with a man she planned on marrying. This rule contrasted to how she saw "Canadian kids" as prone to "sleeping around" while they were in high school. Some of the girls linked multiple sexual partners (that is, being involved in concurrent sexual relationships) with increased risk, believing that your sexual health depended on limiting the number of sexual partners. While some, like Haben, desired to have more freedom in mobility through the city, they did not feel that they were pressured by Canadian norms such as the "promiscuity" of high school students to start sexual relations before they were ready.

Navigating and negotiating "Canadian" sexual culture

Each participant I spoke with had different experiences and their families, too, had distinctive positions on issues such as dating, sex, and relationships. This suggests the complex and

contingent ways in which they have navigated, negotiated, and re-negotiated the idea of "Canadian culture." By emphasizing the diversity of perspectives these women held and by teasing out the particularities of each of my interlocutors' experiences, I am also trying to problematize homogenizing discourses that utilize the broad category of "African." These young women came from varying countries, including Eritrea, Ethiopia, Kenya, Sudan, Rwanda, and Mauritius, and, therefore, their perspectives should be particularized rather than reproduce the notion of "African" as an essential identity or selfhood.

Rules about romantic partners that might seem to be fixed as pan-African or as ethnic turned out to be relatively diverse. For instance, when I asked Dehab, an 18 year old woman from Eritrea and in Canada for only one year, if her parents had any rules about who she could date and what they thought of her dating someone from another ethnic background or religion, she said that she was free to date whomever she wants. Her parents had communicated to her what makes a "healthy relationship," strongly emphasizing compatibility and values. Weyni, an Ethiopian peer-research on the project at the time, was translating this particular interview. She was surprised when Dehab stated that her parents would not mind if she dated a man from outside of the Eritrean community with a different cultural, ethnic, or religious background. Weyni argued that this perspective was not very common. Probing further, after finding out they belonged to a "younger generation" Weyni concluded that their views were unconventional for Eritrean families.

Dehab was not the only participant to agree with border crossing as a possibility in Canada. Candace felt that she wouldn't rule out dating a guy who wasn't Ethiopian, as long as she liked him, he respected her, and he respected her culture. On the other hand, Semira thought

it would probably be easier to date someone from her own background because they would share common values and beliefs.

While Feven said that it would be very difficult to marry someone who was not Eritrean (or Habasha), she felt that her mother would be more accepting of her doing so than her male relatives. Still yet, Cheyenne, who is from Mauritius, stated that her parents would love if she ended up with a "Canadian guy," explaining that a "multicultural" relationship would be prized.

Dating might be one thing but sexual activity was another. Candace believed that if she were talk to her mother about starting a sexual relationship, she would respond practically. Her mother might try to persuade her from having sex but would ultimately give her advice by telling her to be safe. According to Semira, the act of dating was not considered "risky" in and of itself but talking about it with people of an older generation was, explaining,*"Well, you can date. Like you just have to be careful, like make smart choices. It's up to you, there's no one that would you not to do it but like they prefer if you wouldn't. Like just so you can be safe."*

According to Semira, speaking about potential relationships with older family members was not common. Her parents had never explicitly talked to her about dating or sex. They wouldn't encourage it. Religion plays a large role in her life, as she spends weekends attending a youth group at church. During a particular interview, Susan asked if the pastor or youth group leader at their churches would ever talk to them about sex, either by promoting safe sex or in cautioning them not to have sex entirely. Semira and Candace shared nervous glances and then burst out laughing. Their reaction suggested that this line of questioning was unfathomable. Susan asked them if this was a silly question and Semira explained that in this religious context, because young people were not permitted to have sex before marriage..

While these young women had not explicitly talked with their parents or other adults in their community about relationships, I wondered if they ever talked about dating or sex with other relatives, such as siblings or cousins. Semira's older female cousin had spoken with her on the subject, telling her that if she was going to have sex, that there are ways to protect yourself and to "be safe." Candace said that an older female cousin had also given her advice. However, she has impressed upon Candace that it wasn't the right time for her and that she shouldn't do it, specifically asking her to think about the potential consequences of having sex (such as pregnancy). It was at this point in the interview she revealed that her father, who was still living in Ethiopia, had given her some advice since she had come to live with her mother in Canada, explaining, *"Well he told me like since I live here and it's like more open and that kind of stuff, just to be safe. Just like well you have to know what's good for you."*

Cheyenne and Feven also talk about what kinds of messages they had heard from their families, particularly about dating, sex, and relationships. Cheyenne expressed that her mother, who is still living in Mauritius, is very open, which Cheyenne credited this in part to her grandmother's upbringing. Her grandmother was divorced and had raised her children as a single parent, subsequently developing a strong feminist perspective. Cheyenne believes this is the reason her mother does not want her to get married. When I asked her if she had ever talked about sexual health issues at home, she explained that she had always felt free to ask her parents questions about sex when she was growing up. However, her mother did not particularly like to talk about sex, so it was not a frequent topic of conversation and usually resulted in Cheynne going to the library to find more information. She juxtaposed this with how her mother and younger brother had a very close relationship where they shared everything (including his sex

life). She surmised that because she and her mother were not as close, they did not feel open to talk about Cheyenne's sexual relationships.

Some participants felt that coming to Canada has shaped their parents' perspectives on life. Feven thought her mother has changed a great deal since they've been living in Canada, frequently describing her as *"open."* When I inquired as to what she meant by this, Feven explained that while her mother does not directly talk to her about her sex life her mother now feels free to talk about sex with her friends in front of Feven (which she would have never done before). I wanted to know if there were any differences in how her mother would speak about sex and relationships with Feven and her younger brother. One big difference was that her mother had given her brother the "sex talk" when he was 17 (and she was 21); Even though she was older by four years, her mother never gave her a "sex talk" of her own. The salient role of gender in these young women's experiences and perspectives of dating, sex, and sexuality will be explored below.

Openness and gender equality

The perceived openness of "Canadian culture," linked to ideas of "freedom," was also talked about in terms of gender equality. Some participants spoke about how women have increased freedom (in the context of rights) in Canada, but expressed this in different ways. Equality between men and women was a topic these participants spoke about. The role of gender was expressed in the context of women's everyday lives, dating, and sexuality.

Dehab believed that women have increased equality in Canada compared to Eritrea and Sudan, as Canada that has provided them with more opportunities to advance professionally. However, she also pointed out that women in Canada can also face oppression. Dehab said that

even though women can be marginalized or abused in Canada, there is a system in place to deal with these matters, which opens up a space for women to have their voices heard. This was echoed in a comment from Cheyenne, about how much she appreciated the rules and regulations within that Canada has so many rules and guidelines. She explained that if there was any kind of problem, there would be information and personnel available to deal with it. She contrasted this with her experiences in Mauritius, where offices will be shut down for long periods of time or they will not have any protocol to follow, making it impossible to find solutions to problems.

Discussions of gender equality with these young women were not limited to official systems of power, they also fit into the realm of dating and relationships. A comment by Feven pointed to the ways in which being in Canada has changed how she thought men should behave in a relationship. She spoke about how "African guys," specifically those who came from rural areas, can be controlling. After hearing this, Cheyenne laughed and agreed while stating that she would not put up with that kind of behaviour. Feven felt that there is more equality between men and women in Canada opposed to back home. However, Feven and Cheyenne also recognized the ways in which some women in Canada are still oppressed despite the official discourses circulated that claim equality has been reached.

The idea that women have greater equality and can assert their rights in Canada was reiterated by Gretah, although in a different context. Gretah felt that coming to Canada has changed how she thinks about and expresses her sexuality as a woman; she has gained access to new information, including feminist writings, and spoke about the increased freedom she felt here. Her parents were very strict in Rwanda and therefore she felt "suffocated" because she was not allowed to go out at night with her friends. Her previous narrative about dressing "sexy," in Chapter 3, brought up specific themes related to sexual freedom and rights. She heavily credited

her education in Canada opening up new ways of thinking about herself as a woman and changing how she felt about her sexuality and body. She stated,

> *"Until I got here, and now I feel like yeah I'm entitled to that, I'm entitled to not feel guilty about my desires and my needs and what I want. And if I'm in a relationship with a guy and I don't want to do something, he does not have to make me do it. And if I want something, I can ask for it."*

Gretah felt discourses of empowerment circulating in Canada and her exposure to feminism changed how she viewed sexual relationships. These particular narratives suggest that coming to Canada has shaped understandings of gender equality in a framework of human and sexual rights, and spans the realm of their experiences from careers, to relationships and sexuality.

Perceptions of sexual health education in Canadian schools

Even though these participants encompassed a wide range of ages (from fifteen to twenty-five), each one of them had occasion to deal with institutional settings that offered information on sexual health. For the girls in high school, sexual health was largely defined by the Manitoban public school system's sexual education curriculum. Similarly, many of the sexual health discourses they took up can be found in this institutionalized setting. Candace and Semira had taken health classes as a part of their physical education credit, while Dehab took part in a "safer sex" workshop, offered by her school. Candace explained that taking physical education, and therefore health class, is mandatory, saying, *"Well, we have to take it. If you want to graduate you have to take it."*

The positioning of sexual education as mandatory held a central place in the wider landscape of sexual health discourses that the participants were exposed to and sought out. The sexual education programs and curriculum content in the particular high schools that the young women attended varied; however, like many programs in the North American school settings they predominantly focused on the prevention of negative outcomes associated with teen sex (Bay-Cheng 2003; Fitzpatrick and Tinning 2014). According to the high school students who participated in my study, common topics were anatomy and contraception, along with information on STIs, HIV/AIDS, and pregnancy. Risk was something that teachers spoke about frequently, specifically in the context of sexually transmitted infections. Semira recalled that they had talked about the STI-related risks in health class, *"Like with the STIs they do tell you that there are some risks that could happen because some aren't curable, there's no treatment for them. Like there are risks."*

Dehab had only been in Canada for several months at the time of our first interview, so she had not taken any formal health classes yet.. However, in this relatively short span of time, she had already participated in a "safer sex" workshop organized by the school. She described these sessions as *"student-driven,"* covering topics such as relationships, love, protection, and pregnancy. I will elaborate on the specifics of this workshop in the following chapter.

Cheyenne and Feven have not taken any formal sexual education either, since they arrived in Canada after high school. However, they spoke about the sexual health information and resources (such as condoms, pads, tampons and pamphlets) that were available to them on the university campus. They pointed out that they saw a lot of sexual health messaging at this locale, in the form of university groups, information booths, and a centre for women. Cheyenne believed that the reason they were encountering so many of these types of messages was due to

the fact that they were university students. This can point to the formalized and institutional nature of sexual health in Canada. Both women commented on the accessibility of sexual health information they found in Canada, and when I asked how they first found out about these issues, Cheyenne explained, *"Every international student they have their own orientation. So we get, we learn about the weather, how to be protected, and walk-in clinics is, it's free. How to get to walk-in clinics and stuff."*

The majority of the participants encountered sexual health messaging in a school-based setting, but not all of the young women I spoke with encountered the same degree of information and education. Even though she is an international student, Gretah expressed that since she has come to Canada, it was not traditional public health messages that shaped how she came to define sexual health, but rather feminist and theoretical writings that impacted how she saw her own sexual subjectivity.

These individual accounts of the sexual health information and education they encountered, received, or participated in once they were living in Canada reflect a heterogeneity. While these types of information were disseminated in different ways (formal health classes, workshops, university orientations, and information booths), the topics communicated appeared to be very similar. According to the participants, the messages mainly focused on prevention, pregnancy, contraception, and the risks associated with sex. The dominant discourses found in these messages played a central role in how these young women came to understand sexual health in Canada. These discourses can also be understood as privileging heterosexuality, and therefore constructing a dominant sexuality. This heterosexual privilege is constituted and reconstituted through normalizing discourses that position heterosexuality as *unmarked,* and effectively mark sexual identities that do not "conform" to heterosexuality.

Sexual health education in African countries of origin

While the sexual health education that they came across as immigrants and international students new to Canada formed a central aspect of what I call complex sexual health landscapes, the education or messaging about sexual health they received in their home countries was very important as well to understanding how their perceptions of sex and sexuality have subsequently been shaped. Participants had unique migratory trajectories, different educational pathways, and different perspectives on these experiences, which I briefly describe here.

Although Eritrean, Semira and Feven were both born and raised in Kenya before coming to Canada. Semira was 11 at the time of emigration while Feven was 19. Semira and Feven described learning about sexual education in the context of science class, where they learnt about body parts and eventually about prevention of STIs and HIV/AIDS. However, they both spoke about how the teachers did not go into great detail and provided the basics, in comparison to how these subjects are talked about in Canada. As Semira explained, "*They just kinda cover it up.*" Another Eritrean woman, Dehab, was born in Eritrea and spent two years in the Sudan before immigrating to Canada at the age of 17. Dehab had begun taking sexual education in the seventh grade, where they learned about what was going on with their bodies.. When I asked if she had received any sexual education or had any experiences related to sexual health in the Sudan, she shook her head. A peer-researcher, Winta, was also present at this time; she gave me a puzzled look and stated that the Sudan was a Muslim country. She said that she *"doubt[ed] that would be on their agenda"*, clarifying that she could be wrong but did not think teachers in the Sudan would talk about these things.

From Mauritius, Cheyenne moved to Canada when she was 19. She had learned about STIs in school but not in great detail. She had heard about three infections back home—HIV, gonorrhea and syphilis. However, once the rate of pregnancies and STIs began to rise among middle school-aged youth, there was more information being taught in the schools. Cheyenne talked about how there were other spaces, outside of a formal school-based setting, where information on sexual health was given. She specifically mentioned a community centre where meetings were held to discuss how they could prevent the spread of STIs and HIV/AIDS, for which she credited the creation of these sessions to the rise of sex work and intravenous drug use in the area.

But not all of them had been exposed to the same level of sex education in their countries of origin. For Candace in Ethiopia they did not teach anything beyond the biological aspects of sex for reproduction; the teachers felt that teaching sexual education to young people (including the specifics of contraception) would lead them to engage in sexual activity. In her words, *"back home they're not open, they think if they're going to tell you, then you're gonna do it."* The idea that taking sexual education will encourage young people to have sex, in their countries of origin, was a common theme for participants.

These different experiences of sexual education, both in Canada and before, show the complex landscape of information that each participant faced. By looking at their prior encounters with sexual health information before they migrated to Canada or came on student visas, the complexity of messaging becomes apparent, and also suggests that prior exposure to sexual health discourses will also shape their perspectives on the sexual health discourses prevalent in Canada.

"Teen Sex," fear-based messages, and dominant discourses

Within this complex landscape, I want to draw attention to a particularly troubling discourse, present in both the Canadian and African contexts. That discourse, which I refer to as "teen sex," is one that denigrates the sexual practices of teenagers. Of my interlocutors' that are currently attending high school, "teen sex" was frequently talked about in terms of the potential for negative consequences. In this context, risk, fear-based messages and universalized notions of youth are utilized to communicate the dangers of teen sex. I found through examining their narratives that these discursive practices largely viewed young people as prone to poor decision-making, subject to peer-pressure, and not thinking about the long-term consequences of their actions.

These dominant discourses can also be found in the "safer sex" workshop Dehab attended in Winnipeg. She told me that there was an anonymous question box where students could ask questions and receive responses from the workshop. She emphasized gender-segregating of the workshop provided a better atmosphere for sharing because there was *"no reason to be shy"* or feel ashamed. It was clear from her comments that having a safe space where young women could talk freely about issues related to sex, sexual health, and relationships without feeling embarrassed or judged was critical to their ability to share their experiences and ask questions. However, the gender-segregation of these workshops has specific implications for the assumption of heterosexuality. The structure of these events involves the promotion of a heterosexual subjectivity, through their organization and the messages communicated. These workshops can thus be viewed as a pedagogical site, where norms are implicitly communicated and, I contend, are contributing to the idea of what being "sexually healthy" looks like.

Dehab described a scenario where during the question period, a friend had asked for advice to give her sister on how to deal with an older boyfriend who was pressuring her to have sex. The sister was 16 and the boyfriend was 18. The teacher responded by instructing the girl to tell her sister that she should voice her concerns to the boyfriend, and if he insists on having sex she should leave him because he is not respecting her. The teacher also emphasized that she should wait if she was not ready, juxtaposing this with an implicit warning by telling a story about a girl who had sex at a young age, got pregnant, and had to drop out of high school.

On the surface, this "safer sex" workshop purports itself to be an empowering and "student driven" way of learning about sexual health, one in which these young girls are able to freely ask questions without being embarrassed. However, the teacher's reaction to the particular question asked by Dehab's friend demonstrates how moralizing and fear-based discourses creep in a Canadian sexual education setting.

The discourses surrounding "teen pregnancy" can also be found in some of my interlocutors' experiences back home, in their countries of origin. Cheyenne, Feven and Gretah all expressed the shame and stigma which would occur when a girl became pregnant at a young age, in Mauritius, Kenya, and Rwanda, respectively. Feven explained that the consequences of becoming pregnant are much harsher for the girl than for the boy. While the boy could deny he was the father, the girl's family would have to take care of her during the pregnancy and afterwards. In many cases, the girl would not be allowed to back to school afterwards, and her family would feel a great deal of shame about the situation.

Sexual education in schools was not the only space where these types of messages were communicated. The teen girls that I interviewed encountered messages from multiple sources,

including TV shows and their families. Many of these discourses strongly implicated the perils of teen sex and engaging in a sexual relationship before having the skills to negotiate said relationship. The is reflective of the idea that upon turning 18 and becoming an "adult," you will suddenly possess the relevant knowledge and skills. However, young people are still labelled as "risky" in the context of sexual health.

As I explained in Chapter 3, Candace described how her mother would use the television show "Teen Mom" to indirectly express her disapproval of the girls' choices; the implicit message was that teenage sex will lead to pregnancy and negative consequences. She described the awkwardness of the scenario, saying

> *"One time she was home and she was looking at it and she just randomly called me. At first I knew she was watching that one and I said 'hi', and just like went to my room. So she called me and she wanted to know when this show, when they are showing it and that kind of stuff. And then yeah, she don't say directly to me, but just look what's gona happen, their lives, people having a child at this age. Then you don't go to school, you have to take care of the child or something."*

This scenario involved not only the messages she received from the show but also her mother's indirect advice. These negative consequences of having sex were understood by Candace as not being possibilities, but rather inevitabilities. In a subsequent interview, I revisited this subject. I asked Candace and Semira what kinds of messages they thought these shows ("Teen Moms" and "16 and Pregnant") were trying to communicate to young people: Are they warnings? Are they meant to raise awareness? Or what? Semira felt that the main message they were getting from these reality shows was *"don't do it,"* with the "it" in this case being "have

sex." Candace importantly noted that while these shows do not outright say "if you have sex, this will happen to you," she felt that it strongly communicated that this would be the result and therefore would deter young people from having sex because they do not want to struggle and lose their freedom with the responsibilities of a child.

Discourses that position "teen sex" predominantly in terms of prevention and consequences can be found in a discussion with Candace and Semira, for which Susan was present. She asked them to list their top three worries about having sex. I believe that the question was misinterpreted because we had just finished talking about the previously mentioned television shows. Candace and Semira went on to list the consequences of becoming pregnant (financial issues, the interruption of your education, and *"no more freedom"*). Afterwards Susan clarified that their concern was not with contracting STIs (or HIV) so much, but rather the main worry of having sex was the risk of getting pregnant.

I felt that this line of questioning was productive because it allowed us, as researchers, to understand how sex had become a "worry" to these young women and how dominant discourses may have very well shaped these concerns. When I asked Cheyenne and Feven this question, both of them felt that while pregnancy was the predominant worry of having (unprotected) sex, STIs and HIV/AIDS came in at a close second. Cheyenne emphasized that her parents', and especially her mother's, main concern with her having sex was that she might get pregnant. A tee shirt of her brother's that said "make love, not babies," given to him by their mother, accentuated the risk of sex with childbearing and early parenting.. This preoccupation with the possibility of becoming pregnant has been discussed in the literature, wherein "young people's main preventive concern in relation to sexual activity was avoiding unplanned pregnancies (rather than preventing HIV/AIDS)" (Graffigna and Olson 2009: 797).

When asked to talk about her main worries associated with having sex, Dehab was the only one who differentiated between having sex with a partner versus a "one night stand." The latter made her worried about STIs. This is indicative of the dominant discourse, such as public health literature in Canada, that having sexual relations with multiple partners (or outside of a monogamous relationship) can lead to an increased numerical risk of sexually transmitted infections. This demonstrates how bio-medical and clinical approaches to sexual health obfuscate the moral undertones of said messages. Public health discourses that discouraged having multiple partners and link multiple partners to increased sexual risks can be found to influence how Cheyenne felt that limiting the number of sexual partners was essential to her sexual health.

These particular sexual health discourses that marginalized "teen sex," "teen pregnancy" and having multiple partners shaped how these particular young women paid attention to and utilized this information in their own experiences and perceptions of dating, sex, and sexuality. In particular, I underscore how dominant discourses stigmatize multiple partners.

Landscapes of sexual health discourses

When looking at newcomer youth in Canada from African countries and how sexual health discourses shape their perceptions of sex and sexuality, it is clear that their experiences and encounters with sexual health education both pre- and post-settlement are important. Perceptions of Canada as "open" and encountering norms of dating and sexuality in a western country are negotiated through and stem from particular backgrounds. In this chapter, I have shown how these ideas have become entangled to form a complex landscape of sexual health discourses which my interlocutors are navigating, negotiating and re-negotiating.

In other words, I suggest that there is no singular source of information operating from the top-down in the lives of African newcomer young women; rather, they experience messages and discourses from innumerable angles and mediums. As my research shows, these discourses came from different sources, including school, university, friends, family members, and social as well as conventional media. Each person integrated messages in their own lives in different ways, according to many different factors. For example, their individual family dynamics and their migration paths played a role in how these messages were taken up or resisted; some participants came to Canada with their families while others are international students living on their own. In this chapter I have illustrate how participants encountered messages about sexual health, dating, and sex, forming their own perspectives based on not only institutional information but also advice from family and friends. This was done in order to both contextualize and broaden the exploration of their experiences and perspectives.

Chapter 5 – Presentation Counts: How Sexual Health is Talked About

It became apparent over the course of my fieldwork that the way in which sexual health information is presented and is talked about shaped these particular young women's perceptions and experiences of sex and sexuality. The ways in which sexual health information is disseminated involves specific milieus that are embedded in complex power systems that seek to purport a particular idea of how it should be talked about and adopted in a Canadian context. The main purpose of this chapter is to explore how this contributes to the building of a "sexually healthy" nation, namely through the production of biological citizens.

According to Anderson, the "nation" is a cultural artefact, a socio-cultural concept, and an ideology (1983: 48-49). Such a notion challenges the idea of the nation as a taken-for-granted place or entity. Similarly, by defining the nation as "an imagined political community" (Anderson 1983: 49), we are better able to see how it has been constructed through particular and dominant discourses of race, class, gender and sexuality (McClintock 2013; Yuval-Davis 1996; King 2010; Sawicki 1991). In examining how ideas of health and the nation have become entangled, it is critical to question the role of immigration in the production of "biological citizens," specifically in the context of sexual health. First, we must acknowledge that "immigration is a central site through which national communities are institutionally imagined and materially constructed" (Vukov 2003: 335). In the Canadian context, immigration has played a large role in its development as a settler nation, thus leading to discourses pertaining to "desirable" and "undesirable" immigrants (Vukov 2003: 336). It is in this vein that we can explore the "population" as a governmental construct that is entangled with the idea of an ideal nation, and thus population becomes a biological and political problem (Vukov 2003: 337), placing increasing importance attaining "optimal" and thus concerned with producing "sexually

healthy" citizens. What does it mean that these young women felt that sexual health messages (and their subsequent discourses) were aimed at all citizens? Does this point to a one-size-fits-all approach, aimed at the production of a "unified national project" comprised of "sexually healthy citizens?"

Sexual health messages are "everywhere" and "nowhere:" Importance of setting

This section will discuss the prominent perception that sexual health information is simultaneously "everywhere" and "nowhere." I will focus on key examples from the sexual health messages these participants "collected" to demonstrate how the power these messages hold is connected to their location.

The idea that sexual health messages were both common and hard to find came out as my time in the field was winding down and I was finishing the last of my interviews after I had gone through the research activity with my interlocutors several times. While my thesis supervisor and I had discussed the particulars of this research activity, it did not unfold in practice as we had anticipated. Initially we had hoped that each of the participants would bring in physical documents (or images of messages) to the final interview in order to make the activity more visually based. This was not the case with the majority of the young woman who participated in the activity. At first this was perplexing because we had heard, numerous times, that they felt there was a lot more information on sexual health in Canada than in their respective countries of origin. In some of the participant's perspectives, this lack of public sexual health messaging might be linked to the assumption that everyone is Canada is aware of sexual health issues and how to prevent/treat them, including HIV and STIs.

Many of the young women expressed that these messages were hard to find in their daily routine, and the ones that they did "collect" were found in specific locales (a high school hallway, a bus shelter, and the internet). Two participants, Cheyenne and Feven, were particularly shocked to discover how difficult it was to access messaging because they thought it would be easy to find sexual health messages in Winnipeg. I, too, expected them to come with all types of sexual health messages because they had initially stated that there was a lot of sexual health information in Canada, and that these messages were *"everywhere."* When I asked them about what kinds of messages they had brought into the interview, they looked at each other, chuckled, and said that they couldn't really find any messages aside from one poster on a bus shelter which promoted condom usage to prevent STIs.

This nervous laughter was also apparent in my final interview with the youngest of my participants, Candace and Semira. However, they did find a couple of sexual health messages in their high school, located near the gym and in the main hallway outside the guidance counsellor's office. To the girls, these posters communicated to them that they needed to "be safe," and that there were clinics and help they could seek without their parent's permission or involvement. Semira felt that these posters were communicating that sexual infections/diseases were easy to contract and that they were contagious, so it was important to use a condom and be aware of them. When Susan asked about the significance of where these posters were located, the girls felt that the gym made sense because that is where they had health class (and talked about sexual health). As far as the other location, they did not draw a connection between having these kinds of messages near a counsellor's office, but rather focused on their accessibility/visibility in the main hallway. By situating these particular messages, which target

youth, in a high school, the meaning of their circulation was readily apparent; young people need to be aware of the risks associated with sex and how to manage them.

These types of messages were not limited to high schools, but could also be found in the downtown core of Winnipeg. Candace, Semira, Cheyenne, and Feven all mentioned a particular poster seen in a bus shelter. This message was a part of a public health campaign entitled "Heads up?! Use a Condom" which was designed and promoted by the Winnipeg Regional Health Authority (WRHA). I went on the WRHA website (www.wrha.mb.ca) to see if there was any more information on these campaigns. An informational PDF was available, explaining the issue that a recent rise in STIs among young people in Winnipeg had spurred the development of this campaign, how the information is being disseminated (posters, movie advertisements, and social media), and asking for promotional help. This poster features an image of a condom being vertically pulled over the word CHLAMYDIA, with the caption "Protect yourself from what you can't see." This campaign is directed at youth and used the fear of contracting an STI to encourage condom usage.

The use of fear-based messages in the promotion of sexual health has been examined (Lupton 2014; Gagnon et al 2010). In particular, disgust has been used to "persuade members of their target audiences to change their behaviour in the interests of their health" (Lupton 2014: 1). This can be seen in the "Heads up?!" campaign that targets young people, specifically in the way this poster warns them that if they don't take steps to protect themselves, their having sex can lead to negative consequences such as STIs. Subsequently there was has been a "widespread, unexamined agreement that if a public health issue is at stake, then it is appropriate to use confronting tactics" (2014: 5). The social marketing and development of sexual health campaigns is becoming increasingly popular, wherein "a program-planning process that applies

commercial marketing concepts and techniques to promote voluntary behaviour change" are used (Gagnon et al 2010: 254). These types of public health campaigns actively contribute to the idea of biological citizenship, through the production of "sexually healthy" individuals, encompassing behaviours and attitudes that would encourage youth to self-manage the risks of sex.

Many participants, found it challenging to find sexual health messages outside of particular locales. The location of messages and who they target can tell us as much as the content. High school was a prominent source of sexual health messages. I argue that this speaks to the ways in which young people have been targeted for messaging that portrays sex as "risky" and encourages particular behaviours that would create "sexually healthy bio-citizens.," which I further explain below.

The Internet: Seeking out "expert" messages

It became clear that the internet was a popular and, in participants' minds, useful source of information on sexual health. This should not be surprising since we live in a time where using the internet to find out any kind of information is the norm. Other scholars have documented the widespread occurrence of young people utilizing the internet to obtain health information (Gray et al 2005; In this section I will focus on two key examples of seeking out seemingly expert information by visiting the websites of sexual health organizations and situate them in a Canadian context.

When Candace and Semira were having a hard time finding sexual health messages during the course of their daily routine, they explained that they had "searched it up" by googling "sexual health awareness in Winnipeg;" this phrase popped up immediately after they had typed

in “sexual health.” The first site they found spoke about programming for immigrants and refugees that would educate them on STIs, as well as information on an Aboriginal AIDS awareness day. They could not remember the name of the website but they told us that it listed places where you could go for information and was presented in different languages. Susan and I wondered (out loud) whether this could have been SERC (Sexuality Education Resource Centre). Semira believed that having programs that will educate newcomers to Canada about sexual health issues was a good thing. Semira’s perception of this website resonates with the idea that in order for individuals to become “good bio-citizens,” they must be educated on sexual health issues in accordance with a particular public health paradigm.

While Candace and Semira were able to collect messages from their high school and the internet, Dehab focused exclusively on sexual health messages that could be found on the online. During our final interview, she pulled a piece of paper from her backpack and placed it on the table in front of me. She had written down the names of five websites and copied down some information that the first one contained. I asked how she came across these particular sites and she talked about how she had been at Health Sciences Centre, for an appointment. While she was waiting in the lobby she noticed there were television sets that displayed advertisements. She took a picture of the name of the website with her cell phone so she would be able to look it up later. This was the first website she had written down on the piece of paper. It was the American Social Health Association (ASHA). She talked about this particular site at length. She focused on how it was organized and the ease with which she could navigate it and understand what it was trying to communicate. It covered information on healthy relationships, protection, “myths and facts,” and various diseases, among other things. Two particular sub-sections she wrote about were “STIs and young people” and “HIV and AIDS;” the areas she emphasized were concerning

messages about protecting yourself, how STIs are transmitted, and about testing and treatments of STIs. When I asked Dehab if she thought the information provided on these types of websites was useful, she stated that they were because *"you can learn from it"* and she agreed with the messages they were trying to communicate. This agreement with "expert" messages was a predominant theme among my interlocutors. Not one of them questioned the messages they found or their importance.

After I left this meeting, I found myself wondering: What is the significance of an American website being advertised in a Canadian clinical setting? After exploring the ASHA website (www.ashasexualhealth.org), I wondered if there was a Canadian equivalent. I tried searching "Canadian sexual health association" and the first website that came up was "Action Canada for Sexual Health and Rights" (www.sexualhealthandrights.ca). Under a tab that was labelled "sexual and reproductive health information hub" a short video played, with #HeartYourParts underneath; the video focused on communication, planning, and learning. Interestingly, even though none of my interlocutors' mentioned being in contact with this website, the information presented in this short clip can be found in their individual narratives of experiencing sexual health messages in Canada and their perspectives on maintaining their sexual health. This information included practicing safe sex and getting testing in order to "heart" their bodies. I contend that this can be theorized as a part of being a "healthy bio-citizen,", in accordance with normative sexual health frameworks in Canada that encourage everyone to maintain their sexual health in a similar fashion.

The ways in which these young women collected sexual health messages from websites was not the first time the internet came up as a potentially important source of sexual health information. The consensus was that even though there is some reliable information online, it

can be a valuable resource for finding "good" or "accurate" information. This emphasis on finding the right kinds of information in order to maintain your sexual health, specifically how individuals will seek out "expert" advice, can contribute to producing responsible "bio-citizens" according to a narrow definition of sexual health that consists largely of prevention and protection messages, and that does not include any messages about desire, pleasure, connection and emotion.

How is HIV talked about? Comparing Canada and African countries of origin

Through my interviews, I came to realize that there were differences in how these discourses are circulated in Winnipeg compared to their respective countries of origin. I am particularly interested in how HIV is talked about and the prevalence of HIV-related messages for young newcomers. This is not a straightforward issue. Some of the young women I interviewed felt that there was more information on HIV in Canada than in their countries of origin while others felt that HIV-related messaging was largely absent in the public eye in Canada. These differences, and the possible rationale for these differences, will be explored in the following pages.

I sought to elicit participants' narratives about their experiences with HIV discourses, both pre- and post- immigration, to gain a better understanding of how HIV is talked about and what their perspectives are on this subject. The differences in their perceptions of HIV in Canada vis-à-vis African countries of origin suggests how a top-down model of sexual health promotion, which focuses on protection and prevention in a detached manner, serves to reinforce a particular idea of bio-citizenship.

I have situated their narratives in the Canadian context, where HIV and the African community has been written about in great length (PHAC 2012; Yang et al 2010; PHAC 2009;

Gardezi et al 2008; Baidoobonso et al 2013; Omorodion et al 2007; Larkin and Mitchell 2002). One of the major responses in the effort to prevent the transmission of HIV has been in the form of education; this clashes with the "general finding that knowledge about HIV/AIDS does not typically transfer to safer sex practices" (Larkin and Mitchell 2002: 65). In addition, HIV-prevention has focused on lifestyle choices and individual responsibility in Canada, under the realm of neoliberalism (Larkin and Mitchell 2002: 65). As previously mentioned, in the context of sexual health, neoliberalism values the responsibilization of individuals through the self-management of risk, thus leading to a "healthy lifestyle" (Ayo 2012; Leahy 2014; Fitzpatrick and Tinning 2014). If the circulation of information about HIV is proposed to be one of the best defences against its transmission, what does it mean that the majority of the young women I interviewed do not believe that HIV is not talked about as much in Canada as in their countries of origin?

It was the two youngest participants, currently in high school and taking sexual education in the mandatory health classes, who believed that there is more information about HIV available in Canada than back home. In contrast, Dehab, Feven, Cheyenne and Gretah all felt that HIV was not as publicized here and that people did not talk about it in the same ways as back home. However, each of these women had specific experiences with HIV-related messaging in their countries of origin and articulated different perceptions of how Canada was or was not talking about HIV in Canada. Both of the teens who felt that there is more information about HIV in Canada, argued that in their home countries (Ethiopia and Kenya respectively), only provide basic information and do not go into any t detail about the illness. Candace spoke about how they covered HIV in detail in her Canadian health class, and the main message she got was that you should try to prevent it as much as you can. Both teens came to Canada when they were

adolescents (12 and 11 years old respectively) and so this may affect the types of sexual messages they were exposed to back home. When asked about HIV messaging back home, Semira said,

"It's like not that common, like people don't really talk about it that much, I guess."

Semira felt that when she was growing up in Kenya, she did not hear about HIV or see any HIV-related messaging. Both Candace and Semira talked about how back home there was a sense that their countries of origin were "getting better" now, since more information on the transmission of HIV was more readily available, implying that these countries were making "progress." This emphasis placed on education and information is reflective of a Western approach such as Canada has taken up in the effort to prevent the transmission of HIV. Such approaches can be seen as contributing to the production of "sexually healthy bio-citizens" who should always engage in safer sex practices and be armed with the "right" kinds of knowledge.

While Candace and Semira felt that there was more information on HIV available in Canada, Dehab had an entirely different perspective on this subject. Dehab believed that HIV is very openly spoken about and highly publicized in Eritrea. She juxtaposed Eritrea with Canada, where she felt that HIV was not talked about as much. She had only seen one brochure that contained information on HIV in the several months she had been in Winnipeg.

The lack of publicity in Canada, in her perspective, was contrasted with how HIV is talked about in Eritrea. Specifically, Dehab introduced me to the concept of "testimonials." She explained this this was where *"victims"* of HIV/AIDS talk about their own experiences in an effort to raise awareness. These testimonials can be heard on the radio or seen on television. She clarified that sometimes the person will use their real name while others preferred to remain

anonymous. Testimonials were also given at schools, in order to share their experiences with young people. Dehab expressed that she really liked this practice because it was good to hear about "real life stories" of HIV. This personalization of the HIV epidemic can be juxtaposed with the information I have found on HIV, via the PHAC (2012), which focuses on statistics and "at-risk" sub-populations.

According to Dehab, the practice of giving testimonials was not the only difference between how HIV is talked about and publicised in Canada and Eritrea. She described how in Eritrea there is also an emphasis on teaching and disseminating information however these messages can be found on television and *"in the streets."* When I asked what she meant by the "streets," she explained that there is a lot of awareness being raised by and for young people. There are a number of posters being circulated and they have a national holiday called the *"Day of HIV."* During this time the stores will be closed and the streets are shut down. Youth will head to the streets, handing out brochures and *"giving out lessons"* to other young people. I brought up that in Canada, we have World AIDS Day, but that it was not as publicised as in Eritrea, nor was it a national holiday. Particular organizations might hold events but it was not as openly celebrated in Winnipeg. This national holiday in Eritrea also involves an event held in a large building called "Expo," where students in grade 7 and 8 are brought to learn about HIV. I asked her about how this experience was and she expressed that she found it helpful to learn from different people (with different backgrounds) and ask questions.

This highly publicized nature of HIV in Eritrea was contrasted with how Dehab thought it was talked about in Canada. She explained that while she believes that everyone in Canada is aware of HIV, there is a lack of meaningful and person-to-person engagement, suggesting they should talk about it more personally; Dehab clarified that while brochures are helpful and you

can find information if you look for it in Canada, they *"need a personal touch."* She felt that testimonials offered this personal touch and were a *"great way to learn from somebody's experiences"* rather than getting the information from book. The role of testimonials in the context of living with HIV/AIDS has been explored in a Canadian context, specifically using community perspectives to think about how these stories are interpreted (Mensah and Haig 2012). However, Dehab had not come into contact with any since she settled in Winnipeg.

My conversations with Dehab about HIV and HIV-related messaging revealed the importance she places on humanizing/personalizing the epidemic, rather than relying on seemingly cold and detached fact sheets. In expressing her thoughts on the *"Day of HIV,"* she emphasized the role of community participation; community participation contrasts with the seemingly clinical way in which agencies in Canada approaches prevention with the use of "experts" (in the context of public health promotion). In my opinion, it seems to serve to distance experts from their audience. I believe that testimonials can address power differentials arising when an "expert" lectures a particular audience, and thus offer a different way of talking about and drawing attention to HIV.

The older girls I interviewed shared Dehab's perspectives that HIV is not as openly talked about in Canada as in their countries of origin. In order to demonstrate the perceived differences between how it is talked about in Canada and back home, Feven brought up two television series that address issues related to the spread of HIV. The first is a Kenyan scripted series called "Shuga," which aims to demonstrate how easy it is to spread HIV by tracing its movements through a group of young people in a club, using real life situations. For example, a girl who was a virgin at the start of the show contracts HIV the first time she had sex; Feven said that this is meant to challenge the idea that you cannot get it the first time you have sex. She also

spoke about a Nigerian series, which was available to watch in Kenya, that focused on "sugar daddies." It features a young woman who has financial issues because she is a student, so she begins to date an older, wealthy man. They commence a relationship where he gives her money when she needs it and they have a sex. The older man has HIV but tells her that there is a low chance of her getting the infection (because his viral load numbers are not high). They have sex multiple times and she does not contract HIV. However, her sister sleeps with this man once and contracts HIV right afterwards. Feven said that this was a lesson that sometimes you were lucky and sometimes you weren't. She thought if I looked into these series, it would give me a better idea of how HIV is talked about back home. These television series demonstrate the publicized nature of HIV in Kenya; neither Cheyenne nor Feven had seen any television series that talked about HIV like this in Canada. This contrast illustrates the divide between how they perceived Canada as only talking about HIV in a clinical and preventative manner in comparison to the more personal ways their countries of origin addressed HIV.

The lack of publicity surrounding HIV in Canada was also brought up by Gretah, who stated that since she came to Canada, she had not heard about (or seen any messaging) on HIV. It was not until she came into contact with Susan and learned about her project that she heard anything about HIV in Winnipeg, explaining that she initially thought that there might not be any HIV in Canada. This was contrasted with how HIV was a common topic of conversation in Rwanda because in her mind, everyone knew (or knew of) someone who had died from the disease.

This section has explored how the ways in which HIV is or is not talked about can illustrate the effect of dominant sexual health discourses, sanctioning what can and cannot be said about a subject. The majority of the young women I spoke with felt that HIV was not highly

publicized in Canada, and when it was talked about, it was only in the form of messages that were communicating ways to prevent it, representing a singular discourse. It is interesting to note that while these young women have been labelled as "at-risk" in the context of HIV/AIDS, they did not come across any messaging which was tailored to them. I believe this is significant because a singular message is being disseminated and therefore configures an "ideal" type of biological citizen, who engages in the management of their risks.

HIV-related stigma: Is education the answer?

In this section, I will explore how education and access to increased information were frequently positioned by my interlocutors as a way to combat HIV-related stigma. Specifically they pointed to ways in which having more information about HIV and how it is transmitted will result in people lessening their fear of and stigmatizing people living with HIV/AIDS. However, this was talked about in different ways. While Semira and Canadace felt that formal sexual education was the answer, Cheyenne felt that increasing awareness through other, more engaged, approaches was more critical to decreasing HIV-related stigma.

During an interview with Candace and Semira, Susan asked for their own perspectives as to why there was so much stigma surrounding and talking about HIV. Candace explained, *"I think it's more like if you get HIV then there's no chance you, like, in back home there's if someone has HIV, they think they don't have that much education, they would leave that person to not be around them and stuff like that."*

In this narrative, she draws a correlation between an increase in education or information about HIV and HIV-prevention, and a decrease in the stigma attached to HIV. This issue was

revisited in a later interview, when I asked the girls why they thought there was more information about sexual health and HIV in Canada. Semira explained,

> *"Like, especially with the AIDS and the HIV stuff, um I feel like back home, or like back there, they feel like since they're not really too educated about it, they feel like you can only get it from sex or whatever. But here, there's different ways of getting it, people are more educated about it and they feel more free to talk about it cause, to let everyone how it is."*

In this quote, she is not only connecting how being educated will lessen the stigma of HIV but also how it will can encourage people to speak freely about a particular subject. This is an interesting correlation because, as we discussed in the previous section, many of these young women felt that even though there was a lot of information on HIV in Canada, it was not talked about as openly.

The idea that increased information can lessen the stigma of HIV was prominent in Feven's discussion of Kenya. She explained that at first the predominant message they received was *"don't get it,"* citing that there was a lot of fear around HIV. When I asked her why she thought there was such a high stigma around this subject, she said that it is frequently associated with death and that *"everyone has the mentality that it's bad and I can get it."* However, she clarified that things had changed over the years in Kenya, describing an explosion of information on HIV/AIDS when the epidemic was on the rise. Feven talked about how they tackled this tough issue by teaching sexual education in schools (and to younger students in particular) when the epidemic occurred.

Cheyenne took a slightly different approach by talking about all of the efforts that were being made, other than education alone, in Mauritius to combat HIV-related stigma. Specifically she spoke about an artist who had contracted HIV and then started his own organization, whose goal was to tell the community that they shouldn't stigmatize people living with HIV/AIDS; this was partly done by dispelling myths, including the idea that you can catch it just by being near someone. Cheyenne contrasted this with how she saw HIV as being more stigmatized in Canada, by telling me a story about her friend. This friend was applying for a job with a religious organization that works with people living with HIV/AIDS. When she arrived at the facility, it shocked her how these individuals were being treated. Cheyenne described how there were rows upon rows of people lying in their beds. She compared this with how persons living with HIV/AIDS in Mauritius can live, as if they are not affected by the disease and free to be with their families in the community. She expressed that this negative environment and medicalizing context can work to stigmatize HIV.

While Gretah had not come across any HIV-related messaging in Canada, she did explain how in her experiences in Rwanda, HIV carries a lot of stigma, saying,

> *"If you're in any way associated with anyone, with someone who is said to have HIV, everybody's gonna look at you with this pitiful, pitiful way and like, um like no one really wants to I don't know I feel like it's, it's one of the biggest, the most scariest thing to, to ever think that you're gonna end up having it."*

She went on to explain that HIV was not something that her parents would have ever talked to her about but when she went to the more rural areas, this fear of HIV was utilized by the elders in the village as an "incentive" to encourage young people to either be abstinent, or if

they did have sex, to always have protected sex. Gretah explained that they would use "real life" stories of people dying of HIV (someone that you might know) to accomplish this.

Candace and Semira's narratives relay how they felt talking about HIV in a clinical/objective manner in the context of education, can work to lessen stigma. However, Cheyenne thought this highly medicalized approach worked to increase the stigmatization of those living with HIV. I believe that the way in which HIV had been talked about in a predominantly clinical way by public health agencies, utilizing the language of "at-risk", represent implicit fear messages that seek to encourage all citizens to self-manage the risks of sex in order to become "sexually healthy biological citizens."

The role of the sexual education system in Canada

As discussed in Chapter 4, my interlocutors had different experiences within the Canadian sexual education system. Institutionally, sexual health information was presented to the young women in a variety of ways – formal health classes, "safer sex" workshops, and university orientations. They also looked for information in the Internet. Overall, they found sexual health organization that offered information on education, STI and HIV prevention, testing that is available, and clinics.

In this section, I discuss how "sexual health education" is conceptualized in Canada by national and provincial health and education institutions, how it operates, and how its dissemination can contribute to the production of particular "bio-citizens" by overshadowing other ways of thinking about sexual health.

The *Canadian Guidelines for Sexual Health Education* defines sexual health education as "the process of equipping individuals, couples, families and communities with information, motivation and behavioural skills needed to enhance sexual health and avoid negative outcomes" (PHAC 2008: 5). The sexual health aspect of sexual education strongly emphasizes that being sexually healthy is not only about the absence of illness but also the mental and emotional well-being of individuals (PHAC 2008: 5). However, the messages I came across in the field and in the interviews with young newcomer women, point to the ways in which sexual health is most often framed in terms of "prevention" and "protection," which implicitly portrays sex as a (manageable) risk.

My intention is not to demonize public health and sexual health institutions. Rather I wish to be critical of how these messages are constructed, circulated, and disseminated and what affect they have on the subjectivities of individuals from targeted populations. While I recognize that those who work in these sectors are not operating under some malicious intent to spread messages that undermine the agency or individuality or rights of self-determination of individual person, I contend, drawing from critical medical anthropology, that it is productive to reflect on the "who, what, when, where, and how" of these sexual health discourses. Also, these messages from the federal government and international institutions do not simply operate in a top-down manner. What might not be clear in my thesis but is very critical to make note of is the existence of multiple local agencies, such as SERC (Sexuality Education Resource Centre), NEEDS (Newcomer Employment Education Development Services), and IRCOM (Immigrant and Refugee Organization of Manitoba), that filter these messages at the local level and through an assemblage of social actors, including employees who are themselves immigrants and immigrants of colour, in how they relay them to targeted communities.

To better understand how the official discourses of sexual education in Canada are presented in comparison to the particularized context that each of my interlocutors' experienced, we need to examine the elements these guidelines present as integral to positive health outcomes. These elements (PHAC 2008: 14) include:

- A deeper understanding that is relevant to their specific health needs and concerns
- The confidence, motivation and personal insight needed to act on that knowledge
- The skills necessary to enhance sexual health and to avoid negative outcomes; and
- A safe, secure and inclusive environment that is conducive to promoting optimal sexual health

Do these guidelines represent official (and often idealistic) discourses and how do they operate in practice? From the conversations I have had with participants, I have found that in Winnipeg, their "specific health needs" have already been pre-determined, as the curriculum precedes their participation in it. The second and third elements represent very specific and narrow ideals of behaviour and attitude which have been formulated in a Canadian context. Furthermore, there is no discussion about addressing other factors that might play a role in an individual's sexual health, such as desire, gender, sexual orientation and expression, cultural and ethnic background, and pleasure, which thereby homogenizes their experiences by not recognizing that each student will have individually and culturally embedded values and beliefs. The overwhelming consensus among participants I spoke with was that being educated on sexual

health issues was critical to maintaining their sexual health. Therefore, these participants can be seen as echoing the very values that these guidelines are purporting.

The *Sex Information and Education Council of Canada (SIECCAN)*, who are funded by the PHAC, have produced a document that is meant to address various concerns related to the teaching of sexual education in school. An important question they attempt to answer is "why do we need sexual health education in the schools?" (SIECCAN 2010: 4). The response is framed in terms of individual sexual rights – the right to information, skills, and motivation that will lead to improved sexual health outcomes. They present these aspects as important because in their perspective, sexual health is a key aspect of a person's overall health. This approach places an overwhelming importance on being "sexually healthy" in a narrowly defined manner. The power of these organizations to define what sexual education is and the importance that should be place on it serves to reinforce the idea of building a "sexually health nation." How does this effectively erase other ways of being "sexually healthy" and how has this state of being become so important?

Another important issue addressed in this document is whether parents/families want their children to learn about sexual health in schools and if the students themselves want to be taught about such matters (SIECCAN 2010: 5). While they do state that "parents and guardians are an important primary source of guidance for young people concerning sexual behavior and values…as a valuable source of sexuality information" (SIECCAN 2010: 5), they do not qualify which youth or families they are talking about. This statement assumes that all families freely discuss issues related to sexual health and sexual education in a similar manner to formalized education. While I do believe that families provide an important context for the negotiation of

values and expectations, the answer given to the above question does not account for other ways of thinking about sexual health or taboos surrounding talking about sex with family members.

This emphasis on adult family members as being sources of information on sexual health and sex in Canada has not played out in this manner in my own life. While I have had a couple of conversations with my mother about sex (predominantly concerning contraception), I have never once spoken to my father about these things. What does this say about me? According to this approach, open communication between family members supports the production of "sexually healthy citizens." How does this discourse frame individuals who fall outside of this model?

In this document, various studies are quoted and statistics from 1996-2008 are provided to prove to the reader that parents and students want sexual education, stating that 85% of parents want sexual health education in schools, as well as 92% of young people (SIECCAN 2010: 5). I would like to know who was included in this study and the validity of responses given to close-ended questions in comparison to qualitative and ethnographic research. What about the parents and students who do not support sexual education in schools? Does this effectively silence those whose opinion is in the minority?

The mandatory nature of sexual education has been a contested idea (Kendall 2012; *VICE News* 4 May 2015). After I completed my fieldwork and had begun writing my thesis, my thesis supervisor suggested that we organize a meeting with some of the community members in order to discuss my research findings with them and get their feedback. Six African newcomer teen girls turned up for the meeting; Susan, Estella, Adey, Selam and Winta were also present. After I explained that the consensus among my research participants was that being informed about sexual health information was important to maintaining their health and managing their risks, the

majority of the young women who came agreed with this statement. When I asked them whether sexual education should be mandatory, the vast majority agreed that it should be taught in school; even the girls who felt that talking about sexual health went against their religion felt that it was important to have this information.

The idea that sex is a taboo topic was a resounding theme. However, even though talking about sex and sexual health with family members was not seen as advisable, the majority of these particular young women insisted on the importance of being "correctly" informed. Talking about issues that are explored in sexual education with the next generation was an important outcome from this feedback meeting. This shift in how sex and sexual health would talked about in the future represented an interesting development because to Susan and I, it illustrated how the discourses which placed an importance of talking about sexual education as crucial to maintaining individuals sexual health, can be taken up in the production of "biological citizens" and a "sexually healthy nation."

In this section I have explored how the upmost importance has been placed on not only being educated on sexual health matters, but being educated in a specific way, as defined by Canadian governmental and public health bodies. The majority of the young women I spoke with would seem to agree with this idea. Furthermore, the mandatory nature of sexual education in Manitoba can be tied into the production of a particular type of "good bio-citizen" by attempting to reach as many young people as possible with particular discourses of sexual health.

Two approaches: One message

As talked about in Chapter 4, Candace, Semira, and Dehab had different experiences with sexual education, reflecting the approaches taken by the two different schools they attend. Two

of the girls, Candace and Semira (who are in grades 10 and 9 respectively), attended a mandatory health classes that include a section on sexual education. The health class is a part of the physical education curriculum; the process involves the dissemination of information on a variety of topics (STIs, HIV/AIDS, prevention, contraception, risks, etc.) and then the students are tested on how well they know the material in the form of exams.

Since settling in Winnipeg, Dehab has had a different experience; she had been in Canada for less than a year and had not experienced any formal sexual education but she did participate in a safer sex workshop put on by the school. When I asked her if it was mandatory, she told me that it was run through the school and she had decided to take it with a couple of girlfriends. The workshop involves a "student-driven" curriculum, with girls and boys in different rooms. It is run by teachers and led by students; the latter are chosen for their active participation in the community and then given training before the workshop begins. However, the teachers remain in the room in order to address any questions that the volunteer students cannot. Topics covered included relationships, love, protection, and pregnancy.

The experiences these interlocutors' had with the sexual education system represents two different approaches. The health classes that Candace and Semira attend are conducted in a common manner. Students are given information and then tested on it. The workshop that Dehab took part in appears to have moved away from this approach by focusing on engagement and empowerment. The "safer sex" workshop fosters students' participation in two ways. Firstly, the students are involved in choosing the topics that are presented and secondly, some students are chosen to lead the conversation. However, I cannot help but question how much control the youth actually have over the process. The teachers provide training for the selected student-teachers before the workshop began. Dehab described how they are also present for the sessions,

in order to answer questions that the student-teachers do not know how to answer. This begs the question, what would a critical and engaged student sexual education workshop look like in practice? While there are differences between how each of these approaches operated in practice, the ultimate message was the same, emphasizing the importance of having the right kinds of information in order to manage the risks associated with sex.

In this section, I have explored how there were differences in my interlocutors' experiences of sexual education, and similarly differences in how this information was disseminated. Even with the so-called "empowered" approach to sexual education that Dehab's school utilized, it is still apparent that there is an appropriate way of talking about sexual health, those that emphasize the need to manage the negative consequences of having sex.

Biological Citizenship

The sub-themes I have addressed in this chapter examine the question (and relevance) of *how* sexual health information is circulated and disseminated and the ways in which this contributes to my interlocutors' understanding of sex and sexual health. Similarly, the way in which sexual health discourses are disseminated is embedded in complex power relations, recognizing the authoritative voice of the school system, government, and public health. To conclude Chapter 5, I believe that the conversations I had with these young women and the sexual health messages I came across contribute to the idea of building a "sexually healthy nation" through the production of biological citizens who self-maintain their sexual health in alignment with dominant Canadian discourses.

Conclusion: Sexual Health Discourses and the Shaping of Sex and Sexuality

I began my ethnographic research with a broad question in mind: What role do sexual health discourses play in the lives of African newcomer teen girls and young women in Winnipeg? However, this question transformed and became more specific as a result of my analysis and interpretation of the ethnographic data I collected. At the beginning of my thesis, I asked: How have sexual health discourses shaped my interlocutors' experiences and perceptions of sex and sexuality upon settling in Canada? I have strived to answer my research question throughout the three chapters which encompass my research findings.

In Chapter 3, I explored how these particular young women defined the concept of "sexual health," how it took on meaning in their own lives, and how this has been shaped through their settlement in Winnipeg. I came to learn that even though sexual health is a dynamic yet ambiguous construct, the importance placed on being informed and taking an active role in the maintenance of one's sexual health was paramount. I traced the ways in which these ideas have been shaped via Canadian sexual health discourses, and in particular, how the language of risk played an integral role in encouraging youth to take up particular behaviours and attitudes in order to avoid the negative consequences of having sex. This last argument served as a jumping off point for examining how these sexual health discourses have the power to contribute to the novel idea of "sexual health subjectivity."

In Chapter 4, I examined how sexual health messages are embedded in a complex landscape of discourses, encompassing diverse contexts and involving innumerable actors. The young women I spoke with encountered these messages in a variety of ways – high school health classes, university orientations, "safer sex" workshops, family, and friends. After speaking with

my interlocutors, it became apparent that these messages did not simply operate in a top-down manner, but rather involved negotiation and re-negotiation in how these young women took up or resisted them. Through exploring their perspectives, in this chapter I show how ideas concerning freedom, openness, sexuality, sex, gender, and rights fit into this complex landscape of sexual health messages.

Finally, in Chapter 5, I explore the need to understand how sexual health information and discourses are circulated and disseminated. Specifically, I examined the ways in which the setting in which these messages are deployed matters, involving the authoritative voice of "experts" and how the value placed on obtaining the right kinds of information contributes to the ideas of a "sexually healthy bio-citizen." In particular I focused on the ways in which we talk about HIV, and what this can tell us about the larger system. This was done by comparing and contrasting the participant's experiences in Canada with their respective countries of origin.

If there is one thing that I want to say about what I learned from the interviews and participant observation, it is that in Canada sexual health discourses operate as a form of bio-pedagogy that serve to instil a notion of sex as risk, for "African" youth and in particular heterosexual female African youth. I argue this because of how the young women I spoke with defined sexual health in predominantly bio-medical terms and how they placed a high degree of importance on being "correctly" informed in order to work against the "risky" nature of sex. Given that African female youth more generally have been labelled as "at-risk" within the public health literature for negative sexual outcomes, it is interesting to note that my interlocutors did not come across any sexual health (or HIV-related) messaging that targeted them as young African newcomer women in particular. However, I believe this serves to bolster my use of the theoretical concept "biological citizenship," through the dissemination of sexual health messages

(and their implicit/explicit discourses) wholesale, it contributes to the idea of producing a particular, and singular, idea of a "sexually healthy citizen;" this sexual citizen, paradoxically, seems extremely vulnerable, constantly under attack, in need to prevention and protection.

Although this argument is complicated by the fact that each of these participants, as all African newcomer teen girls and young women, have had diverse experiences both pre- and post-immigration, including innumerable factors such as age, ethnic background, country of origin, age of emigration, individual cultural values, past experiences with sexual health/sexual education, current experiences in Canada, living arrangements, and family dynamics. This was demonstrated by Nagan's story, the narrative I chose to open my thesis with. I also need to emphasize that the conclusions I have drawn are based on the research I conducted with these particular young women, and does not reflect all young African newcomer women's experiences or perspectives.

In this thesis, I present my argument by first showing what discourses were repeated by the youth when I was tracing how they encountered sexual health messages and in spending time hanging around with them, and second, showing how they interpreted these messages. I argue that the majority of these participants felt that the safer sex message that is prevalent in Canadian public sexual health discourses was seen as "a good thing" even though this message contradicted specific cultural norms about sex and sexuality in their respective African communities.

Over the course of my fieldwork, the ideas I had of what constituted "African newcomer youth" have been both challenged and transformed. It is one thing to say that everyone has their own experiences and perspectives it is another to listen to their oral narratives and hear these

differences in action. It became apparent that even though I would have prided myself as wanting to avoid homogenizing these particular youth upon entering the field, my pre-conceived ideas crept in from time to time. It was only after I was able to reflect on this, that I truly understood the power of universalizing discourses, which only made me want that much more to resist and challenge them. I would also like to acknowledge how my ideas surrounding sexual health, sexual education, and "sex positivity" have changed over the span of time it took me to write my thesis proposal, conduct my research, and write up my thesis. If you had asked me five years ago what my perspective on having sexual education in school was, or the importance of know about sexual health issues, I would have completely different answers than I do now. This research has allowed me to think critically about these concepts by investigating the power of discursive practices and questioning how these discourses are established. However, my stance on these issues is conflicting, while I want to believe that being "sexually healthy" is a good thing, I cannot help but question who gets to define "sexually healthy" and what the broader implications of this are. For the women who participated in my study, sexual health education played an important role in how they conceptualized sexual health and the meanings that they ascribed to being "sexually healthy." I have come to question the value of sexual health education in a school-based setting, where there are other important power dynamics and moralities at play (for example, between teachers and students) and the way in which it is taught is fraught with challenges. Do African newcomer young women feel as though they can voice their own perspectives (cultural or otherwise) in the classroom? The ways in which sexual education is taught were portrayed by my study participants as fairly clinical and focusing on the negative consequences, or the "risks", with engaging in sexual relations and practices and this clinical and risk-oriented notion of sex and sexuality has caused me to contemplate what a student-driven and

individualized sexual health education would look like in the future, or even if school is the appropriate venue.

Nagan's story also caused me to question my own assumptions about African newcomer teen girls and young women. Whether I realized it or not, we all come into research with our own baggage and pre-conceived ideas of what people will (or should) be like. Through the fieldwork I have conducted, spending time in the downtown core, volunteering with organizations that serve newcomer youth, going for coffee with Winta and Weyni (the project's female peer-researchers), and having lengthy conversations with Dehab, Candace, Semira, Cheyenne, Feven, Haben, and Gretah, I believe I was able to gain a better understanding of African women's lives.

I was constantly surprised by the participant's willingness to share their personal stories of dating, sex and sexuality with me, which contrasts with findings from the larger project (see Migliardi and Frohlick 2015). As a Euro-Canadian third generation young heterosexual woman who has not dated an African and spent six years in a monogamous relationship, I was also challenged by some of the things that they told me. I encouraged them to ask question, which often resulted in interesting conversations. For example, when Haben found out that I had been dating my then-boyfriend for several years, she questioned when we were going to get married. I opened my mouth to reply and realized I did not have an answer. I had been asking these girls about their experiences and perceptions of dating, and this exchange had brought me to the realization that I needed to reflect on my own ideas of dating, and how this can influence the way I approached the subject. I have thoroughly enjoyed diving into ethnographic interviews, which operated as a form of dialogue between these young women and myself. I was able to listen to, and engage with, their thoughts and perspectives on my research interests, and at the same time

learn about their lives as a whole, not just as participants, but as individuals with *storied realities*.

My thesis contributes to the literature on African newcomer youth, specifically girls and women by how conducting ethnographic research and exploring my interlocutors' perspectives on sexual health I was able to examine how their experiences of sex and sexuality have been shaped by larger sexual health discourses. In formulating my research question and approach, it was never my intention to "educate" these youth on sexual health nor impose specific ways of thinking about sexual health; rather, through eliciting their own opinions, I was able to see the power of the discourses in question and provide particularized accounts. My research question came out of the revelation that African newcomer teen girls and young women have been triply-burdened by the label of "at-risk" by public health agencies in the context of HIV. Subsequently, through my fieldwork, I came to realize that this categorization did not fit with how these young women saw themselves[9] but not in the way I initially thought; many of them expressed the sentiment, "aren't we all at-risk?"

Reference Cited

Anderson, Benedict

1983 *Imagined Communities: Reflections on the Origins of and Spread of Nationalism* London: Verso.

Ayo, Nike

2012 "Understanding health promotion in a neoliberal climate and the making of health conscious citizens" *Critical Public Health* 22 (1): 99-105.

Baidoonbonso, Shamara, Greta R Bauer, Kathy Nixon Speechlet, Erica Lawson and The BLACCH Team

2013 "HIV risk perception and distribution of HIV risk among African, Caribbean and other Black people in a Canadian city: mixed methods results from the BLACCH study" *BioMed Central Public Health* 13 (184): 1-17.

Bay-Cheng, Laina Y.

2003 "The Trouble of Teen Sex: The construction of adolescent sexuality through school-based sexuality education" *Sex Education: Sexuality, Society and Learning* 3 (1): 61-74.

Berry, John W.

2013 "Research on multiculturalism in Canada" *International Journal of Intercultural Relations* 37: 663-675.

Besley, Tina

2010 "Governmentality of Youth: managing risky subjects" *Policy Futures in Education* 8 (5): 528-546.

Bordo, Susan

2003 *Unbearable Weight: Feminism, Western Culture, and the Body.* Berkley: University of California Press.

Briggs, Charles L.

2003 "Why Nation-States and Journalists Can't Teach People to Be Healthy: Power and Pragmatic Miscalculation in Public Discourses on Health" *Medical Anthropology Quarterly* 17 (3): 287-321.

Browne, Rachel

2015 “Thousands of Canadian Students Are Ditching Class to Protest Their Province’s New Sex Ed Curriculum” *VICE News* 4 May 2015.

Butler, Judith

1993 *Bodies That Matter: On the discursive limits of “sex”* London: Routledge.

DeVault, Majorie L. and Glenda Gross

2007 “Feminist Interviewing: Experience, Talk, and Knowledge” in Sharlene Nagy Hesse-Biber (ed.) *Handbook of Feminist Research: Theory and Praxis.* London: Sage.

Fitzpatrick, Katie and Richard Tinning

2014 “Health education’s fascist tendencies: a cautionary exposition” *Critical Public Health* 24 (2): 132-142.

Flicker, Sarah, Adrian Guta, June Larkin, Susan Flynn, Alycia Fridkin, Robb Travers, Jason D. Pole, and Crystal Layne

2010 “Survey Design From the Ground Up: Collaboratively Creating the Toronto Teen Survey” *Health Promotion Practice* 11 (1): 112-122.

Foucault, Michel

1982 T*he Archeology of Knowledge and the Discourse on Language* New York: Pantheon Books.

Foucault, Michel

2010 *The Foucault Reader.* Paul Rabinow (ed.) New York: Vintage Books.

Frankenberg, Ruth

2001 “The Mirage of Unmarked Whiteness” in Birgit Brander Rasmussen, Eric Klinenberg, Irene J Nexica, and Matt Wray (eds.) *The Making and Unmaking of Whiteness.* London: Duke University Press.

Frohlick, Susan

2011 "Doing White Girls:” Race, Sex, and Tactics of African Immigrant Youth in Multicultural Canada. Paper presented at the Society of Applied Anthropology meetings in Seattle, WA, March 29- April 2.

Gardezi, F., L. Calzavara, W. Husbands, W. Tharao, E. Lawson, T. Myers, A. Pancham, C. George, R. Remis, D. Willms, F. McGee, and S. Adebajo

2008 “Experiences of and responses to HIV among African and Caribbean communities in Toronto, Canada” *AIDS Care.* 20 (6):718-725.

Gastaldo, Denise

1997 “Is health education good for you? Re-thinking health education through the concept of bio-power” in Alan R. Petersen and Robin Bunton (eds.) *Foucault, health and medicine.* New York: Routledge.

Glen, Evelyn Nakano

1999 “The Social Construction and Institutionalization of Gender and Race: An Integrative Framework” in Myra Marx Ferree, Judith Lorber, Beth B. Hess (eds.) *Revisioning Gender* USA: AltaMira Press.

Gunnarson, Lena

2015 “Why we keep separating the ‘inseparable’ : Dialecticizing intersectionality” *European Journal of Women’s Studies* 1-14.

Graffigna, Guendalina and Kärin Olson

2009 “The Ineffable Disease: Exploring Young People’s Discourses About HIV/AIDS in Alberta, Canada” *Qualitative Health Research* 19 (6): 790-801.

Gray, Nicola J, Jonathan D. Klein, Peter R. Noyce, Tracy S. Sesselberg, and Judith A. Cantrill

2005 “Health information-seeking behaviour in adolescence: the place of the internet” *Social Science & Medicine* 60: 1467-1478.

Habecker, shelly

2012 “Not black, but Habasha: Ethiopian and Eritrean immigrants in American society” *Ethnic and Racial Studies* 35 (7): 1200-1219.

Harwood, Valerie

2008 “Theorizing Biopedagogies” in Jan Wright and Valerie Harwood (eds.) *Biopolitics and the ‘Obesity Epidemic: Governing Bodies.*

Ibáñez-Carrasco, J. Francisco

1997/1998 “Explorations and Border-Crossings: The Risks of Safer Sex Discourse” in Black et. Al. (eds) *Trans/forms: Insurgent Voices in Education.*

Israel, Barbara A., Amy J. Schulz, Edith A. Parker, Adam B. Becker, Alex J. Allen, and J. Ricardo Guzman.

2003 "Critical issues in developing and following community based participatory research principles." *Community-based participatory research for health.*

Kelly, Peter

2000 “The dangerousness of youth-at-risk: the possibilities of surveillance and intervention in uncertain times” *Journal of Adolescence* 23: 464-476.

Kendall, Nancy

2012 *The Sex Education Debates* Chicago: The University of Chicago Press.

King, Leslie

2010 “Demographic trends, pronatalism, and nationalist ideologies in the late twentieth century” *Ethnic and Racial Studies* 25 (3): 367-389.

Larkin, June and Claudia Mitchell

2002 “Gendering HIV/AIDS Prevention: Situating Canadian Youth in a Transitional World”.

Leahy, Deana

2014 “Assembling a health[y] subject: risky and shameful pedagogies in health education” *Critical Public Health* 24 (2): 171-181.

Leslie, Keith

2015 “Ontario sex ed curriculum gets first overhaul since 1998” *CTV News* 23 Feb.

Lewis, Linwood J.

2004 “Examining Sexual Health Discourses in a Racial/Ethnic Context” *Archives of Sexual Behavior* 33 (3): 223-234.

Lupton, Deborah

2013 *Risk Second Edition* London: Routledge.

Lupton

2013b “Risk and emotion: toward an alternative theoretical perspective” *Health, Risk & Society* 15 (8): 634-647.

Madden, Raymond

2010 *Being Ethnographic: A Guide to the Theory and Practice of Ethnography.* London: Sage.

Mascia-Lees, Frances E.

2010 *Gender & Difference in a Globalizing World.* Illinois: Waveland Press, Inc.

Mensah, Maria Nengeh and Thomas Haig

2012 "Becoming visible, being heard? Community interpretations of first-person stories about living with HIV/AIDS in Quebec daily newspapers" *International Journal of Cultural Studies* 15 (2): 131-148.

Migliardi, Paula and Susan Frohlick

n.d. Figuring the Silence: Immigration, Decoding Practices and African Newcomer Girls' Sexualities in the Urban Prairies" Unpublished Paper Manuscript.

Minkler, Meredith and Nina Wallerstein

2010 "Community-Based Participatory Research for Health: From Processes to Outcomes (2nd edition). USA: Jossey Bass.

Omorodion, Francisca, Kenny Gbadebo and Philippine Ishak

2007 "HIV vulnerability and sexual risk among African youth in Windsor, Canada". *Culture, health & sexuality*. 9 (4): 429-437.

Petersen, Alan and Deborah Lupton

1996 *The New Public Health: Discourses, Knowledges, Strategies* London: Sage Publications.

Phoenix, Ann and Pamela Pattynama

2006 "Intersectionality" *European Journal of Women's Studies.* 13 (3): 187-192.

Public Health Agency of Canada

2008 *Canadian Guidelines for Sexual Health Education*. Ottawa: Her Majesty the Queen in Right of Canada.

Public Health Agency of Canada

2009 *Population-Specific HIV/AIDS Status Report: People from Countries where HIV is Endemic (Black people of African and Caribbean descent living in Canada).* Toronto: Her Majesty the Queen in Right of Canada.

Public Health Agency of Canada

2012 HIV/AIDS

Public Health Agency of Canada

2012 Populations at Risk

Public Health Agency of Canada

2012 “Fact Sheet: People from Countries Where HIV/AIDS is Endemic”.

Public Health Agency of Canada

2012 “Fact Sheet: Youth at-Risk”

Public Health Agency of Canada

2012 “Fact Sheet: Women”

Pylypa, Jen

1998 “Power and Bodily Practice: Applying the Work of Foucault to an Anthropology of the Body” *Arizona Anthropologist* 13: 21-36.

Rose, Nikolas

2007 *The Politics of Life Itself: Biomedicine, Power and Subjectivity in the Twenty-First Century.* U.S.A.: Princeton University Press.

Sawicki, Jana

1991 “Discplining Mothers: Feminism and the New Reproductive Technologies” in *Disciplining Foucault: Feminism, Power, and the Body.* New York: Routledge. Pp.67-94.

Sex Information and Education Council of Canada

2010 *Sexual health education in the schools: Questions & Answers (3rd edition).*

Shoveller, Jean A. and Joy L. Johnson

2006 “Risky groups, risky behaviour, and risky persons: Dominating discourses on youth sexual health” *Critical Public Health* 16 (1): 47-60.

Singer, Merrill and Hans Baer

1995 *Critical Medical Anthropology* New York: Baywood Publishing Company , Inc.

Spencer, Grace, Marion Doull and Jean A. Shoveller

2012 “Examining the Concept of Choice in Sexual Health Interventions for Young People” *Youth & Society* 46 (6): 756-778.

Strebel, Anna and Graham Lindegger

1998 “Power and Responsibility: Shifting Discourses of Gender and HIV/AIDS” *Psychology in society* 24: 4-20.

Vander Schee, Carolyn and Benjamin Baez

2009 “HIV/AIDS education in schools: the ‘unassembled’ youth as a curricular project” *Discourse: Studies in the Cultural Politics of Education* 30 (1): 33-46.

Vukov, Tamara

2003 “Imagining communities through immigration policies: Governmental regulation media spectacles and the affective politics of national borders” *International Journal of Cultural Studies* 6 (3): 335-353.

Wallerstein, Nina B. and Bonnie Duran

2006 “Using Community-Based Participatory Research to Address Health Disparities” *Health Promotion Practice* 7 (3): 312-323.

Winter, Elke

2015 “Rethinking Multiculturalism After its “Retreat”: Lessons From Canada” *American Behavioural Scientist”* 59 (6): 637-657.

Wong, Josephine Pui-Hing, Karen B. K. Chan, Renee Boi-Doku, and Simone McWatt

2012 “Risk discourse and sexual stigma: Barriers to STI testing, treatment and care among young heterosexual women in disadvantaged neighborhoods in Toronto” *the Canadian Journal of Human Sexuality* 21 (2): 75-89.

Wright, Jan

2008 “Biopower, Biopedagogies and the Obesity Epidemic” in Jan Wright and Valerie Harwood (eds.) *Biopolitics and the ‘Obesity Epidemic: Governing Bodies*.

Yang, Quiying, David Boulos, Ping Yan, Fan Zhang, Robert S. Remis, Dena Schanzer, and Chris P. Archibald

2010 “Estimates of the Number of Prevalent and Incident Human Immunodeficiency Virus (HIV) Infections in Canada, 2008” *Canadian Journal of Public Health* 101(6): 486-490.

Yuval-Davis, Nira

1996 “Women and the Biological Reproduction of the Nation” *Women’s Studies International Forum* 19 (1/2): 17-24.

Notes

[1] I use pseudonyms throughout the thesis to protect the privacy of my participants. Some were chosen by the participants themselves, others I chose. I chose names to reflect the cultural backgrounds of the participants. The names of places have also been changed to protect people's privacy.

[2] I have italicized the actual words of my interlocutors.

[3] In this context, "sex" refers to physical act(s) of engaging in sexual relations and not an axe of identity.

[4] Information taken from "What Risk, Whose Voices?" Grant Proposal

[5] The concept of age is a little more fluid in African newcomer communities than what Canadians tend to believe as absolute ages. Some participants might have been older or younger in chronological age than stated, the implications of which are not addressed in this thesis but will be examined in the larger project.

[6] Susan first came up with this line of questioning while we were interviewing Candace and Semira for the final time. She asked the girls to picture one person who was "sexually healthy" and another person who was not. Susan wanted to know what they thought the differences and similarities were between these two people. This indirectly allowed us to see how they define "sexually healthy."

[7] After our initial interview, I was unable to get a hold of her for a follow-up. This experience made me realize the contingent and dynamic nature of community-based and ethnographic research. My interlocutors all have lives of their own and sometimes the timing just does not work out, which makes me truly appreciate the time they took to share their experiences and perspectives with me.

[8] Habasha refers to a "separate non-black ethno-racial category that emphasizes their Semitic origins" (Habecker 2012: 1200) and is how Eritreans and Ethiopians of Amhara and Tigrinya ethnicity self-identify.

[9] These particular young women's perspectives were related to unwanted babies rather than related to contagion of HIV; if they followed their parents' warnings against pre-marital or youth sex they would be worried about pregnancies, whereas once they became socialized to the Canadian safer sex discourses the notion of risk shifted from unwanted pregnancy to unwanted infection and disease.

Appendix A: General Interview Schedule for Participants

1) Tell me about yourself.

- For example:
    - How old are you?
    - Where are you from? Where were you born? Do you consider yourself [insert ethnicity implicated]?
    - Do you have brothers or sisters? If so, how many? How old are they? Do they live in Winnipeg or elsewhere?
    - Do you live with your parents or grandparents?
    - Are you attending school and/or working?
    - Do you and your family go to church or a mosque? If so, where do you go?
    - How important is religion in your life?
    - What religion do you practice?
    - Do you go to religious events?

2) Tell me how you came to Canada, that is, do you migrate here from what country/countries, with whom, and how long have you been in Canada?

- For example:
    - Before you came to Canada, did you go through, or live in, any other countries?
    - Did you stay in any other Canadian cities before coming to Winnipeg?
    - How did you come to Canada (family sponsorship, provincial nomination, or refugee)? [probe for details]
    - How long have you been in Canada?

3) Tell me about your family and your household, current here in Winnipeg.

- For example:
    - Who lives in your home?
    - What area of the city do you live in?
- For girls:
    - Do your brothers want to know what's going on in your life?
    - Do they try to offer you advice or tell you what they think you should do?

4) Tell me about your schooling.

- For example:
    - What grade are you in?
    - What school do you attend?
    - What kinds of classes are you taking right now?
    - Do you go to any newcomer Programs (programs targeting newcomer youth)?

5) Tell me about first experiences in Canada. What was it like at first as a young person? What was different? Not so different, etc?

- For example:
    - What was it like at first as a young person?
    - Did you notice anything that was different, or not so different, when you first came?
    - Did anything surprise/shock you? Why or why not?
    - [Probe] Norms of gender, dating, sexuality, "sexual freedom"
    - How did you learn about Canadian values/norms?
- How do you think Canadian norms (or values) can be different or similar to the values of your family's and "African"?

6) Tell me about your everyday life in Winnipeg.

- For example:
    - How do you find it with respect to freedom (geographical mobility, sexual freedom, gender equality, etc, however they interpret freedom), and with
    - What do you think of the idea of multiculturalism? Do you think that Canada (and Winnipeg in particular) really is a multicultural society? Why or why not?
    - Do you think Winnipeg is culturally diverse?
    - Have you experienced any forms of racism? What about when you first arrived in Winnipeg? Can you describe these experiences?
    - Do you think Winnipeg is a safe city? Do you feel comfortable being in the downtown area?

[At this point you will want to try and get more specific with questions about sex and sexuality, so move forward at a pace that makes sense for the participant. you might want to end the first interview at this point and make a plan for a second one, or you might feel it is appropriate to continue]

7) Tell me about your own experiences with dating or marriage

- For example:
    - Is having a boyfriend [girlfriend] something that is important to you? Why or why not?
    - If you wanted to, would you be allowed to date? What kind of reaction would your family have?
    - Have you dated in the past?
    - If you were going to date someone [in the future], would you want to date someone with a similar background, or a person from outside your culture/religion? Would your family have an opinion on this subject?
    - Have you been sexually active? At what age and with whom? [not names, but categories of persons, such as long-term boyfriend, fiancé, someone they met in a bar/casual hook-up, etc.]
    - Does your family/parents know about this?

8.) Tell me about your experiences with sexual health education and/or messaging (e.g. in school, refugee camps, at home, from peers, etc.)

- For example:
    - What messages have you encountered?
    - Where did you read or heard about them? In what contexts?
    - What do you think of these messages and how do you make sense of them in your own life?

9) Tell me about your attitudes and perceptions about HIV.

- For example:
    - When did you first hear about HIV/AID? [probe for context]
    - Do you think that HIV/AIDS is talked about differently in Canada (and Winnipeg in particular) than where you grew up?
    - If so, in what ways?

Appendix B: Research Topic and Research Activity Script

I asked you these about this subjects because as a researcher, I am interested in what role sexual health messaging plays in the lives of African newcomer teen girls and young women, specifically what these messages mean to them.

Sexual health means different things to different people. What do you think sexual health is?

In general, sexual health can be associated with sexual well-being, sexuality, prevention, and reproduction.

Do you know what I mean by sexual health message? How would you define it? I mean any medium that communicates information concerning sexual health. These methods may or may not describe/illustrate particular models for behaviour.

I am interesting in knowing where these messages are located and how you came across them. For example, if a teacher handed out a pamphlet or if you saw a flyer in your neighborhood.

I am interested in learning about your perspectives/opinions on sexual health messaging in Winnipeg and, in particular, your communities. This information is valuable for creating culturally appropriate and sensitive sexual health messaging.

We also have a website called "African Youth Talk Sex" (www.africanyouthts.com). It has a 'stories' page where African newcomer youth can voice their perspectives (anonymously through the use of a pseudonym.

I am calling my research activity a "sexual health message biography". This activity involves tracing a self-history of encountering sexual health messages. In the course of your daily routine, I would like you to collect and/or record 10 sexual health messages you come across, over a period of 3 weeks.

Examples of such messages could include billboards, posters, sexual education materials, news stories, pop-ups for a website, advertisements or scenes from a film or television show. It is up to you to decide which messages you would like to collect. You are welcome to collect any other examples of sexual health messages that you can think of.

You can record these sexual health messages by taking a photograph with your cellphone (or if you wish we will provide you with a disposable camera). In the case of sexual health messages in the form of physical documents, such as a pamphlet, you are welcome to bring the actual document in. It is important that you record when you collected the message, where the message was found and if it makes sense, who gave the message to you (for example, a teacher).

After the three week period, we will meet one more time for an interview to discuss the sexual health messages you recorded and collected. We will discuss the particulars of each message as well as your perspectives and opinions on sexual health messaging in Winnipeg.

While I said earlier that you should collect this messages as you come across them in your everyday life, if you cannot see or find any during you regular routine, you are welcome to look for them in your community. If you are unable to find/record any sexual health messages, we can still meet for an interview to discuss your own perspectives on sexual health messaging.

Appendix C: Final Interview Script A

Circulation and Dissemination:

Where are these messages located?

How did you find them? Where did you go?

Did you feel comfortable collecting (or searching for) these messages? Why or why not?

Significance, Symbolism & Responses:

Why did you pick these particular messages? [Make note of the types they brought]

Do you agree/disagree with the message(s)?

Do you think these messages are useful/effective (in general and to you personally)? What would you change?

Personal Sexual Health Message Biography:

When did you first hear stuff about sex? When did you first start learning about these types of things? [Probe for context: school, family, church, community, etc.]

How has this changed since you've come to Canada? Are the messages different? Are they talked about differently? Do you see more (or less) of sexual health messages here?

Who told you about it? (Teacher, relative, etc.)

How did you feel about it, and can you describe this experience?

Do you think these kinds of messages would be communicated differently to your brothers (if you have any) or guys in general?

When did you first start hearing about HIV/AIDS? How did this come about?

Perspectives and Meaning-Making:

If you were thinking about being/hooking up with a guy, would you seek out these kinds of messages? Or other messages?

Where would you look? Magazines? The internet? Family members?

Have you received (or seen) any messages that talk about risk? If so, what did they say?

What does risk mean to you?

I want you to picture two people; one if sexually healthy and the other isn't. What are these people doing differently?

What are the top three worries of having [unprotected] sex?

Appendix D: Final Interview Script B

Personal Sexual Health Message Biography:

That's okay if you didn't collect any messages. Let's talk about that. Did you not feel comfortable looking for them? Could you not find any?

When did you first hear stuff about sex? When did you first start learning about these types of things? [Probe for context: school, family, church, community, etc.]

How has this changed since you've come to Canada? Are the messages different? Are they talked about differently? Do you see more (or less) of sexual health messages here?

Who told you about it? (Teacher, relative, etc.)

How did you feel about it, and can you describe this experience?

Do you think these kinds of messages would be communicated differently to your brothers (if you have any) or guys in general?

What about guys looking for sexual health messages, do you think it would be easy for them?

When did you first start hearing about HIV/AIDS? How did this come about?

Do you think these kinds of messages are more common in Canada or back home? Why do you think this is?

What about how people talk about sexual health, do they focus on different things?

You said that sometimes you parents will use TV shows to communicate their disapproval of certain behaviours (such as dating or getting pregnant). What kinds of messages do you think these shows are trying to relay to youth?

Perspectives and Meaning-Making:

If you were thinking about being/hooking up with a guy, would you seek out these kinds of messages? Or other messages?

Where would you look? Magazines? The internet? Family members?

Have you received (or seen) any messages that talk about risk? If so, what did they say?

What does risk mean to you?

I want you to picture two people; one if sexually healthy and the other isn't. What are these people doing differently?

What are the top three worries of having [unprotected] sex?