Barbie Meets the Bindi: Discursive Constructions of Health among Young South-Asian Canadian Women

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Stereotypes emphasizing passivity, docility and uncleanliness all contribute to cultural (mis)understandings of Canadian women of South-Asian background. Such understandings are a part of dominant racist discourses, including “bodily” discourses related to health. This paper focuses on the discursive constructions of health among ten young, second-generation South-Asian Canadian women from the Ottawa and Toronto areas. In this qualitative study, feminist postcolonialism and poststructuralism are used as a lens through which we analyse and interpret the transcripts of conversations with these women. The results highlight these young women’s discursive constructions of health and particularly how racialized and gendered notions of ‘looking good’ constitute a crucial element in their understanding of what it is to be ‘healthy.’ We discuss and conclude on how these young women locate themselves as un/healthy subjects within larger cultural discourses of traditional (white) femininity, heteronormativity and consumption.

While recognition of the heterogeneity of women’s lives is becoming more apparent in the health literature, research examining the social and cultural patterning of health, illness and well-being among women is still insipient (Janzen, 1998). Yet, the life experiences of some groups of women seem to differ markedly from those of others and of the female population as a whole. For instance, class position, race and ethnicity intersect with gender to produce variations in gender inequality and social variability in health status among women (Bolaria & Dickson, 2002). Racial minority women are doubly disadvantaged because they may encounter inequality due to their race in addition to sex discrimination. In brief, while we do not know much about the situation, we note that the social and economic differentiation of women tends to produce subgroup differences in health effects and outcomes (Bolaria & Bolaria, 1994a).

Relatively few studies have examined the health status of Canadian women belonging to ethnic minorities. Most of them (Bolaria & Bolaria, 1994b; Kim & Berry, 1986; Perez, 2002; Statistics Canada, 1995; Walters et

1 Please address all correspondence to Geneviève Rail, Vice-Dean (Research), Faculty of Health Sciences, University of Ottawa, Ottawa, ON, Canada, K1H 8M5 (e-mail: genrail@uottawa.ca)
al., 1995) have been quantitatively-based, employing surveys, psychological tests and statistical analysis on complex issues. The concern with many of the studies investigating the health and well-being of minority populations is that they tend to include too few variables to adequately capture the complex interplay of factors which likely influence their mental and physical health. No doubt that the increasing cultural heterogeneity of the Canadian population poses a challenge for health researchers and invites the consideration of the intersection of race, class, gender, sexuality and disability within the larger social, cultural and economic context.

In the past 20 years, the Canadian population has undergone increasing cultural diversification. Several researchers (i.e., Bottorff et al., 1998; Choudhry, 1998; Vissandjée, 2001) have investigated the role of culture with respect to health services and have argued that increased cultural diversification challenges the public health system in many ways. For instance, current health services are not geared towards clients of different cultures and are often dysfunctional for people with non-Western values (Vissandjée, 2001). Similarly, limited research has been conducted on disease prevention and health promotion programs, but it seems that the concepts of ‘health’ and ‘disease’ are not always understood in the same way by women from various social and cultural locations. As a result, many discursive constructions of health may not coincide with the North American or European definitions of health (Vissandjée, 2001). With respect to South-Asian Canadian women, the existing literature provides little information on how they construct notions of health or how they interpret and respond to their experiences of ‘health.’ It may be that their cultural location plays a role in their discursive constructions of health, but the latter may also be affected by a dominant (white, Anglo-Canadian) cultural landscape that has much to do with the body and health.

**SOUTH-ASIAN CANADIAN WOMEN & PHYSICAL CULTURE**

During the 1980s, trendy catch phrases such as “Keep fit and have fun! Say nope to dope! No glove, no love! Break free! Just say no!” were constantly beamed into homes as part of the aggressive campaigning by health promotion specialists to encourage young Canadians to engage in healthy lifestyles. The various messages with respect to smoking, drinking and driving, safe sex and physical activity were all part and parcel of the health and fitness movement of that decade. Granted the Canadian government’s disinvestment from health and fitness programs,
the health ‘boom’ that ensued was largely driven by a private sector industry rooted in the promotion of consumerism and the maximization of profit (Rail & Beausoleil, 2003).

To further maximize profits, the health and fitness industry has and continues to target individuals at their core by selling very specific definitions of male attractiveness and female beauty. These messages, packaged as ‘looking great’ and ‘feeling sexy,’ are all part of a dominant discourse on traditional femininity and the responsibility women must take for achieving it. Saturating the market with images of beautiful and hard-bodied women, advertising firms are also selling the idea of consuming various products and services as a way to improve fitness, health and beauty. The notion of the flawed female body as promoted by various industries and perpetuated by the media becomes even more disturbing when taking into account what kinds of bodies are constructed as particularly in need of improvement. On top of the list for correction are too long Jewish noses, too flat African-American ones, ‘Oriental’ eyelids and various signs of aging (Darling-Wolf, 2000). Those whose bodies are not white enough, not young enough, not thin enough or not able enough are considered flawed.

An additional and significant idea that has been promoted over the last two decades is the idea of health as an individual and moral responsibility (Howell & Ingham, 2001; Lupton, 1997). Some authors have written about the parallel idea of individual salvation through consumption of ‘health’ products and programs. For instance, Colquhoun (1987) and Kirk and Colquhoun (1989) have examined the twin discourses of ‘healthism’ and ‘individualism’ and shown how they have permeated many health promotion programs. As defined early on by Crawford, healthism is “a preoccupation with personal health as a primary—often the primary—focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of the life styles” (1980, p. 368). When healthism works in tandem with individualism, the result is the notion that achieving health is the responsibility of the individual (Kirk & Colquhoun, 1989). Health problems are seen as behavioural in nature and thus solutions rest within the individual’s determination to resist culture, advertising, institutional and environmental constraints, disease agents, or simply lazy or poor personal habits.

Within the Canadian context, a holistic definition of health encompassing social, spiritual, emotional, mental and physical aspects has been promoted in school-based health education programmes, in accordance with principles advanced in the World Health Organisation’s (1986) Ottawa Charter. While studies have not been conducted in Canada,
Burrows and Wright (2004) as well as Wright and Burrows (2004) have documented the situation in New Zealand (which has also adopted the Ottawa Charter), and found that despite the promotion of this conception of health, students are continuing to conceptualise health as primarily a matter related to the physiology (e.g., healthy heart, strong muscles) and appearance of their bodies.

Similarly, a number of researchers (Bartky, 1998, 2002; Beausoleil, 1994; Bordo, 1993; Kirk & Colquhoun, 1989; White, Young & Gillett, 1995) have demonstrated how contemporary healthist culture configures body shape, size, weight and we would add ‘whiteness,’ as indicators of one’s health, well-being and moral status. The popular images beamed into homes, endorsed by celebrities and recited through government messages fix in the minds of Canadians the notions of the ‘healthy’ and ‘moral’ citizen. Of note, such notions are often in sharp contrast with the stereotypical representations of visible minority women in Canada (e.g., frail, passive, sheltered, ‘othered,’ unfit, unhealthy) who are hence perceived as ‘costly’ citizens in terms of social and health programs.

In Canada (MacNeil, 2000; Vertinsky, Batth & Naidu, 1996) and elsewhere (Burrows & Wright, 2004; Wright, 1995), researchers have highlighted the ways in which physical education and health programs fail to engage many students, particularly young girls. In the case of girls belonging to ethnic minorities, Vertinsky, Batth and Naidu (1996) have found the problem to be exacerbated. In their qualitative study, they have examined some of the problems and barriers to sport and physical activity participation faced by Indo-Canadian girls and young women within schools and greater society. Among other things, they have found the presence of popular ‘racist’ and ‘sexist’ representations that inform the dominant ‘physical culture’ as well as particular myths and stereotypes regarding Indo-Canadian women that are compounded with the colonial idea that there is one, homogenous Indian culture that is repressive, traditional and in direct opposition to Western culture. As a result, despite the differences that exist among Indo-Canadian women, physical educators still prescribe to the prevailing stereotypes and this affects interactions with students. As Vertinsky and her colleagues state: “a number of teachers still assume that since Indian women ‘look’ the same and ‘seem’ similarly weak and passive, they can’t be possibly interested in sports and that if they were, they would be prevented from such participation by their controlling male relatives” (p. 7). Given such findings, it is not surprising that young women from certain ethnic minorities ‘drop out’ from physical and health education or are simply ‘turned off’ and become alienated from their bodies and themselves.

Although we found no studies to document the situation of minority
young women when they move into adulthood, we suspected that their views on health are marked not only by their South Asianness, but also by their early experiences with physical activity and health education programs as well as by current discourses circulating in popular culture, notably those of traditional (white) femininity and consumption. Handa (2003) has found that second generation South-Asian Canadian women are constantly negotiating and resisting elements from the dominant culture and what they understand to be their South Asianness. We were thus curious to know how minority women are appropriating and/or resisting elements of what we could call a ‘physical culture’ as well as appropriating and/or resisting bodily discourses available within their own family and/or ethnic community. Since few studies have addressed this concern among minority women, we attempted, in this paper, to help in filling this gap and more generally, to inject contemporary theoretical debates about bodies and health with grounded material. In the pages that follow, we report the results of our study about how young South-Asian Canadian women construct notions of health as well as how their constructions are infused with cultural negotiations.

THEORETICAL & METHODOLOGICAL CONSIDERATIONS

Our study is informed by feminist poststructuralist and postcolonial theory (Bhabha, 1994; hooks, 1994; Minh-Ha, 1995; Rail, 2002; Spivak, 1995; Weedon, 1997). From such a standpoint, an individual’s subjectivity is made possible through the already gendered and racialised discourses to which she has access. We thus endeavoured to not only map the range of discourses to which young South-Asian Canadian women have access in constructing their meanings for health but also to investigate how they position themselves in relation to these discourses. For example, do they passively accept and enact the health messages promulgated in mainstream (white) media? Are such messages consistent with or divergent from knowledge and values inculcated in other contexts? How do they construct meanings for health alongside discourses about what it means to be gendered, racialised? Using a poststructuralist orientation also means that we were interested in ‘constructions,’ a term that reflects the notion that reality is made and not found; young women construct ‘reality’ through language and cultural practices. With respect to ‘identity,’ we understood it as being not fixed but rather dynamic and multiple (Tsoldis, 1993). Identity is negotiated in relation to various sets of meanings and practices that individuals draw on as they participate in the culture and come to understand who they are (Gilbert & Gilbert, 1998). In
this sense, identity involves a notion of agency and performance; a re-experiencing of meanings already socially established (Butler, 1990, 1997). As for ‘discourse,’ Like Foucault (1973), we understood this concept as not being about objects but as constituting them. Discourse refers not only to the meaning of language, but also to the real effects of language use. Discourses are ‘regimes of truth’ (Foucault, 1973), and as such, they specify what can be said or done at particular times and places, they sustain specific relations of power and they construct particular practices. It is through discourse that meanings, subjects and subjectivities are formed. Although discourse is not equivalent to language, choices in language (e.g., choosing to classify overweight as an illness) point to those discourses being drawn upon by speakers and to the ways in which they position themselves and others. Like Weedon (1997), we worked with an understanding that experience is given meaning in language and through a range of discursive formations that are often contradictory and that constitute conflicting versions of social reality.

Our postcolonial stance allowed us to consider issues of history, migration and identity, specifically ‘diaspora identities’ that can be characterized by a connection to the ‘old country.’ Differences of gender, race, class, generation, religion and language make diaspora spaces dynamic, shifting and open to repeated construction and reconstruction (Minh-Ha, 1995). We agree with Brah (1996) that a diasporic space is “the point at which boundaries of inclusion and exclusion, of belonging and otherness, of ‘us’ and ‘them’ are contested” (p. 181). Diasporic spaces highlight the manner in which a group is inserted within the social relations of class, gender, sexuality and various other dimensions of differentiation in the country to which one migrates. Handa (2003) has claimed that it is in the moments of crossing and resisting norms that the boundaries around community and cultural, ethnic and racial identities become apparent. She suggests that “their articulations, challenges and resistances to prevailing narratives of ‘South Asianness’ and ‘Canadianness’ set them apart and/or exclude them from dominant readings of what it means to be a young South-Asian woman in Canada” (pp. ii-iii).

Wyn and White have spoken of research that is “sensitive to the actual lived reality of young people if we are adequately to understand [their] cultural worlds” (1997, pp. 77-78). Our study took up this challenge and involved conversations with ten South-Asian Canadian women—South Asian was defined here in the diasporic sense and referred to people who have a cultural or historical connection to the South-Asian subcontinent (India, Pakistan, Bangladesh, Sri Lanka, Nepal). All women were between 20 and 25 years old and, in terms of religion, three were Muslim, three
were Catholic, two were Hindus, one Sikh and one Zoroastrian. Seven out of the ten women were students at the time of the conversations while the others were in the workforce. Purposeful and snow-ball sampling techniques were used and all women were contacted through the South-Asian Canadian community in Toronto and through the student association that is well known to young South-Asian Canadian women at the University of Ottawa. The conversations with the participants lasted between one and two hours and followed loosely the order of the questions listed in our Conversation Guide. Open-ended questions were favoured so as to maximize discovery and description (Reinharz, 1992). These questions focused on four main themes: a) the constructions of health—how the young women have experienced health in their own lives, what they think health is, how they know when one is healthy, what health ‘feels’ like, etc., b) the sources of their constructions of health or where they get their ideas about health, c) culture and the constructions of health or what the ideas of health are in the various communities they belong to and how they are the same or different from theirs and d) the integration of their constructions of health in their day-to-day life. The conversations were tape-recorded, transcribed and then organized with the assistance of the Nud*ist Vivo qualitative data analysis package. To insure anonymity, self-chosen pseudonyms were used in the transcriptions and in the current paper.

The conversation transcripts represented the ‘cultural texts’ that were analyzed using a discourse analysis method informed by feminist poststructuralist theory (Rail, 1998; Weedon, 1997; Wright, 1995). The focus of analysis was on how young South-Asian Canadian women construct health, on the role discourses play in constituting their understandings about health and on the ways in which their meanings about health were constructed in specific cultural circumstances. The analysis was based on ‘close readings’ of the data and recognition of contestative/alternative interpretations of language and meaning in keeping with poststructuralist critique (Scheurich, 1997). This approach enabled a complex picture of the young women’s constructions of health to be developed. Rather than simply coding their responses to questions about health, the grounding of the project in poststructuralist and postcolonial theory meant that the analysis took account of the cultural practices and discourses that shape the way they come to think about health. Links between the young women’s discursive constructions of health and wider discourses at work in Canadian society were drawn upon in an attempt to understand why certain meanings are favoured and not others. It is through discourse analysis that we explored how the young South-Asian Canadian women occupy the diasporic spaces that
they share with others and how they come to re/awaken ethno cultural consciousness in conjunction with their discursive constructions of health.

**DISCURSIVE CONSTRUCTIONS OF HEALTH**

In our study, the conversations began with a question about what health meant to the young South-Asian Canadian women. At first, the kinds of meanings to which most of these women referred corresponded very closely to what is promoted in most health-related classes and in the media (Rail & Lafrance, 2004). Various themes emerged from their narratives and they are presented in Table 1. To summarize, the themes

**Table I: Themes in the Discursive Constructions of Health among Young South-Asian Canadian Women**

<table>
<thead>
<tr>
<th>Health is...</th>
<th>No. of women (N = 10)</th>
<th>No. of mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking Good</td>
<td>10</td>
<td>50 (total)</td>
</tr>
<tr>
<td>• Having good appearance/glowing skin/fresh look/presenting one’s best self</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>• Not being overweight</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>• Taking care of one’s body, appearance</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Being in Control and Achieving Balance</td>
<td>7</td>
<td>32 (total)</td>
</tr>
<tr>
<td>• Being disciplined</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>• Being comfortable with who you are what you are doing</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>• Having goals</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>• Being able to do what you want to do</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>• Minimizing stress</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Being Physically Active/ Fit</td>
<td>9</td>
<td>29 (total)</td>
</tr>
<tr>
<td>• Exercising regularly</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>• Having a lot of energy</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Feeling Good</td>
<td>9</td>
<td>25 (total)</td>
</tr>
<tr>
<td>• Having self-confidence, contentment</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>• Being in a positive mental state</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>• Being in a state of happiness</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Eating Well</td>
<td>7</td>
<td>19 (total)</td>
</tr>
<tr>
<td>• Eating fruits and vegetables</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>• Not eating “junk food”</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Having Good Personal Attributes</td>
<td>7</td>
<td>14 (total)</td>
</tr>
<tr>
<td>• Having no physical limitation</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>• Having good personal attributes</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>• Having no chronic illness or disease</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Having Holistic Health</td>
<td>2</td>
<td>4 (total)</td>
</tr>
<tr>
<td>• Being healthy in a comprehensive manner (physical, mental, spiritual, and emotional)</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>
that were most frequently present in the young women’s constructions of health were: looking good, being in control and achieving balance, being physically active/fit, feeling good, eating well, having good personal attributes and having holistic health.

By far the notion of ‘looking good’ was the most reiterated in these young women’s narratives. Looking good was characterized as having ‘a healthy glow’ or ‘a fresh look.’ When these women felt they looked good, they reported feeling good about themselves, their health and their bodies. ‘Looking good’ basically meant taking care of their body and presenting themselves in a respectable manner. This is well illustrated in Cindy’s terms: “Healthy to me means, um, taking care of your body, like maintaining a decent weight, looking presentable, you know, like being healthy and fit. I think if you work on your body, you’ll look good, feel good and you’ll also be healthy.” Cindy clearly emphasized how taking care of one’s body is a sign of being healthy. At the same time, her narrative is marked by the notion that one has to ‘work’ on one’s body to reach health. Such work is therefore not strictly ‘being healthy’ it is also ‘becoming healthy.’ The equation ‘looking good = health’ is evident in Emily’s description of a healthy individual:

I think a healthy individual would probably have the glowing skin, not necessarily the slim trim body, but, ah, just like, I don’t know really how to explain it. I’d say I’d look at health from the face type thing. If their eyes are sparkly and their skin is nice and glowing… And I think you can tell a lot from the way a person treats their body from just their face. I don’t really think you need to look at their body at all because there’s a lot of people who don’t look fit but really are much fitter than people who are really thin so…

‘Being in control and achieving balance’ were also seen as important components of health, although to a lesser extent than looking good. Being in control was described as making good choices and not engaging in destructive behavior such as abusing alcohol, smoking or using drugs. Being in control also meant being disciplined, having goals and being able to do things. This is well illustrated in Amar’s statement:

Healthy to me means being fit, feeling good, eating right, having a lot of energy, not having physical limitations. Like to be able to do whatever it is you want to do physically, I guess and mentally also. I guess I don’t really think health is strictly physical. Like, it’s just being your best self so that you can take on whatever it is that you want to take on.
Also highlighting the notion of being in control and achieving balance, Emily described what kinds of personality traits a healthy individual would possess: “Someone who’s healthy would have, personality wise, I would consider them to have a high a self-confidence, they’re comfortable with who they are, they have goals and achievements, and they want to achieve certain goals in their lives. Something like that.”

‘Being physically active/fit’ and to a lesser extent, ‘eating well’ were also mentioned by the participants. Considering the pervading public health messages about fitness and nutrition, it is interesting to note that these ideas were not as prevalent in the young women’s narratives. Some participants did allude to the opposition between ‘junk food’ and health but the issue seemed more complex than this, as can be seen in this excerpt from a conversation with Mary:

I don’t know if I would be able to tell if someone was healthy. I’d only be able to tell if they were trying to be healthy, if I know that they’re going to work out, if they plan on working out or if they are, and if they’re eating properly. If they’re eating fruits and vegetables as opposed to eating like poutine and burgers everyday, I guess, that would be an indication. Like I eat a lot of junk food, but I go to the gym and work it off because I don’t want to gain weight. Does that mean I’m not healthy?

In speaking about her own bodily practices, Mary drew on shared meanings and dominant understandings of the body as a mechanical body dependent on the regulation of the relationship between food and physical activity. In the next section we discuss in more detail how such regulation was found to be intertwined with the participants’ narratives on health.

A last important theme in the discursive constructions of health was the notion of ‘feeling good’ and encompassed ideas such as having self-confidence, self-contentment, being happy and having a positive mental state. A positive mental state was seen to contribute to one’s overall disposition and outlook on life and that was thus perceived as having a healthy outlook. In the following excerpt, Kavitha offers a description of the relationship between mental state and health:

I think [that] for overall health, physical fitness is not as important as your mental state. I think your mind dictates more your health, I think, I don’t know why… Like physical activity definitely is an issue. You can’t tell me it isn’t. Like, if I see someone who’s sedentary and doesn’t do any physical activity, I won’t say that they’re healthy. I don’t think
it’s a healthy trait, but I don’t think you need to do that much to be healthy. A healthy person is a good person. Yeah, cause I really believe mind controls the state of your health.

Katie emphasized self-satisfaction as a necessary component of health, as grounded in one’s personal position in life. According to her, this idea of self-contentment contributes to ‘feeling good.’ Her notion of health encompasses a level of comfort with the body that was discussed by her and the other young women as well:

I think eating well, exercise, just generally, I mean, going outside and getting sunlight, having a good outlook, just like a generally good feeling about the way you are when you wake up in the morning, that you’re satisfied with who you are... It doesn’t have to do with size or physical appearance, but just to make sure that you’re comfortable with what you’re doing in your life physically and how you eat and things like that.

As can be seen in this last excerpt and in the narratives more generally, constant links were being made between nutrition, physical activity, feeling good and looking good. These links followed a logic so that health (often constructed as ‘looking good’) tended to be connected to a mechanistic interpretation of the body that deals with food (energy in) and exercise (energy out) in a way that often results in excess weight.

A Heavy Weight to Bear: The Connection between Health & Weight

Unequivocally, all the South-Asian Canadian participants reported subjecting themselves to bodily regulation and discipline to meet the requirements of conventional femininity. Some young women emphasized the need for a healthier diet in order to lose weight; others discussed the struggle to maintain their weight while one woman was concerned about gaining weight. Mary’s statement is illustrative in that regard:

Yeah, I’d say I am [concerned about my weight]. Yeah, I wouldn’t say I’m obsessed with it, but I’d say I notice when I put on a couple of pounds. And I’m like: ‘ah crap, I have to stop eating this junk food.’ Yeah, I’d say I’m concerned about it. I’d like to stay the weight I am, try to maintain it.
Another example of the general trend in the conversations involved Katie, who articulated a discontentment with gaining weight:

[Gaining weight] is important to some people, and it’s important to me personally, but not even because I want to impress my fiancé because that’s not what it is, it’s something personal that I want to do and I think it’s because I used to be a lot skinnier than I am now and that’s had an effect on the way people will say ‘Oh, you’ve gained some weight there…’ Things like that which shouldn’t bother me but do.

In the above excerpt, Katie admitted that comments on her weight should not bother her. In this way she showed signs of resistance to dominant discourses of (white) beauty although she confessed to being bothered and therefore to accepting the conventions. The next conversation fragment provides an example of a bodily concern of a different nature:

I want a six-pack and I don’t know why, but I’m obsessed with a six-pack. Also, I prefer not to have my legs as large as they are [laughs]. But what drives me right now is that quest for a six-pack. I’m also concerned about my facial hair; it’s a bitch for me and annoys me because there’s nothing I can do physical fitness wise to turn it on or off. It’s a different problem for me. (Kavitha)

In many ways, this narrative coincides with the dominant discourse on conventional femininity and the responsibility women have to take for achieving its standards (Markula, 1995). The ‘large’ legs are disliked and the undesired facial hair is noted. But what is striking is Kavitha’s use of the term ‘six-pack’ (an idiom anchored in dominant masculinist discourses) to convey her desire for a flat mid-section where muscles are evident. Kavitha’s self and desires seem at the same time captive and reflective of the language she uses. Although Kavitha’s narrative is subversive with respect to dominant ideals of femininity (which are not usually inclusive of prominent muscles), her self-satisfaction seems nevertheless dependent on the attainment of the body she desires—something not so different from the other women in our study.

The young South-Asian Canadian women in our study rearticulated many elements of the dominant discourse on conventional femininity that sees ‘fat’ bodies as a challenge to the ideal of bodily perfection. According to such discourse, fat bodies are blatantly sexual, unapologetically physical, primitive, uncultured and out of control (Darling–Wolf, 2000). Fat bodies are under the most pressure to submit to regimes and at times
to surgery. Those who remain fat in spite of exercising machines, diet pills or weight loss programs are deemed lacking in moral character: “The firm, developed body has become a symbol of correct attitude; it means that one ‘cares’ about oneself and how one appears to others, suggesting willpower, energy, control over infantile impulses” (Bordo, 1993, p. 195). Kirk and Colquhoun (1989), as well as Tinning (1985) and Sparkes (1989) have shown how body shape, size, weight, firmness and beauty have come to be seen as markers for physical fitness and health. Such elements of the dominant discourse on femininity were recuperated by the participants to constitute themselves as healthy or less healthy subjects.

A Hairy Situation: Health & Grooming Practices

For the young South-Asian Canadian women who participated in our study, the discursive construction of health (e.g., ‘looking good’) and the quest for health were associated with a whole host of grooming practices. The quest for perfection not only resided in a constant monitoring of their weight, but also of their overall appearance. Perfection is signified by their comments on themselves and others who are ‘roly,’ ‘chubby,’ ‘fat’ and ‘gross’ when they are in an undesirable state which is mainly attributed to a lack of exercise and bad eating habits. According to Wright (2004) ‘normality’ has become embodied. The bodily feeling that occurs when these women move beyond what they consider ‘normal’ is uncomfortable and serves to motivate them to modify their eating, exercise or grooming practices, however temporarily. The idea of ‘normality’ is, of course, a socially constructed one and inklings of resistance to this idea could be heard. Amar, for instance, explained what she meant by her ‘own standard’:

I think if you didn’t care what you looked like, it would be, not something wrong, but I think it would be a little unusual to not care entirely. And caring what you look like doesn’t mean, you know, being a supermodel. Caring what you look like is just maintaining a certain level of what you think, how you want to appear and how, like, what I was saying: when you look good, you feel good, you look healthy. You know, so if you get up in the morning and you don’t wash your face and you don’t comb your hair or whatever, that’s going to catch up with you eventually. You know, you’re going to notice. It’s going to have its effects, physically or what not. But it’ll take its toll on you when you look at yourself in the mirror. You feel like you can face the world when you look good. And looking good doesn’t mean wearing more makeup or looking good doesn’t mean fitting into someone else’s standard of looking good. It’s fitting into your own standard of looking good.
While Amar’s notion of her ‘own standard’ seems less influenced by social constructions, her larger narrative includes elements of a dominant (racist, sexist, heterosexist) discourse on beauty. For instance, when later asked what other grooming practices she engaged in, Amar responded in the following manner: “Oh, tons of hair removal. [Tammy: Yeah?] Man you name it, I’ve tried it. Waxing, tweezing, right now, I’m getting electrolysis done. [Tammy: Really?] Yup, on my eyebrows as well as upper lip area. I also bleach.” In this exchange, Amar admits to bleaching—a practice used by women to lighten facial hair and skin. Often darker facial hair contributes to a darker tone of the skin, so women will engage in bleaching techniques in an attempt to obtain a fairer complexion. Cultural constructions of white, heterosexual female attractiveness have real life consequences on women’s bodies and ideas of health. Lakoff-Tolmach and Scherr (1984) have studied the hierarchy of skin color within the African-American community and found that lighter-skinned women—those closer to the white ideal—are considered as most attractive according to this hierarchy. The women they interviewed spoke of the pain of being deemed ‘ugly’ because of the darkness of their skin within a community that is supposed to provide them with the support they need in the larger racist cultural environment. The idea of attractiveness is invariably racialized, which means that the experiences of many women of color are structured by the racist aesthetics that are derived from colonial discourses (Mama, 1995). This seems to have been the case here. Both bleaching and waxing (which involves the removal of dark hair from the face to provide what is believed to be a fairer, cleaner and neater complexion) are less about South-Asian Canadian women wanting to be white than about South-Asian Canadian women wanting to be ‘attractive.’ In a world that associates beauty to being blonde and blue-eyed, certain health practices are seen to be imperative for women to succeed with men and society in general.

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2 The term Indian is problematic and has been internally contested and debated. However, regardless of where they were from (Pakistan or India), the young women in our study commonly referred to themselves as “Indian.” This finding points to the continuing dominance of “Indian” as an identity within the South-Asian diaspora.
The following excerpt from the conversation with Priti illustrates how imperative waxing is perceived:

Tammy: You exercise a lot and mentioned that you try to eat well. Are there any grooming practices you engage in?

Priti: Yes, waxing cause I’m Indian, we’ve got the facial hair [laughs]. Yes. Mostly brows and the sides, face, I wax just about everything.

Tammy: Have you been doing that since you were young?

Priti: I think the… My face especially, probably since I was about 18 because it was something, it was one thing that bothered me in high school. It’s funny that I didn’t get teased about it a lot… Mostly from my sister, more than anyone!

What is telling in Priti’s admission is that she associates waxing to being “Indian.” She assumes that all “Indian” women have the same experience of hair removal. Priti’s notion of hair removal is grounded in what she believes to be an ‘Indian’ cultural discourse of femininity.

3 While the importance of skin colour and the preference of a lighter skin complexion are beyond the scope of this paper, the complexity of this issue does warrant some discussion. Women in this study believed that the removal of facial hair or bleaching the skin were practices very much linked to an “Indian” discourse on femininity. Within the North American context, we can attribute this desire for fair skin to hegemonic North American standards that enslave all women. In her study, Rahman (2005) discusses the role of skin color in the lives of Hindu women in India and black women in the United States to develop a framework for understanding skin color and its impact on U.S. first generation immigrant Indian-American women. Rahman argues that the politics and implications of skin color in the Indian community and among black Americans are extraordinarily similar. Three commonalities between Indians and black Americans are noted. First, both race and caste are systems of social closure. Second, black women in America and Indian women are sexualized and racialized in a similar manner. And third, skin color and other facial features play a significant role. Thus the message relayed to the women of both cultures is that light skin is more attractive than dark skin. Internalizing the “ivory skin model,” women in both cultures go to great lengths to alter their phenotypic features. Parallel to this, if we look at the aggressive marketing campaigns in the South-Asian subcontinent (Sri Lanka, India, Pakistan, Bangladesh, Nepal) with respect to achieving fair skin, different issues surface. Rahman (2005) has suggested that skin colour came to be strongly tied to the caste system which preceded colonialism by a few thousand years. Lighter skin, which was equated to beauty, was also associated with a higher caste and hence more social prestige. British colonialism sought to fashion a Western-style state structure in colonial India which has meant white rule and supremacy (Kaviraj, 1997). The British produced a cultural consensus in India in which could be observed the political and socioeconomic domination of white and lighter skinned people over darker skinned people (Nandy, 1982). In brief, skin colour is an extremely complex question grounded is issues of class, colonialism and both Western and Indian notions of beauty.
For other participants, grooming practices were important as well, but they were more clearly linked to health. Katie’s narrative is a good example, in this regard:

> Like, well, I eat healthier now, a lot healthier than I used to eat. I try to get more fruits and vegetables and water in my diet. I think just maintaining… I don’t think there’s anything wrong with maintaining yourself and grooming yourself to look good, like moisturizing your skin or cleaning your hair or keeping things neat. I think that is a part of being healthy, to keep bacteria and dirt away: it’s a way to be proud, to be able to walk out of the house. I’m not saying to go out of the house with a ton of make-up or anything like that, but to be presentable, I think that’s OK.

In much the same way as Katie, Mary confessed to a whole host of grooming practices. In her narrative, there was an emphasis on being ‘neat’ and ‘clean.’ However, another trend is well illustrated and it is the link that is made to beauty as a commodity. There is a sense of pleasure and personal accomplishment through the purchase and use of expensive skin care products. Consider the following excerpt:

> Oh, that kind of stuff, ah, yup, I wax my upper lip, I shave my legs, my armpits, what else, well… I can give you a whole bunch. I use whitening tooth paste, I use a skin brush when I take my shower, I buy like the most expensive face products, Biotherm, and waste all my money. [Tammy: Do you find that they’re worth it?] I feel good when I use them actually. Like I know that you probably wouldn’t notice a difference because you haven’t seen me before, but my face feels a lot more moisturized, like I can feel it right now: ‘oh, it feels so soft.’ Like I used to use Beautiful Skin products as well. I would, say, I feel better using Biotherm, of course, I could just be saying that because I spent money on them, making myself feel that way, but I like them a lot. Um, my nails, I haven’t really painted in a long time so I don’t really keep up with that. Same with my toe nails but I put on make-up once in a while. Not today. (Mary)

To the young South-Asian Canadian women in this study, health meant ‘looking good’ and looking good meant following and adhering to certain rules—skin care, hair removal, make-up—prescribed by a dominant discourse on femininity (Bartky, 1998, 2002; Bordo, 1990, 1993). This is not surprising, according to Bartky:
A host of discourses and social practices construct the female body as a flawed body that needs to be made over.... The media images of perfect female beauty that bombard us daily leave no doubt in the minds of most women that we fail to measure up; we submit to these disciplines against the background of a pervasive sense of bodily deficiency. (2002, p. 248)

The narratives of the young South-Asian Canadian women in our study reveal how they use the traditional discourses of femininity and consumption to construct their identity. The link that is made between health and looking good explains in part the vested interest in grooming practices. At the same time, the reasons motivating their involvement in such practices go far beyond health.

Health = Looking Good = Being Successful

Understanding how the young South-Asian Canadian women in our study come to construct health and what discourses they draw on to inform their notions of health contributes to understanding why they engage in certain ‘health’ practices. Throughout the conversations, the young women were asked questions about how they felt about their bodies and whether or not they thought they were healthy. They were also asked why it was necessary to be healthy. In her own way, Isabella seems to voice here the concerns of many participants:

Good-looking people get away with a lot of shit.... I want to look good. I want to be able to be the best I can be. There is no reason why we can’t look as good as we can or feel as good as we can. [Tammy: Where do you think this comes from?] I’d say our family plays a role in what we look like because there’s always someone having something to say about how we look, whether it is our grandmother or mom or dad. They sort of equate success with how you look. Whether that’s true or not, they don’t want us to be discriminated against because of how we look. So, I guess some or a lot of my ideas come from that. If we’re not dressed a certain way or look bigger, we’ll hear about it.

In the above excerpt, Isabella considers this relationship between success and physical appearance and believes that the latter contributes to her overall value as an individual. She mentions her family as playing a significant role in her conceptions of ‘looking good’ and also admits that her parents and grandmother see ‘looking good’ as a strategy against discrimination. Later in the conversation, Isabella confides that her parents have encountered instances of racism in Canada. She knows that being South-Asian Canadian means ‘being brown’ and she agrees that there is a potential for her color to work against her. In her view, focusing
on physical appearance and presenting ‘the best [she] can be’ are well worth the efforts to ‘get away with a lot’ or to ward off discriminatory encounters. In the following narrative, Kavitha also links health to success. She prescribes to the discourse of the healthy and hence productive and successful body. Kavitha realizes that engaging in health practices will benefit her in the short term but also in the future:

*I’m in this success phase where you should be the best you can be. Why? I don’t think I’m unhealthy, I think I have my basis covered, but I think I can do better. On a scale of 1 to 10, I think I’m a 7 or a 7.5, but why can’t I be a 10 or 9.5? Why not do all I can do and why am I not doing it? Then that line my mom always says: “You’re the one that benefits from studying.” But with respect to physical fitness, who’s the only one going to benefit from me being healthy?*

In keeping with the idea of ‘looks for success,’ Cindy candidly expressed how physical appearance plays a vital role in one’s interactions with others. She stated that “if you look weird or different, people won’t come up to you…. It’s the kind of, like, you have to suit the projected image of society. You should always try to look your best.” Cindy linked the idea of ‘look[ing] your best’ to achieving the standards society has established for women with respect to physical appearance. Another participant, Katie, spoke of how such standards are gendered:

*I think [there’s more pressure to look good] for women than men. It’s a huge concern for women. And again it’s the media, the skinny supermodel. When you look at the things that are popular, the movies, the TV shows all the things that are doing extremely well, they all got their tiny really beautiful women and it makes it really difficult for a girl who’s average-looking to be able to go out and try and meet someone or whatever, just to feel confident about being out of the house when you know that there’s some girl down the street looking gorgeous and she may not have half the personality that you have and she may not be as nice as you are, but that’s what the mentality is: that person is beautiful where you’re just sort of average…. Oh there’s so many [benefits to looking good]: the men are going to flock to you and, you know [laughs], umm, even just job opportunities…. I would almost love to do a study, a beautiful woman and an average-looking woman and they go for the same job, they have the same qualifications: who’s going to get that job? There’s just so many factors, I think, it effects. For example, if we’re to go to a bar and I was wearing jeans and a sweatshirt, I may not get anyone coming to talk to me, but I know when I dress up and I have a little bit of make-up and a tight top, I’ve got all these guys who are: ‘Hey,
how are you doing?’ And it’s like: ‘Hey, why didn’t you talk to me before? I’m the same person!’

According to Rice (2002), a woman’s body is often her currency, its value measured according to heterosexual standards of desirability. This seems to be the case for many participants here as the young women appear to develop a sense of their body as a result of others’ assessments of their sexual attractiveness. In the above narrative, Katie noted the attention she can receive and showed her awareness of the benefits of beauty on the occupational front and in terms of the male gaze. In the next conversation fragment, Emily describes the importance of physical appearance in terms of appealing to the male gaze and finding a partner:

Tammy: Why do you think this [physical appearance/looking good] is a concern for you or girls our age?
Emily: I don’t know. I guess maybe it has to do with not being able to find a boy or just...
Tammy: Do you think it’s a real concern?
Emily: Well, yeah. Not for me because I have a boyfriend. But a lot of girls our age want to make sure that they look good so that they... because that’s the first thing you see, right? They could be an amazing person, but the guy sees your body first, so I need to make sure I look good so that I can attract a certain type of guy. So I think it’s a concern for us.

Rice (2002) has pointed out that a woman’s awareness of her appearance is heightened by the evaluative gazes she absorbs. This process begins at puberty and girls become increasingly focused on regulating, managing and controlling their bodies to meet an internalized ideal (Bordo, 1993). For the participants in our study, becoming a woman seems to involve exactly this: the internalization of cultural structures relating to appropriate appearance and behavior, and the adjustment of one’s body in an effort to reproduce an acceptable or desirable form.

CONCLUSIONS

Furthering the understanding of how young second-generation South-Asian Canadian women construct their own meanings of health has been the focus of this paper. Our results show that these women’s discursive constructions of health are very much tied up with the larger discourses of conventional femininity, heteronormativity and consumption. Such constructions are highly gendered and, in certain
instances, racialized. We do not mean to suggest that the young women prescribe to a cultural ideal of femininity as ‘passive dupes’ of dominant (white) ideology. On the contrary, they have shown important moments of resistance, at best, and accommodation, at least, to various dominant discourses. For instance, the participants resisted the discourse of meritocracy in that they recognized that despite someone’s efforts or qualifications, the better jobs await those who ‘look good.’ All of the women discussed the varied ‘health’ practices in which they engaged, however, the grooming practices, understood as one type of health practices, were the ones that allowed them to bond with family and friends and to become knowledgeable about a culture and its repertoire of cultural practices.

Many of the young women accommodated to the dominant discourse of beauty. Although they mocked its premises and expressed their frustration with the feminine ideal, they ultimately felt trapped and thus continued to strive for the socially acceptable ideal. The South-Asian Canadian women in this study found it difficult to discipline their bodies (e.g., waxing, bleaching, shaving, exercising, dieting), but found it to be a good strategy for success and against the discrimination which they recognized to be part of their day-to-day lives although to a lesser extent than their parents.

The young South-Asian Canadian women in our study were not exempt from being consumers of commercialized and commodified products of our healthist culture. Since this culture provides discursive resources for making sense of health, these women constructed their own meanings of health and, at the same time, their own identities using such resources. They did so sometimes in highly subversive, but often in reproductive and conformist ways. Their narratives on health were infused with elements of their cultural heritage and elements of the white colonial discourse. Young South-Asian Canadian women located themselves at the intersection of these sometimes competing discourses and constructed their position as shifting between ‘healthy’ and ‘unhealthy’ subjects. Their position shifted as they mentioned their involvement (or not) with certain ‘health’ practices. In all cases, their discursive constructions of health integrated the discourse of individual responsibility for health. We regard such integration as being quite dramatic since we know that the first determinant of health in Canada is socio-economic status and, therefore, that health is more of a social issue than it is a personal one. Re-articulating the discourse of personal responsibility for health tends to blame the victims while governments generally continue to disinvest from social spending that affects health (e.g., healthcare, social welfare, education, physical education, fitness, the
Connecting health foremost with outward appearance and notions of beauty (i.e., non-health factors if we consider the W.H.O.’s definition of health) is both interesting and problematic. Interesting, in that it forces health professionals and public health officials to rethink their policies, approaches and programs whose focus has so far been on negative behaviours such as smoking, taking drugs, abusing alcohol, not sleeping enough, having unprotected sex, drinking and driving and so on (none of those have been discussed by our participants). Interesting also because defining health as ‘looking good’ may appear antiquated yet it is seen by the participants as a pragmatic strategy with which to combat racialization, discrimination and marginalization. We also note that the main result (health is ‘looking good’) is problematic because constructing ‘health’ in this manner means that, paradoxically, some ‘health’ practices (e.g., waxing, bleaching, dieting, wearing high heel shoes) can be hazardous to health.

Perhaps the most significant consequence of equating health with ‘looking good’ remains the fact that we have very narrow ideas of what is beautiful—ideas that are grounded in racist and colonial views. When young South-Asian Canadian women recite dominant discourses to construct their own ideas of health, it may ultimately lead to uneasiness, shame or guilt. Indeed, their ‘Indianness’ sets them up for failure: they may strive but will never really attain ‘health,’ that is, white notions of beauty. Unless dominant discourses change or subversive discourses are given a more prominent place, the acquisition of new subject positions will remain limited, and ‘health,’ constructed in whatever way, will remain elusive for most women, particularly those who are racialized and marginalized.
REFERENCES


