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Oakland Asian Youth Envisioning Health Through Photovoice

by

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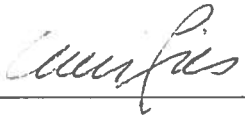
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Part 1
Oakland Asian Youth Envisioning Health Through Photovoice:
A Review of the Literature

Health status of Asian Americans and Pacific Islanders

Currently, Asian Americans and Pacific Islanders (AAPIs) are the fastest growing racial/ethnic population in the United States (U.S. Census, 2004a). From 1980-1990, the AAPI population increased 95% and from 1990 to 1999, another 43%. At this soaring rate, the AAPI population, at currently 10.6 million people and 4% of the US population, is expected to reach 33.4 million or 8% of the US population by the year 2050 (U.S. Census, 2004a).

Despite recent increasing numbers, a dearth of attention has been focused on the health needs of this population, mainly due to the idea that Asians as a group generally enjoy superior health status; an idea promulgated by the "model minority" myth. The term "model minority" was coined in the mid-1960's by William Petersen (1966), a social demographer studying the alleged success and assimilation of Asian Americans and Jewish Americans into American culture. In recent decades as the AAPI population has grown in the US, media representations of Asian Americans have predominantly been of a hard working, wealthy, intellectually superior, self-sufficient group who demonstrate by example the achievability of the American Dream, and are therefore model minorities (Fong, 1998). While aggregated statistics do demonstrate that Asian Americans have high educational attainment as well as a relatively high median family income, further scrutiny reveals a more complicated picture. Although some segments of the AAPI population have achieved higher educational and income levels than the country's average, other groups have some of the lowest incomes and educational attainment levels in the country (Ong, 2002).

This fallacious model minority stereotype has served to portray Asian Americans as a homogeneous group that has overcome social discrimination and therefore no longer warrants societal assistance. While superficially flattering, the ultimate effect of this stereotype is not only to pit minority groups against each other, but also to obscure the true difficulties and discrimination faced by the Asian American population in the United States, such as social and linguistic isolation, socio-economically disadvantaged status, and lack of access to education and health care.

The reality is that the AAPI population consists of 49 distinct ethnic groups speaking over 100 languages, and displays a rich diversity in cultural practices, languages spoken, socioeconomic environments, and colonization and immigration histories, as well as widely varying health needs. The aggregation of a group exhibiting such diversity creates formidable obstacles to understanding the unique health problems faced by each distinct ethnic subgroup.

The pervasive model minority epithet has not only indelibly imbued the social arenas such as educational attainment for Asian Americans, but it has also influenced the manner in which Asian Americans are perceived in the health arena. These stereotypes and preconceptions can have very detrimental effects on the health of Asian Americans, as serious health problems in this population continue to be neglected. Codification of these public perceptions is apparent in the neglect of data collection and research on

AAPI health. Only 0.2% (342) of 150,369 National Institute of Health grants addresses the needs of AAPI populations from 1986 to 2000 (Ghosh, 2003).

The gap in literature around AAPI health is now capturing the attention of the public health community. Healthy People 2010 acknowledges eliminating health disparities as a top priority in current public health practice. Of the need for data regarding the AAPI population, Ghosh (2003) writes, "Without more data, in 50 years, when AAPIs reach 11% of the US population, the medical community will be floundering over how to provide care for this group. If subgroup analyses are not performed, the United States runs the risk of creating a health policy on the entire AAPI population based upon data from a few of its subpopulations".

Oakland AAPI youth health

To describe Oakland AAPI youth health, we must engage both the literature concerning the health inequities and the social determinants of health affecting the AAPI population as well as the available literature concerning adolescent health at the city, county and state levels.

Context: Oakland AAPI demographics

The city of Oakland is located in the San Francisco Bay Area of California, and is the largest city in Alameda County. The total population of Oakland is 399,484 (US Census, 2000). The youth population of Oakland is very diverse. The largest racial/ethnic groups among youth aged 10-24 years in Alameda County include Latinos (28%), Whites (25%)

and Asians (25%). The total AAPI population in Oakland is 69,616, comprising 17% of the city's population (US Census, 2000). Of this population, Chinese make up 49%, followed by Vietnamese at 14%, Filipino at 12%, Cambodian at 5%, Laotian at 5%, Native Hawaiian or Pacific Islander at 5%, Japanese at 5%, Asian Indian at 3%, Korean at 3%, and Thai at 0.4% (US Census, 2000).

History of AAPIs in Oakland

Asian Americans and Pacific Islanders first arrived in Oakland in substantial numbers starting in the 1860s following the conclusion of the Gold Rush. Over the last century, the AAPI population has increased significantly. The concentration of AAPIs is now higher in Alameda County than it is statewide or nationally. The AAPI population almost doubled between 1980 and 1990, and the percentages of most ethnic subgroups have consistently increased or remained steady since 1950 (US Census 1950-2000). In fact, despite the overall small population size of AAPIs in the US, they are the fastest growing minority group in the US. This steady population growth is largely due to the passage of the 1965 Immigration Act, which loosened immigration laws and provided immigration preference to reunifying families and to promote the immigration of individuals with professional skills (Fong, 1998). Later, in the 1970s and 80s, refugees from Southeast Asian countries such as Vietnam, Cambodia, and Thailand entered the US in significant numbers following political unrest in their home countries. After the fall of Saigon in 1975, many Vietnamese families with high education levels with English speaking ability entered the US as refugees. This initial wave of refugees was subsequently followed by a cohort of less educated and less financially secure

Vietnamese refugees. The second wave of refugees from Southeast Asia included those from Cambodia and Laos. Many Cambodians fled Pol Pot's killing fields and genocidal political actions. During the war, one third of the Laotian population was killed, and several groups, including the Mien and Hmong, were able to leave Laos with the aid of American forces. Many of these Southeast Asian refugees were placed in urban settings such as Oakland (Fong, 1998).

Social determinants of health for AAPIs: Socioeconomic factors

The correlation between socioeconomic status and health is well established. Socioeconomic status can affect health through multiple pathways, including access to and quality of health care, health behaviors, psychosocial processes, physical environment and social environment, and health policies (Satcher & Higginbotham, 2008). Several major socioeconomic indicators have been identified as affecting AAPI health, including income and poverty, educational attainment, immigration and citizenship status, language, and other household indicators (APIAHF, 2003).

Income and poverty

National family income statistics for AAPIs are deceptive not only because they disregard the vast discrepancies between different ethnic groups that constitute the Asian racial category, but also neglect the fact that Asian Americans on the average have more wage earners per family and are concentrated in cities like California, Hawaii and New York, where the average income, as well as the cost of living, is much higher (Takaki, 1998). Taking this into consideration, while Asian Americans on the average have higher

education levels than white Americans, they still earn significantly less per capita (Fong, 1998). Ironically, although it is important to note that while Asian Americans on the whole generally have a higher income, they also have higher poverty rates than the average American.

In Oakland, related to the population as a whole, Asian families have lower median household incomes and lower per capita incomes. The median household income in 2005 for Asian American families in Oakland was $36,958 as compared to the general Oakland population's median household income of $44,124 (American Communities Survey, 2005). In certain Alameda County neighborhoods, a very high proportion of youth are living in poverty. These neighborhoods include West Oakland, San Antonio, Fruitvale, East Oakland, and portions of South Berkeley (ACDPH, 2006). Many AAPI youth in Oakland are living in poverty and experience an array of interrelated life stressors. Overall, AAPI youth face higher poverty levels than the average Oakland resident (Asian Pacific Islander Youth Violence Prevention Center, 2007). In Alameda County, the percentage of Cambodian and Laotian families living below the federal poverty level is 40% and 32% respectively, while 15% of the total Alameda County population lives below the poverty level (US Bureau of the Census 2000).

Educational Attainment

While it is true that a few AAPI groups have achieved high levels of educational attainment, this does not reflect the challenges that many AAPIs still face in the area of education. A wide spectrum of levels of educational attainment is demonstrated among

different AAPI subgroups. For example, Southeast Asian groups, including Cambodian, Laotian, Vietnamese and Hmong groups, have much lower rates of high school completion than the general population. For instance, Hmong were almost 3 times as likely to be without a high school diploma than the general US population (APIAHF, 2003). Various obstacles to educational achievement plague AAPI youth in Oakland, including the aforementioned high poverty rates and environmental contextual factors, as well as cultural factors, including language barriers. A large percentage of AAPI residents of Alameda County have less than a high school degree. Sixty-six percent of Hmong residents and 55% of Cambodian residents have not graduated from high school, compared to the overall rate of 23% (US Census, 2000).

Household size

For a variety of reasons including economic and cultural reasons, the average household size in Oakland is greater for AAPIs than for the total population. In fact, the average AAPI household (3.1 individuals per household) is almost 20% larger than the average US household (2.6 individuals per household). Data disaggregated by subgroup reveals that all AAPI groups except the Japanese had average household sizes greater than the US average (APIAHF, 2003). Of note is the average household size for Cambodian and Laotian families, at 4.5 and 5.5 respectively. Tongan families report the highest household size, at 6.0 (US Census, 2000).

Linguistic isolation

Linguistic isolation is a severe problem in regards to access to services for AAPI communities in Oakland and elsewhere. A household is considered linguistically isolated if no person age 14 or over speaks only English and no person age 14 or over who speaks a language other than English, speaks English very well. Asian language households have the highest percentage of linguistic isolation in Oakland, followed by Spanish-speaking households. In Oakland, 12.2% of the population speaks Asian and Pacific Island languages in the home, and of these households, 48% are linguistically isolated. As a comparison, Spanish is spoken in 15.1% of Oakland households, and 30.7% of these households are linguistically isolated (US Census, 2000, Summary File 3). In the Oakland Unified School District, the top five languages spoken by the district's 2348 English Learner students in the 2003-04 school year were Spanish (60%), Cantonese (15%), Khmer/Cambodian (7%), Vietnamese (6%), and Mien (4%) (OUSD, 2005).

Immigration status

Immigrant status confers a variety of health risk factors. New immigrants face the hardship of meeting the expectation of assimilating themselves into the dominant culture. Immigrants manage these hardships with little or no assistance. They not only face the daily challenges of navigating unfamiliar Western social and educational systems, but also are faced with the daunting challenge of figuring out the complexities of the health system and applying for appropriate public assistance programs.

For many AAPIs, such as Southeast Asian immigrants, immigration and resettlement in the U.S. is linked to a history of war and displacement. Furthermore, post-migration stresses associated with resettlement in the U.S. include language difficulties, cultural conflicts, poverty, racism, and exposure to crime and violence in urban settings where many AAPI immigrant and refugee families were placed. For instance, research on Southeast Asian refugees seeking mental health care consistently find high rates and numerous risk factors for post-traumatic stress disorder (PTSD), relating to the traumatic experiences they had before immigrating to the US (Kinzie et al., 1990). In one large community study, Chung & Kagawa-Singer (1993) revealed that for Southeast Asian refugees, the experience of trauma in their home countries as well as in refugee camps, was a significant predictor of psychological distress, even beyond five years after migration. The same study also indicated that distress levels differed by ethnic subgroup, with Cambodians reporting the highest level, Laotians the second highest level, and Vietnamese the lowest level.

Many AAPI youth in Oakland are recent immigrants themselves or have recent immigrant parents and relatives. Beyond the stressors of emerging into adulthood and living in poverty, these youth have additional stressors that put them at increased risk of negative health and social outcomes, stemming from their pre-migration history and post-migration circumstances. These youth often find themselves in a position where they must serve as interpreters or mediators for family members, disrupting the family power dynamic. This added responsibility places an immense amount of stress on youth when combined with the detrimental impact of poverty (Yeh, 2008). A recent study found that

immigrant youth are likely to take on financial responsibility to support their families, adversely impacting their ability to develop their academic and career aspirations (Yeh, 2008).

Access to health care

Despite the many faulty presumptions regarding AAPIs, they are disproportionately unable to access health insurance. For instance, many AAPIs are uninsured because they work in small businesses or services industries that do not offer health insurance (Ro, 2000). Moreover, language barriers and immigration status are also barriers to accessing and navigating the increasingly complex health safety net system. Consequently, AAPI patient needs are neglected and left severely unmet as compared to the general population. The national average for uninsured Asian Americans is 17%. Of all Asian American subgroups, Korean Americans have the highest uninsured rate at 34% (Ro, 2000). Moreover, the rate of public health insurance enrollment for low income AAPIs likely qualifying for Medicaid, is well below that of whites from the same income bracket (DHHS, 2001). Living without health coverage often forces people to forego seeking medical care and to leave chronic conditions untreated, lowering the overall health status and quality of life for the community and people who constitute that community (Hadley, 2007).

For recent immigrants, the welfare reform laws have had a significant impact upon eligibility for social services, including public health insurance. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) granted

authority to the state to determine immigrants' eligibility for public benefits. Popularly known as welfare reform, this set of laws has been responsible for leaving countless Asian immigrants uninsured. Contrary to the popular ideology suggesting that welfare reform only affects populations such as undocumented immigrants, welfare reform has excluded many working, legal Asian immigrants living in poverty from federal and state-funded Medicaid programs. For example, in California, there has been a 33% decrease in Medicaid coverage among Asian Americans since the instatement of welfare reform in 1996 (Foo, 2002). Again, the model minority label serves to obscure a sizable number of Asian immigrants who do not enjoy the success attributed to their race. Under PRWORA, which took effect in August of 1996, legal immigrants have been restricted from using Medicaid or State Children's Health Insurance (SCHIP) until they have lived in the U.S. for five years, and undocumented immigrants have been restricted from Medicaid altogether (Families USA, 2001). Welfare reform effectively ended the entitlement program Aid to Families with Dependent Children (AFDC), cutting off many families- especially families headed by single mothers- from coverage. AFDC was replaced by Temporary Assistance to Needy Families (TANF), which only allows use for an absolute total duration of 5 years. Moreover, all immigrants were excluded from receiving any federally funded food stamps and supplemental security income for the elderly and disabled.

In addition to these barriers to healthcare, AAPI youth are further at risk for being uninsured on the basis of their vulnerable age bracket. Lack of insurance disproportionately impacts adolescents and young adults. According to the California

Health Interview Survey in 2003, about 16% of Alameda County youth aged 10-24 years were uninsured. The uninsured rate was similar at the state-level at 17%. It is important to note that as youth age out of safety-net programs designed for children, lack of health insurance increases. Consequently, in Alameda County, 28% of 18-24 year olds were uninsured as compared to 7% of youth age 10-17 years (CHIS, 2003).

Adolescent Health

In addition to the multitude of socioeconomic stressors affecting the health of Oakland AAPI youth, these youth additionally face a host of other challenges to maintaining health and wellbeing related to their status as adolescents. Adolescents comprise a unique age group that faces specific health risks as they transition to adulthood. Often the initiation of risky behaviors is in adolescence. These behaviors are linked to major causes of morbidity and mortality in adolescence as well as in adulthood.

Adolescents are heavily influenced by their social environment as they transition from childhood to adulthood. It is well established that low income and low education levels are consistently associated with a variety of poor health outcomes for adolescents (Pamuk et al., 1998). Studies have shown that low income adolescents are especially at risk for depression, obesity and suicide (Goodman, 1999). Low family income is further associated with reduced ability to obtain social goods such as housing, healthy food, health care, and the opportunity to live in a safe environment.

Furthermore, adolescent development is negatively impacted by exposure to violence. Studies demonstrate that early exposure to violence during childhood can lead to increased risk factors and risk-taking behaviors as adults, such as high-risk sexual activity and drug use; psychological health risks, such as depression and suicide, as well as to some leading causes of death, including cancer and heart disease (Felitti et al., 1998; Anda et al., 1999; Anda et al., 2002; Hills et al., 2000; Dube, 2001).

While much existing literature focuses on the negative structural risk factors affecting youth health, a growing body of research on youth resilience is investigating how youth negotiate these risks and challenges in their daily lives. Youth resilience literature has identified preliminary external protective factors and well as individual resilience traits, or internal assets, which are interrelated and associated with positive academic, social and health outcomes for adolescents (Sieving et al., 2001). Major protective factors include caring relationships, high expectations, and meaningful participation at home, in the schools, and in the community (Resnick et al., 1997; Constantine, Benard, & Diaz, 1999). Key internal resilience traits include social competence, autonomy and sense of self, and sense of meaning and purpose (Constantine, Benard, & Diaz, 1999).

Adolescence is a critical period comprised of many significant physical, cognitive, and emotional changes, and thus is a crucial time in the formation of health behaviors. The patterns of behavior adopted during adolescence may have lifelong consequences to health status and quality of life, making adolescence a particularly propitious time for intervention.

Health Indicators of Oakland AAPI Adolescent Health

Nutrition, Obesity and Access to Healthy Foods

There is growing concern over the mounting evidence that nutritional habits among adolescents are worsening, leading to unprecedented numbers of overweight and obese youth (Neumark-Sztainer 2002, Hedley et al.. 2004). Thirty-one percent of Alameda County 9th graders were overweight in 2004-05, which is was slightly lower than the state rate of 33% (ACPHD 2006). In 2003, two-thirds of the youth ages 12-17 and 18-24 years living in Alameda County did not eat the five or more recommended servings of fruits and vegetables each day. The findings are similar at the county and state level (CHIS, 2003). The ubiquity of fast food restaurants in low income communities mirrors the high levels of fast food consumption by urban youth. One study of Alameda County youth found that 42% of youth ages 12-17 ate fast food at least once a week. The same study further indicated that the majority of youth ages 12-17 consumed at least one soda per day (ACPHD, 2006). According to the 2005 California Health Interview Survey, Asian teens consume more fast food than their white counterparts. Forty-three percent ate fast food daily, compared with 35 percent of whites (CHIS, 2005).

Sexual health and teen pregnancy

There is continued concern about the prevalence of sexually transmitted diseases and high unintended teen pregnancy rates among sexually active youth. The 1999 California Youth Risk Behavior Survey indicated that 40% of high school students have engaged in sexual activity, and 12% have had multiple partners (CDC, 1999). Furthermore, only 60% of sexually active students in grades 10-12 reported using a condom at last

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intercourse (CDC, 1999). Similar sexual activity statistics are observed in Alameda County adolescents. Chlamydia and gonorrhea are the most common sexually transmitted diseases among Alameda County youth. Of all the counties in California, Alameda has the highest incidence of chlamydia and gonorrhea for young women aged 15-24 years (ACPHD, 2006).

Asian American youth are often stereotyped as a group not engaged in high-risk sexual behavior. While it is true that AAPI adolescents have a later onset of sexual behavior than their peers, once sexual debut is reached, the risk patterns of AAPIs, such as HIV prevention behaviors like condom use, match those of the general population (Cochran et al.. 1991, Grunbaum et al.. 2000).

Despite public perceptions of teen pregnancy as being a trivial issue for Asian Americans, disaggregated analyses reveal that teen pregnancy is in fact a major issue in certain Asian subgroups. A recent study that broke down pregnancy rates by ethnic subgroup indicated that Laotian women have the highest teen pregnancy rates in the entire state of California at 18.9%, followed by African Americans and Latinas, at 18% (Weitz, 2002). The same study found that over 60% of Laotian teens giving birth were married, revealing that the promotion of abstinence-only-until-marriage programs may not be addressing the more complex needs of this particular group (Weitz, 2002).

Substance use and tobacco smoke

Among the US adolescent population, morbidity due to drug use and violence continues to rise, especially among poor and minority youth (Sells, 1996). Currently, over a third of adolescents report tobacco use (Neumark-Sztainer, 2002). In a study of Alameda County 11th graders, one third of respondents admitted to drinking alcohol in the past month. In addition, 18% reported binge drinking (CHKS, 2003-04). These trends are concerning because excessive alcohol use can have many short and long-term effects. Studies have shown that youth who drink alcohol before the age of 15 are 5 times more likely to become alcohol dependent than adults who begin drinking at the legal age (Office of Applied Studies, 2004). Moreover, youth alcohol use has been linked to increased risky sexual behaviors, poor academic performance, and an increased risk of suicide and homicide (Substance Abuse and Mental Health Services Administration 2006, CDC ARDI, Miller et al., 2007).

Mental health

Very little is known about the mental health of AAPI youth. The sparse amount of information we do have is unsettling. Second only to unintentional injuries, suicide is the leading cause of death among AAPI youth (CDC, 2000). Moreover, of all racial groups, Asian adolescent women aged 15-24 have the highest rates of depressive symptoms in adolescent women (Schoen, 1997).

Mental health is an area in which AAPIs youth prove to be an extremely underserved group. The lowest mental health services utilization rates of all ethnic groups in the

country are found in the AAPI population, and this group is found to be underrepresented regardless of gender, age, or geographic location (DHHS, 2001). This low utilization of mental health services can be attributed to stigma and shame in accessing mental health services, lack of financial resources, lack of cultural appropriateness of services, unfamiliarity with Western approaches to mental health, and the use of alternative health services within the AAPI community (DHHS, 2001). The Surgeon General Report on Mental Health (2001) reported that nearly half of AAPIs face obstacles to accessing mental health services due to limited English proficiency and the lack of health providers with appropriate language skills. Among those AAPIs who do utilize mental health services, the severity of disturbance tends to be high, hinting that that these patients delay accessing services until problems become very severe (DHHS, 2001).

Youth violence

It is apparent that adolescents are disproportionately affected by violence. Among 15-44 year olds in the world, suicide, interpersonal violence, and war-related deaths are the 4th, 5th and 10th leading causes of death respectively (Mercy et al., 2003). Violence plays a significant role in the lives of Oakland youth. The leading cause of death among youth in Alameda County is homicide. In fact, from 2001-2003, the homicide rate among 15-24 year olds was 21 per 100,000, 7 times higher than the national Healthy People 2010 objective of 3.0 per 100,000 (ACPHD Vital Statistics). The California Healthy Kids Survey Technical Report for Alameda County (2003-04) indicates that 16% of 11th graders in Alameda County have been in a physical fight on school grounds in the past year and 6% reported feeling unsafe or very unsafe at school. One Oakland-based study

found that, at some point in their lives, 27% of AAPI youth surveyed had been on the receiving end of a violent act from another AAPI youth (The Services and Advocacy for Asian Youth Consortium, 2004). Moreover, a recent increase has been observed in violence and delinquency in AAPI youth populations, represented by heightened arrest statistics in California, especially among Southeast Asian youth (Le & Arifuku, 2005).

Southeast Asian youth are disproportionately represented in the state's juvenile justice system (Go, 2005). When arrest rates are disaggregated by AAPI ethnicity, Cambodian, Laotian, and Vietnamese youth account for about 58% of all AAPI arrests in Oakland in 2006, despite only constituting 38% of Oakland's total AAPI youth population (Alameda County Probation Department, 2006). In 2006, Samoan youth were found to have the highest arrest rate out of all ethnic groups in Oakland at 140 arrests per 1,000, while African Americans had the second highest arrest rate at 116 arrests per 1,000 (Alameda County Probation Department, 2006).

Very little is known about how many AAPI youth in Oakland are affiliated with gangs. One reason for this lack of information is that when youth are arrested or otherwise involved with the juvenile justice system in Alameda County, information about possible gang affiliation is not documented. However, anecdotal evidence strongly suggests that gangs are an increasing problem within the AAPI community, especially among Southeast Asians (Asian Pacific Islander Youth Violence Prevention Center, 2003).

Research Methodology

Qualitative methods with AAPI youth

It is becoming increasingly apparent that there is a great need to challenge the model minority discourse and engage ideas that provide insight into the true health experience of urban AAPI youth. Qualitative methods, including Photovoice, can aid in explaining the meaning and significance behind the lived experience of youth. Qualitative methods such as focus groups have been used successfully in past exploratory research involving AAPI youth populations. Researchers in psychology posit that the group dynamic of focus groups support the Asian cultural emphasis on relationships and interrelatedness (Yeh, 2008; Markus & Kitayama, 1991). Much existing research on AAPI youth and young adults has focused on cultural barriers and immigration experiences, particularly in the context of school environments. Several studies have explored the cultural adjustment experience of immigrant AAPIs in college and graduate school, and have discussed implications for mental health provision for this population (Kim et al., 2003; Swagler & Ellis, 2003; Constantine et al., 2005). Recently, several qualitative studies have explored the experiences of AAPI adolescents in the contexts of acculturation and adjustment (Yeh, 2008), youth violence prevention (Lai, 2008) and perceptions of health provision (Vo, 2007).

Community-based participatory research

It is becoming increasingly evident that more comprehensive and participatory approaches to research and interventions are necessary to address health inequities and the social determinants of health underlying these inequities (Israel et al., 2003). As more

momentum has been building regarding the elimination of health disparities, community-based participatory research (CBPR) methods are gaining recognition as powerful tools to address this daunting challenge. In fact, a recent Institute of Medicine Report names CBPR as one of the eight areas of critical importance to public health education in the 21st century, and suggests that all public health professionals need to be trained in CBPR (Gebbie, Rosenstock & Hernandez, 2003).

Community-based participatory research is an orientation towards research which relinquishes the more traditional research paradigms in which the outside research "expert" largely controls the questions asked, tools used, interventions developed, and ultimately, the results documented and valued (Gaventa, 1993). There are several fundamental characteristics which community based participatory research possesses. It is participatory; it is cooperative, engaging community members and researchers in a joint process in which both contribute equally; it is a co-learning process; it involves systems development and local community capacity building; it is an empowering process through which participants can increase control over their lives; it achieves balance between research and action (Israel et al., 1998). As Bud Hall explains, "participatory research fundamentally is about who has the right to speak, to analyze and to act" (Hall, 1992). The aim of community-based participatory research is to equitably involve community members and researchers in all aspects of the research process and share in decision making and ownership (Israel, 1998). Furthermore, CBPR aims to increase knowledge and understanding and direct that knowledge towards policies and social change to improve community health (Israel, 1998).

The Photovoice Method

Introduction to Photovoice

Photovoice is a community-based participatory research method that blends a grassroots approach to photography with social action (Wang & Burris, 1999). As its creators describe, "Photovoice is a process by which people can identify, represent, and enhance their community through a specific photographic technique. It entrusts cameras to the hands of people to enable them to act as recorders, and potential catalysts for change, in their own communities" (Wang & Burris, 1997). The Photovoice concept and methodology was first conceived of by creators Caroline Wang and Mary Ann Burris, who applied it first in a participatory action research project with women in rural China (Wang & Burris, 1997).

Photovoice involves community participants in taking pictures, telling stories, and enabling them to act as agents of social change in their communities. This method uses the immediacy of the visual images and accompanying stories to promote an effective, participatory means of sharing community experiences and influencing public policy.

Photovoice has three main goals (Wang & Burris, 1997):

- To enable people to record and reflect their community's strengths and concerns;
- To promote critical dialogue and knowledge about personal and community issues through large and small group discussions of photographs; and
- To reach policy makers.

Several stages comprise the Photovoice process, beginning with the conceptualizing and framing of the specific issues to be explored within the project. This is followed by the training of participants in technical photography methods, and a discussion about the safety and ethics of taking pictures. After the participants initiate taking photos, they meet as a group where critical reflection and dialogue revolve around the photos. During these sessions, participants share their photos with the group, focusing on contextualizing and storytelling. This is followed by the codifying of issues, themes and theories regarding community issues, and leads to critical dialogue around building positive change in the community. Mobilizing community awareness and policy change is the end goal of Photovoice; which may take the form of a community exhibition of photos or political action. The premise of Photovoice is to provide cameras to people traditionally with less power and authority in making decisions affecting health policy. Photovoice gives imaging power to community members and acknowledges them as critical thinkers and assets to their communities (Wang & Burris, 1997).

Conceptual Roots of Photovoice

Three main sources comprise the conceptual underpinnings of Photovoice: education for critical consciousness, feminist theory, and documentary photography. The idea of critical consciousness-raising, or conscientization, is attributed to Paolo Freire, a Brazilian educator who worked to promote rural adult literacy programs. His approach to teaching was to break down the traditional power dynamics between teacher and student, and encourage instead a more egalitarian, participatory approach to gaining knowledge through communal introspection and critical dialogue (Freire, 1970). Freire prompted

introspective group discussion through the use of emotionally charged triggers such as drawings or photographs. The goal of this dialogue was for people to engage in a combination of reflection and action, which he termed praxis (Freire, 1970). Photovoice utilizes photographs taken by participants as triggers for critical reflection and group dialogue to define and challenge problems in the community. This process is unique because it is accessible to marginalized populations in ways that other methods are not (Wang & Burris, 1997).

Feminist theory also contributes significantly to Photovoice's theoretical roots. Feminist methodologies, according to Weiler, appreciate women's subjective experiences, carry out policies and programs by and with women as opposed to imposing them from the outside, and honor women's intelligence (Weiler, 1988). In keeping with these tenets, Photovoice gives voice to those with traditionally less power and authority, such as marginalized groups, and creates a protected space where the deconstruction of oppression is encouraged.

Documentary photography has strongly informed Photovoice as well. Documentary photography has been referred to as the social conscience presented in visual imagery (Rosler, 1987), as it strives to reveal and focus everyday realities. Photovoice builds on traditional approaches to documentary photography in that it "gives cameras to people who might otherwise not have access to such a tool, so that they may record and catalyze change in their communities, rather than stand as passive subjects of other people's

intentions and images" (Wang & Burris, 1997). The accessibility of Photovoice has made it popular and the method has been used in very diverse populations worldwide.

Photovoice as a health assessment tool

A substantial amount of literature suggests that Photovoice is a powerful and effective tool for health assessments. Community inventory, community assessment, context evaluation, diagnostic evaluation, and process evaluation, have all been described as gaining advantages from the use of Photovoice (Wang & Burris, 1997). The concept of Photovoice highly values the knowledge contributed by community members. Through this quality, it directly challenges a frequent problem faced in many needs assessments: what the researchers and policy makers believe is important may not match what people at the grassroots level believe is important (Wang & Burris, 1997). In addition, Photovoice is extremely accessible to anyone who can learn how to handle a camera, therefore it does not alienate vulnerable populations. Furthermore, participants are able to record issues that are out of the perspective of health professionals.

Photovoice provides a unique way to reaffirm or redefine program goals for a needs assessment through the power of images, which captures information about goals in ways that traditional needs assessment methods such as surveys and structured interviews may overlook. Through this process, longer-term community relationships are cultivated, and community members are not only encouraged to document and critique the community's needs, but also its assets. This fact, along with Freirian problem-posing education, leads to a stronger sense of agency and working towards solutions for community concerns

(Wang, 2006). Photovoice has been used successfully by public health departments to assess the needs of the community while giving voice to its residents (Wang & Pies, 2004).

Photovoice has been successfully used around the world as a strategy for engaging youth in policy and social change (Wang, 2006). Youth participation "expresses the view of youth as competent citizens and active participants in the institutions and decisions that affect their lives" (Wang, 2006). The Photovoice method goes beyond the collection of data to encompass an empowering process for its participants. Photovoice is a participatory research strategy that incorporates principles of community change, social action, and advocacy. To give a few examples, Photovoice has been used with teenagers in Flint, Michigan to discuss their experiences and perceptions of violence in their communities, and in Alameda County, California with Black and Latino youth to raise awareness about the HIV/AIDS epidemic in the county (Morrel-Samuels et al.. 2005; May, 2001).

Conclusion

Research has begun to uncover the social determinants of health affecting AAPIs and adolescents. Information regarding the health of low income, urban AAPI youth in particular is very sparse. Despite the model minority myth, AAPI youth in Oakland face many structural challenges to maintaining health and wellbeing. On the whole, AAPIs in Oakland have lower per capita incomes, lower median earnings, less educational attainment, and more people per household. Furthermore, language barriers, lack of

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health insurance, and immigrant status pose further challenges for this population. In addition, as adolescents, Oakland AAPI youth are in a critical transitional period in their lives where many risk behaviors, such as substance abuse and risky sexual behaviors begin to take shape. These contextual factors undoubtedly hold powerful influence over the health status of AAPI youth, and warrant further research in order to eliminate health inequities affecting this population. The implications of structural and personally-mediated violence on the health and wellbeing of AAPI youth are not well understood, and even less is known about the strengths and resilience factors affecting the health of this population.

The paucity of health research on urban AAPI adolescents presents a challenge for measuring the health status of this population and responding with evidence-based interventions, programs and policies. Given the important influence of structural violence and resilience on the health of youth, further research is needed to examine how AAPI youth in Oakland describe the impact of their environment - including physical space, social ecology, and structural forces - on their physical and psychosocial health. This exploratory research is a critical first step in understanding the risk and resilience factors influencing the health of urban AAPI youth. Such an understanding can then inform best practices and approaches to promoting health and wellbeing for this population.

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Part 2
Oakland Asian Youth Envisioning Health Through Photovoice

Background and Significance

Health Status of Oakland AAPI Youth

Asian Americans and Pacific Islanders (AAPIs) are the fastest growing racial/ethnic population in the United States. Currently making up 4% of the US population at 10.6 million people, AAPIs are expected to constitute 33.4 million people, or 8% of the US population by the year 2050 (US Census, 2004a). Despite their increasing numbers, AAPIs have been largely neglected in research regarding health status, health inequities, and social determinants of health. This disregard is largely due to the pervasive "model minority" stereotype, an epithet purporting that AAPIs are a homogeneous group that has overcome social discrimination and generally enjoys elevated socioeconomic status, educational achievement and health, and is thus undeserving of any societal assistance (Lee, 1996). While some AAPI populations have achieved relatively high levels of income and educational status, this stereotype has served to obscure the fact that many AAPIs continue to face challenges related to socioeconomic status, such as poverty, limited English proficiency, low educational attainment, and discrimination (APIAHF, 2003).

Contrary to the pervasive model minority stereotype, AAPI youth in Oakland face many challenges to maintaining health and wellbeing related to socioeconomic status, including poverty, street violence and associated psychosocial stress. Overall, AAPI youth face higher poverty levels than the average Oakland resident (Asian Pacific Islander Youth Violence Prevention Center, 2007). In Alameda County, of which Oakland is the largest

city, the percentage of Cambodian and Laotian families living below the federal poverty level is 40% and 32% respectively, as compared to 15% of the total Alameda County population (US Census, 2000). Another important indicator of socioeconomic status, educational attainment, is disproportionately low in AAPI youth living in Oakland. A large percentage of AAPI residents of Alameda County have less than a high school degree. Sixty-six percent of Hmong residents and 55% of Cambodian residents have not graduated from high school, compared to the overall rate of 23% (US Census, 2000). Moreover, it is evident that street violence plays a significant role in the lives of Oakland youth. A recent increase has been observed in violence and delinquency in certain AAPI youth populations. Southeast Asian youth are disproportionately represented in the state's juvenile justice system (Go, 2005). When arrest rates are disaggregated by AAPI ethnicity, Cambodian, Laotian, and Vietnamese youth account for about 58% of all AAPI arrests in Oakland in 2006, despite only constituting 38% of Oakland's total AAPI youth population (Alameda County Probation Department, 2006). In 2006, Samoan youth were found to have the highest arrest rate out of all ethnic groups in Oakland at 140 arrests per 1,000, while African Americans had the second highest arrest rate at 116 arrests per 1,000 (Alameda County Probation Department, 2006).

Structural Violence

Low socioeconomic status and urban living confer unique risks resulting from structural violence, as access to vital resources necessary to maintain health is constrained. The term structural violence, introduced by Galtung (1969), describes the forces that create and reinforce patterns of social inequity, such as concentrated poverty, institutionalized

racism and educational disparity. It describes social arrangements that are structural because they are entrenched in the political and economic organization of society. These forces are violent because they cause harm to people; typically those who are marginalized (Farmer, 2006).

Structural violence recently has been a focus of public health scrutiny because of its relevance to the social determinants of health. Research has shown that adolescents are heavily influenced by their social environment as they transition from childhood to adulthood. It is well established that low income and low education levels are consistently associated with a variety of poor health outcomes for adolescents (Pamuk et al., 1998). Studies have shown that low income adolescents are especially at risk for depression, obesity and suicide (Goodman, 1999). Furthermore, adolescent development is negatively impacted by exposure to violence. Studies demonstrate that early exposure to violence during childhood can lead to increased risk factors and risk-taking behaviors as adults, such as high-risk sexual activity and drug use; psychological health risks, such as depression and suicide, as well as to some leading causes of death, including cancer and heart disease (Felitti et al., 1998; Anda et al., 1999; Anda et al., 2002; Hills et al., 2000; Dube, 2001).

While much existing literature focuses on the negative structural risk factors affecting youth health, a growing body of research on youth resilience is investigating how youth negotiate these risks and challenges in their daily lives. Youth resilience literature has identified preliminary external protective factors and well as individual resilience traits,

or internal assets, which are interrelated and associated with positive academic, social and health outcomes for adolescents (Sieving et al., 2001). Major protective factors include caring relationships, high expectations, and meaningful participation at home, in the schools, and in the community (Resnick et al., 1997; Constantine, Benard, & Diaz, 1999). Key internal resilience traits include social competence, autonomy and sense of self, and sense of meaning and purpose (Constantine, Benard, & Diaz, 1999).

Though the literature has begun to uncover the social determinants shaping the health of adolescents, little is known about the health of low income, urban AAPI youth. The implications of structural and personally-mediated violence on the health and wellbeing of AAPI youth are not well understood. Even less is known about the strengths and resilience factors affecting the health of this population. This paucity of health data regarding urban AAPI adolescents presents a challenge for measuring the health status of this population and responding with evidence-based interventions, programs and policies.

Given the critical influence of structural violence and resilience on the health of youth, we undertook a qualitative study to examine how AAPI youth in Oakland describe the impact of their environment - including physical space, social ecology, and structural forces - on their physical and psychosocial health.

Qualitative methods, including Photovoice, can aid in explaining the meaning and significance behind the lived experience of youth. Qualitative methods such as focus groups have been used successfully in past exploratory research involving AAPI youth

populations. Researchers in psychology posit that the group dynamic of focus groups support the Asian cultural emphasis on relationships and interrelatedness (Yeh, 2008; Markus & Kitayama, 1991). Much existing research on AAPI youth and young adults has focused on cultural barriers and immigration experiences, particularly in the context of school environments. Several studies have explored the cultural adjustment experience of immigrant AAPIs in college and graduate school, and have discussed implications for mental health provision to this population (Kim et al., 2003; Swagler & Ellis, 2003; Constantine et al., 2005). Recently, several qualitative studies have explored the experiences of AAPI adolescents in the contexts of acculturation and adjustment (Yeh, 2008), youth violence prevention (Lai, 2008) and perceptions of health provision (Vo, 2007).

Methods

Study Site

Our study was based at the Asian Health Services Youth Program (AHSYP) in Oakland, Chinatown. The AHSYP is a community health organization that serves youth of all backgrounds in Alameda County, offering comprehensive reproductive health services, counseling, a peer leadership program, and a weekly Teen Clinic.

The Photovoice Method

We used Photovoice, a community-based participatory research method that blends a grassroots approach to photography with social action, as our method of inquiry. As

Photovoice creators Wang and Burris describe, "Photovoice is a process by which people can identify, represent, and enhance their community through a specific photographic technique. It entrusts cameras to the hands of people to enable them to act as recorders, and potential catalysts for change, in their own communities" (Wang & Burris, 1997). Photovoice as a qualitative and exploratory research method has its theoretical roots in health promotion principles and Paolo Freire's idea of critical consciousness-raising. Freire, a Brazilian educator, used images to trigger reflection and dialogue in a process that challenged participants to gain insight into the world around them and to create solutions to the problems thereby identified (Freire, 1970). Drawing from this idea, Photovoice uses the immediacy of the visual images and accompanying stories to promote an effective, participatory means of sharing community experiences and influencing public policy.

Photovoice has three main goals: To enable people to record and reflect their community's strengths and concerns, to promote critical dialogue and knowledge about personal and community issues through group discussions of photographs, and to reach policy makers (Wang & Burris, 1997).

As a community-based participatory research method, Photovoice provides a unique way to assess community needs and strengths through the power of images and storytelling. It promotes information gathering in ways that traditional needs assessment methods such as surveys and structured interviews may overlook (Wang & Burris, 1997). Through its participatory quality, Photovoice directly challenges a frequent problem faced in many

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needs assessments: what the researchers and policy makers believe is important may not

match the priorities of those people at the grassroots level (Wang & Burris, 1997). In

addition, Photovoice is accessible to anyone who can learn how to handle a camera;

therefore it does not alienate vulnerable populations. Furthermore, participants are able

to record issues that may not be reached by or are out of the perspective of health

professionals.

The Photovoice method has been gaining recognition for its effectiveness in community

assessments. It has been used worldwide with a variety of communities that historically

have had little power in affecting policy. It has also been used successfully by health

departments to assess community health needs (Wang & Pies, 2004). To our knowledge,

this is the first published study of Photovoice as applied to AAPI youth.

Study Participants and Recruitment

Eight AAPI youth participants were recruited from the AHSYP client population through

flyers and by oral invitation from AHSYP staff.   The study participants included two

males and six females, aged 14-17 years, including 2 Chinese, 2 Mien, 2 Cambodian, 1

Vietnamese, and 1 Indonesian youth.

Human subjects

All aspects of this project were approved by the UC Berkeley Institutional Review Board

in advance. Informed consent was obtained in the form of written assent from minors

and written consent from a parent or legal guardian. Participants were compensated $15 for each focus group attended and $10 for each interview.

Data Collection

The Photovoice process comprises several stages, beginning with the conceptualization and framing of the specific issues to be explored within the project: in this case, the most salient health issues affecting the participant's communities. The framing of this Photovoice project was deliberately left flexible for open exploration of the multifaceted issues that affect youth health in the Oakland community as seen through the eyes of the participants. In the first Photovoice meeting session, participants received training in technical photographic methods, and on the safety and ethics of taking photographs in the community. A total of six Photovoice meeting sessions were facilitated weekly and audio recorded, beginning in July and ending in August of 2007. During the structured Photovoice meeting sessions, participants selected several of their photographs to write about in a "freewrite" format, and then to share with the group. The participants then engaged in critical reflection and dialogue about their photographs, using a Freirean-based facilitated questioning method summarized by the acronym SHOWED (What do you *see* here? What is really *happening* here? How does this relate to *our* lives? *Why* does this concern, situation, strength exist? How can we become *empowered* through our new understanding? What can we *do*?) (Shaffer, 1983). This led to critical dialogue around building positive change in the community. Mobilizing community awareness and policy change is the end goal of Photovoice, which may take any variety of the forms, including community exhibitions of photos or political actions.

Traditional qualitative methods, including individual interviews, were also employed. Semi-structured 1-hour individual interviews with Photovoice participants were conducted within 2 months of completion of the Photovoice project. The purpose of the individual interviews was to delve deeper into the themes presented during the Photovoice sessions, and to elicit individual responses regarding their perspectives on health issues.

Analysis

Audio recordings of the Photovoice sessions and individual interviews were transcribed by a professional transcriptionist. All identifying information was deleted. Qualitative analysis included content analysis of photographs and open coding of written photo captions, transcripts of Photovoice sessions, and of transcripts of individual interviews. Content analysis of photographs, including the analysis of accompanying "freewrite" essays, was conducted through the creation of matrix displays, in which each photograph was analyzed according to its title (named by the youth participant who took the photograph), the main subject or symbolic representation presented in the photo, the problem or issue identified by the photo, the effect of the stated problem, and the proposed solution to the problem. Grounded theory (Strauss & Corbin, 1998) guided the qualitative analysis portion of the study. We first conducted open coding of written caption, focus group and interview data for prominent themes. Creation of theoretical memos followed, after which memos were sorted to develop explanatory models through the process of drawing connections between concepts elucidated from the data. Coding

was performed utilizing hyperRESEARCH™ 2.6.1 software (ResearchWare, Inc., 1988-2005). Field notes were integrated into the analysis and directed further theoretical understanding and interpretation.

One follow-up focus group was conducted 3 months subsequent to the completion of Photovoice sessions. With the participatory goals of Photovoice in mind, this session served as an opportunity for collaboration, member checking and assumption checking regarding the qualitative analysis. Preliminary versions of themes and explanatory models were shared and discussed amongst the group of youth participants during this session, and feedback was solicited.

Results

Through the Photovoice process, the youth participants elucidated various challenges to their health, as well as numerous protective forces. The issues that were articulated by the youth participants ranged from detailed descriptions of personal experiences shaping their everyday lives, to critical discussions of societal issues at large. As the analysis proceeded, it became apparent that the issues identified by the participants fit within the ecological framework, a model we subsequently adopted to inform the analysis and organize the results emerging from this study.

Our conceptual model is summarized in Figure 1. This model builds on previous work in both the fields of violence prevention and youth resilience research.
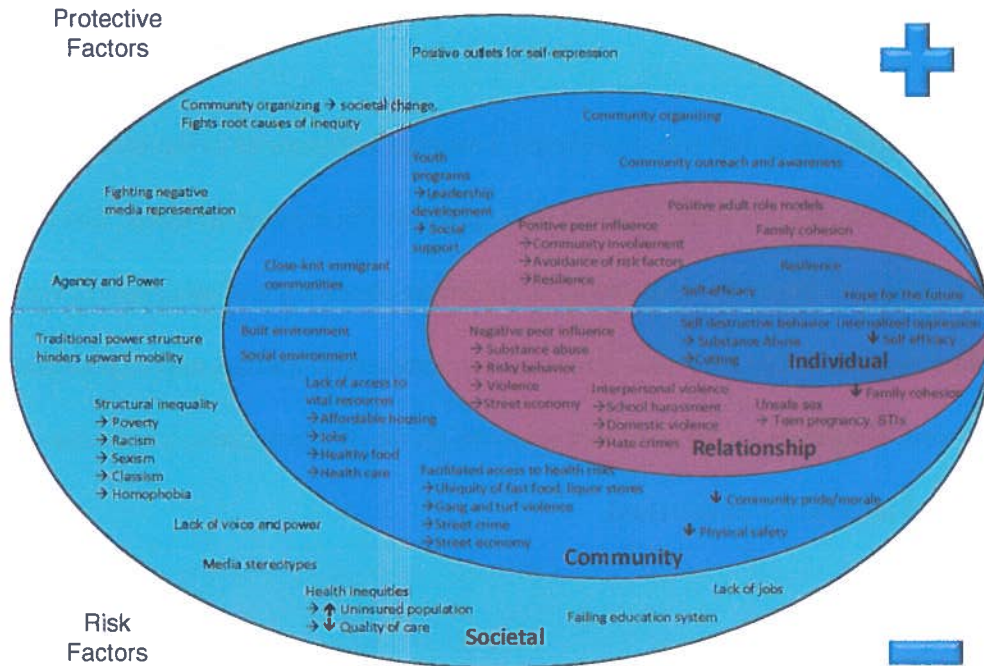

Figure 1. Conceptual model diagramming study results according to levels of ecological framework and designation as a risk factor or resilience factor. This model is adapted from Dahlberg and Krug's (2002) ecological framework.

The Ecological Framework as an Analytic Tool

First described by Bronfenbrenner (1979), the ecological framework outlines an all-encompassing view of the influence of social, economic, environmental, and psychological contextual factors on health status. In the context of violence prevention, Dahlberg and Krug (2002) described violence as a complex interweaving of individual, community, environmental, cultural, and socio-political factors, with the understanding that contextual factors must be taken into account in order to address violence as a public health problem. The first level of the ecological framework is the individual level, and

represents the biological and personal history factors that an individual exhibits. The second level is the relationship level, which indicates how proximal social relationships, such as between family members or peers, increase the risk for violence. The third level of the ecological framework, the community level, symbolizes the wider community contexts in which social relationships are encompassed, such as neighborhoods, and institutions such as schools and workplaces. The fourth and final level is the societal level, which encompasses the larger societal factors that influence violence, such as cultural norms that promote violence and its social acceptance.

Individual Level

Youth participants discussed many problems arising at the individual level of the ecological model. Individual-level internalized violence and destructive behavior were identified as widespread strategies for coping with stress in the daily lives of Oakland youth. Many youth expressed concern about young people engaging in self-destructive behavior, including self-injury, substance abuse and reckless conduct.

A particularly striking example of self-destructive mechanisms of coping is illustrated by the photo titled "Peer Pressure and Cutting", taken by a 14-year old participant from West Oakland. She explains this problem through a description of her photo:

> "This is a photo of a teenage girl whose wrists have been cut. Like many teens, she cuts herself because of the problems that she faces in her life. Nobody is really there for her. She chooses to hurt herself because everybody around her hurts her. Teens like her need someone that will always be there for her and who understands her, like a good friend or a youth counselor."

Figure 2. "Peer Pressure and Cutting"

Individual-level problems were discussed at length during the Photovoice sessions,

during which participants concurred that cutting is one of many rampant self-destructive

coping behaviors practiced by peers. Likewise, substance abuse as a coping mechanism

emerged with great frequency in the youth's photos as a subject of great importance. In

particular, alcohol abuse was highlighted in many of the youth's photos. An example of

this is illustrated in one 17-year-old's description of his photo, titled "Underage

drinking":

> "This is a photo of an underage drinker. He had drunk so much that night
> that he couldn't even stand anymore. For some people this is an everyday
> routine. Drinking everyday can affect young people's liver and their
> behavior. I think it's a problem because it's making people act up and it
> makes people want to drink every few hours and it's a bad habit.
> Sometimes drinking alcohol can lead to a lot of different things, and you
> never know if they are going to get into a car accident. I always try to tell
> people who are drinking that if you are the driver you shouldn't drink.
> People should try to kick it when they are sober and have fun instead of
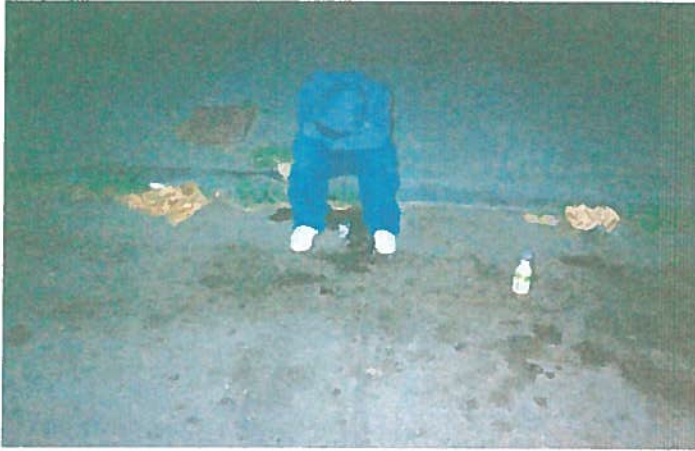> drinking or using some kind of drugs just to have fun."

Figure 3. "Underage drinking"

Despite describing many individual-level risk factors and challenges faced by Oakland youth, the participants also identified several protective factors serving to increase self-efficacy at the individual level. For instance, a 17-year-old participant's photo, titled "Harm Reduction", relates a positive experience participating in youth programs that educate youth about reproductive health and raise awareness about methods for reducing the risk of contracting HIV:

> "I was in this program called Health Initiatives for Youth (HIFY) and I learned a lot about our community and youth problems. We believe in harm reduction, which is when you don't stop someone from using or doing something, but you try to find ways to prevent that person from being harmed. In our society, youth might have HIV or other diseases. Condoms are a way to protect against HIV and other diseases. Programs like HIFY and Asian Health Services Youth Program go out and do workshops with teens to help get people educated. Giving workshops is a good way to protect your health because you're giving out amazing information. Before I joined these programs, I had no clue what a condom was. Having these programs really helps our community."

Figure 4. "Harm reduction"

Throughout the Photovoice project, the youth collectively and consistently identified youth programs as a source of resilience and self-efficacy in their lives.

One 15-year-old participant shared how youth programs played a significant role in raising her self-confidence levels, especially relating to public speaking:

> "I'm in so many programs now... I have to speak in front of an audience. So it's like I'm like not nervous no more. I used to be scared even though it was just a little group. But now it's like, 'oh, it's nothing.'"

Relationship Level

In addition to individual-level factors affecting health, the youth identified many risk and protective factors at the relationship level of the ecological model as playing a significant role in helping or hindering their health. Relationships with peers emerged as a strong contributor to youth health, with the potential of operating as either a negative or as a positive influence, depending upon the situation.

An example of negative peer influence is illustrated in this 15-year-old participant's description of his photo, "Youth Probation":

> "These photos are about youth being on probation. In these pictures, you see a teen on house arrest with an ankle bracelet. Some of the reasons why youth can be on probation are because they steal cars, rob houses, violate one of their probations, or other illegal activities. Most teens do these things because of peer influence and peer pressure. One solution to this problem would be if there were more jobs that teens could have, and if these jobs were easier to apply to."

Figure 5. "Youth probation"

Another youth spoke about his personal experience growing up with older peer figures exposing him to the world of drug dealing and the street economy:

> "When I was younger, [one of] my older friends, he used to sell drugs in front of me but he never told me what it was. When I got older he tried to hide it from me and that's when I got curious about it. I was thinking of doing it but I heard about and I knew people got killed from selling drugs, and that just changed everything. I barely be having money nowadays and I be feeling bad, and I gotta pass on people in front of me getting cash from selling drugs. I could have took that path a lotta times but I choose not to because I don't wanna be known for selling drugs and people try to rob me, cuz a lotta people get robbed too."

In this youth's biographical account, he reflects on the influences that impacted him as he was coming of age in East Oakland, and identifies his social environment and peer networks as forces that drove him towards a path that, while offering a rare chance at making a living, also confers serious risks, including potentially fatal physical violence. He continues,

> "I'm 2 years behind in credits. I was telling my mom I just wanna get a GED at least and try to get a job. I just want a stable job so I don't have to worry about getting fired and all that. I don't want my nephew to mess up like I did and do the stuff I did, and I don't want him to follow in my footsteps. I just want him to have a brighter future, a better way to grow up and all that. Cuz my environment was messin' with they mind cuz they little kids and they don't know what's going on. I just want him to live a better life instead of have to worry about money and all that when I could just give it to him if I got it."

In addition to highlighting the extremely influential role of key relationships and social networks in guiding important life decisions as youth develop, this participant emphasizes that youth themselves are capable of being positive role models to their peers; in this case, to younger family members. Moreover, this youth reiterates the obstacles posed by the lack of viable job options for youth in Oakland, and sheds light on the factors that push Oakland youth towards illicit, street economy means of making a living.

Again, youth leadership programs emerged as a prominent positive force in the lives of youth, operating not only on the individual level by increasing self-efficacy, but also operating at the relationship level, increasing awareness, education and positive influence

among peers.   A 17-year-old participant explains her involvement in a program that

promotes positive peer influence:

> "I recently joined a youth program called Youth Advisory Council (YAC).
> Dating/domestic violence is more common than expected in our
> community, because of so many cases that go unreported each year.
> Speaking with friends, I realize a lot of them are/were in an abusive
> relationship, whether it's emotionally, physically, or verbally. It motivated
> me to join this youth program, because I want to make a difference even if
> it's just helping one person. It would be rewarding to know I made a
> change in someone's life.   Youth dating violence is highly ignored and it
> cannot continue to be ignored. Through YAC, we create awareness of
> dating and domestic violence among our youth. A way we have formed
> awareness is by creating a website called www.ThatsNotLove.org. This is
> a new way for teens to come to another person who is about the same age
> and ask questions about domestic violence, how can they stop the abuse,
> etc. and be able to remain anonymous. We took advantage of the internet,
> because we believe youth may be more comfortable talking and chatting
> online about these issues instead of coming face to face with someone."

Figure 6. "Youth Advisory Council"

This youth's discussion of an important issue pertaining to domestic violence, a form of

interpersonal violence, demonstrates the power of speaking one-on-one to peers and

discovering the prevalence of a problem in one's own social network.   This personal

touch motivated this youth to become part of the solution to this problem at the relationship level by joining a youth program to raise awareness and address the issue with peer counseling.

Community Level

Many factors relating to the community level of the ecological model were identified by the youth as contributing a significant influence on their health and wellbeing. The participants painted a picture of problems rooted in poverty, the built environment, lack of access to vital resources necessary for health, and facilitated access to health risks in their communities.

A frequently cited example of facilitated access to unhealthy and unsafe risk factors was the rampant street violence and drug dealing associated with certain spaces in the community environment, such as liquor stores. One 15-year-old participant from West Oakland photographed her neighborhood liquor store to describe the multifaceted problems plaguing her surrounding community. She explains,

> "I took a picture of the liquor store on my block because I felt like the store was a target to the community. People post in front of the store selling drugs, while making themselves targets to getting shot at. I feel like that puts everyone in the community in danger because people are scared to walk to the liquor store. One time this Cambodian lady went to go visit her friend and she stepped out of the car and she got shot in the head. And she was hella innocent. This picture also tells us that there are liquor stores on almost all corners in Oakland. Liquor stores provide all the junk food and liquor and it promotes unhealthy eating in the community. We can improve this issue by asking liquor stores around Oakland to put more healthy foods in their stores."

Figure 7. "Green Valley Foods"

Just as the community offers facilitated access to unhealthy risk factors, it also presents

restricted access to vital resources, such as health care, healthy food and housing. An

illustration of this is one youth's relating of her experience of being evicted from

subsidized housing:

> "Around 2004, people were evicted from Pacific Renaissance plaza in
> Oakland Chinatown. A 13-year old child didn't know exactly what was
> happening; she only knew that she had to leave this apartment. It is very
> hard to find affordable housing in Oakland because it's all very expensive.
> Everyone had to search for housing before the deadline to leave. With this
> state of mind, low income people living in the building were scared, and
> some of them were having a mental breakdown. This can be a very
> traumatizing event for some people. Since the 13-year old's family was
> evicted, the family had to leave their old life behind."

Figure 8. "Pacific Renaissance Plaza"

This youth's account of her experience echoed the prominent observation of lack of choice and decision-making power in the lives of low-income Oakland youth and their families. The repercussions of this lack of choice translate to reduced power in maintaining health and wellbeing. This concept is also captured poignantly by another youth's description of the lack of healthy food options in her community though her photo titled "Youth Obesity":

"This photo is concentrated on the price values they have at KFC. The more good cheap deals and advertisements they have, the more customers they will get. This was important to me and my community because I know the prices at these places. It may to be bad for your health, but people won't look at the nutrition facts sheet when they are hungry. This targets low income communities. In Oakland, a low income community, people can see that we have a large variety of fast food restaurants surrounding us by driving up every block. Every one should know the truth about what is going inside their bodies. Maybe if the community knew what was really in the food, they could try to eat healthier."

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Figure 9. "Youth Obesity"

The ubiquity of fast food restaurants and the inaccessibility of affordable, healthy food options was a prominent theme discussed at length by the participants, and epitomized community-level structural obstacles to maintaining health.

Despite the identification of multifaceted risk factors at the community level, the participants also discussed many positive and constructive community-level factors. The vast majority of the participants lauded youth programs for their elevated self-efficacy and subsequent motivation to engage in efforts to improve their community and fulfill a newfound sense of civic duty. One participant comments,

> "Working with AYPAL (Asian Youth Promoting Advocacy and Leadership) for my second year and doin' that Photovoice Project has

made me really think a lot about the community. And I'm also working with the youth center at Skyline [High School]. So it's making me do a lot of community stuff; change for the community. I actually want to be a youth organizer when I'm like 20-somethin'. Somewhere in the future I just wanna be a youth organizer."

This participant's reflection on how his past engagement in youth programs has shaped his current commitment to playing a leadership role in improving his community, exemplifies the progression of critical consciousness that many youth discussed throughout the Photovoice project. Ultimately, community organizing is a tool for social change at the community level, which leads to change at the societal level.

Societal Level

Structural violence at the societal level surfaced as a prominent theme in this study and discussed at length by the youth participants. Many participants highlighted the structural injustices that they observe in their everyday life, such as in this participant's description of her photo about graffiti:

"In our society, graffiti is considered bad; it's illegal. I've only seen graffiti in poor communities. Since I live in a poor community, our voices aren't heard. That's why graffiti is here in our daily life. Once I step out of my house I see graffiti on the walls of buildings. Graffiti is a mark to show that we poor people are here. We need graffiti to have our voices heard. We need to find a way to express our thoughts and feelings so that our mental health will not be in jeopardy."

Figure 10. "Graffiti"

This youth emphasized a point that was echoed repeatedly throughout the project: disempowerment and invisibility have detrimental effects on health. An individual's perceived voice, control and power in society, significantly affects self-efficacy, emotional wellbeing, a sense of worth, and a sense of hope for the future.

The participants continued to discuss many societal issues, adding their voices and perspectives to issues such as health insurance, an issue debated at the highest level of policymaking in our society:

> "This is a picture of a newspaper stand with the sign "Free Take One". I wanted to focus on the sign and relate it to health insurance, because everyone in the community is not insured, and one reason for that is it's extremely expensive. A couple of years ago, I attended a conference with Asian Health Services and several Peer Leaders. It was a conference to motivate the elderly to stand up for free health insurance. Many stories were passed around about not being able to afford medicine or being denied of Medi-Cal. This gave me a new view on how unfair our health system is in the U.S. I would have never expected an elderly man who works two jobs would be unable to afford his own medication. It shows that wealthy people have a better chance of surviving in America. I want health insurance to have a sign that says "Free Take One". No one should be denied of protecting their lives."

Figure 11. "Free health insurance"

With an action-oriented and imperative tone, this 17-year-old participant takes a stand on

human rights and offers a stern critique of our society that allows certain communities to

suffer more than others solely based on wealth. This youth's experience with attending

community organizing forums such as conferences with youth leadership programs

echoes the prominent sentiment of the value of youth programs at the community level.

Moreover, throughout this process of critical dialogue and reflection encompassed within

the Photovoice method, the youth demonstrated that they can respond in positive ways to

structural violence and other societal challenges in their lives, and that they see

themselves as agents of social change who are capable of changing the society in which

they live. One 17-year-old participant expressed her agency through a description of her

photo titled "Photovoice":

> "If youth were mute, there still would be many other ways for us to speak.
> With activities like youth programs, internships, after-school programs
> and sports, youth can gain self-confidence and I believe we can change

our community for the better. Youth can say something even if we are from low income communities. We are the next leaders of the future and this is a great way to prepare ourselves and to make a difference."
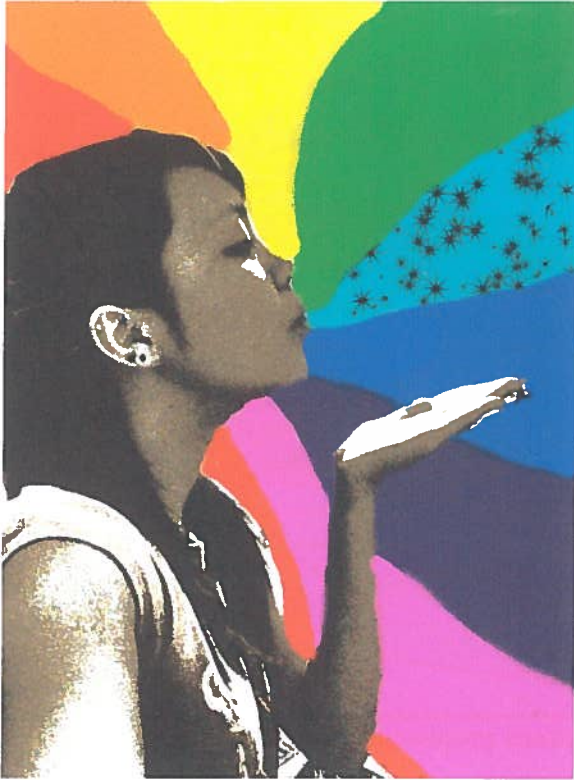

Figure 12. "Photovoice"

In summary, through Photovoice, participants identified many issues ranging from the individual, relationship, community, and societal levels of the ecological model. The participants touched on multiple, interacting contextual factors that contribute to or detract from AAPI youth health at each of these levels.

Proposed Solutions

Photovoice is an intervention in and of itself, in that its goal is to raise critical consciousness and spark social change. In this project, the youth participants engaged in

group discussions to brainstorm solutions to the problems identified through the
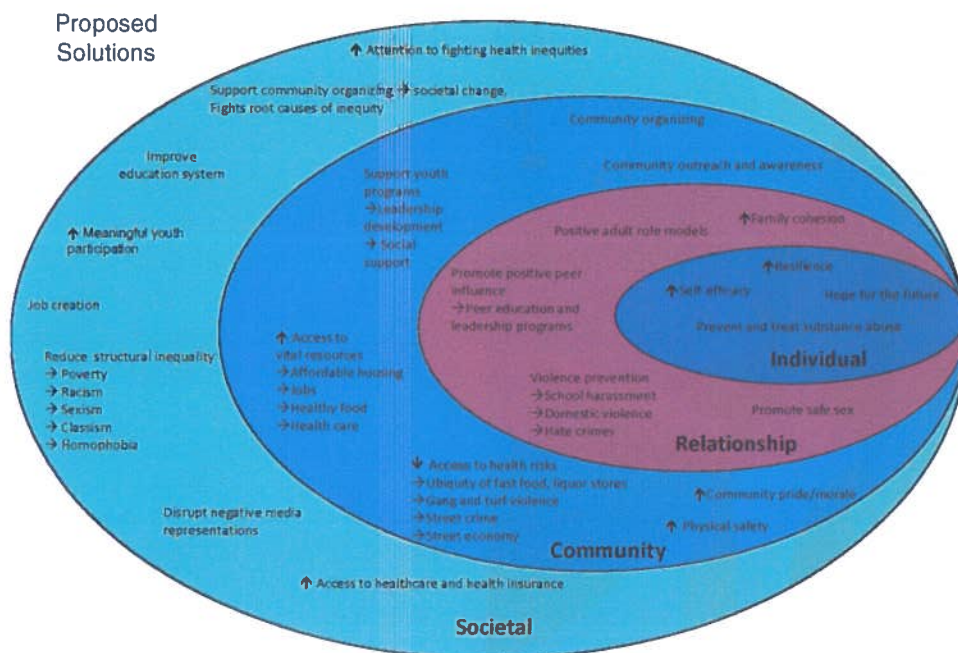
Photovoice process.

Figure 13. Summary diagram of solutions proposed by youth participants.

A diagram summarizing the solutions proposed by the youth participants is shown in

Figure 13.

At the individual level, youth emphasized the need to foster self-efficacy, a key resilience

factor for youth, in order to promote a sense of self-worth and hope for the future.

Furthermore, they expressed a need for prevention and treatment approaches to address

the widespread problem of self-injury resulting from substance abuse and other

destructive means of coping with stress.

At the relationship level, youth praised relationships that bolster individual self-efficacy, such as positive peer influences and adult role models. They proposed solutions that involved strengthening family cohesion, promoting peer education programs, promoting education and awareness about safe sex practices, and preventing interpersonal violence.

Stemming from the collective observation that youth programs serve as a strong protective factor for youth, the participants proposed the expansion and support of more youth programs that build youth leadership and community engagement as a community-level solution. They also proposed working towards decreasing health risks by changing aspects of the built environment such as limiting the amount of fast food restaurants and liquor stores. Efforts to reduce gang and turf violence through community organizing and awareness-raising were discussed as strategies to restore physical safety in the community.

Proposed solutions at the societal level included addressing social determinants of health by fighting root causes of structural violence. These approaches include job creation, investment in education, and support for programs that increase financial literacy and job readiness. Furthermore, increasing access to social goods such as affordable housing and healthcare was suggested as a key component of the solution to the problems discussed in this project.

Programmatic results

In response to the solutions proposed by the youth participants, many community action steps and awareness-raising efforts resulted from this project. This project culminated with a 3-month-long exhibition of the photos at the Asian Resource Gallery in Oakland Chinatown. This was accompanied by a presentation by the youth to the community at the exhibit reception, where health professionals, community members, policy makers, and local and ethnic news media attended. Since the completion of the project, the youth have also had the opportunity to present their photos on several occasions at community venues, including to an audience of 150 health professionals working at Asian Health Services. Other outcomes include the creation of a Photovoice curriculum for long-term use at AHSYP and the continuation of a yearly summer Photovoice program at AHSYP. The photos have been used in awareness raising campaigns regarding safe sex and drug and alcohol abuse with the creation of posters and outreach at community events like the Oakland Chinatown Autumn Street Festival. Finally, a silent auction of several youth photos took place to raise funds for AHSYP.

Discussion

Photovoice as a tool for identifying social determinants of health

Photovoice proved to be an appropriate and effective tool for assessing community needs and strengths on all levels of the ecological model. While health interventions have

primarily focused on the medical model of emphasizing individual level risk factors, the ecological framework transcends this perspective and addresses the larger contextual factors contributing to health. Socioeconomic status can affect health through multiple pathways, including access to and quality of health care, health behaviors, psychosocial processes, physical environment and social environment, and in overriding health policies (Satcher & Higginbotham, 2008). Each one of these pathways was represented in the photos taken by the participants and in the group discussions that followed.

Applying features of Freirian education for critical consciousness, Photovoice enhances people's ability to identify and analyze historical and social patterns that shape their life circumstances (Freire 1970, Wallerstein & Bernstein 1988). This facet of the Photovoice method proved useful in realizing this project's goal of identifying social determinants of health and forces of structural violence in the lives of urban AAPI youth.

Solutions targeting root causes of health inequities

This Photovoice project not only succeeded in identifying social determinants of health for AAPI youth, but also in effectively motivating youth to advocate for improved health through solutions they collectively identified. Youth participants enthusiastically elucidated strategies to target the root causes of poor health in their communities. The participants discussed at length the dire need for alternative means of economic survival for themselves and their families, outside of the narrow scope of dangerous and illicit options offered by the street economy. Numerous youth spoke of peers who regularly engaged in illegal activities, such as prostitution, drug dealing, theft, and gambling, in an

attempt to achieve economic stability. Discussions regarding proposed alternatives to youth being pushed towards risky behaviors ultimately concluded that increased availability of jobs, aid in job skill training through community programs, and increased access to education beginning early in childhood would be critical steps towards maintaining community health. Results of this study draw attention to the evident, yet crucial conclusion that improving health provision alone will not solve health inequities for AAPI youth. As suggested by the project participants, the solution to the problems identified in this project entail a critical look at the programs and policies that serve to perpetuate the structural violence which affects the social determinants of youth health.

Youth programs as a source of resilience

This project gave youth an opportunity to identify factors that enhance their resilience traits. The prominent resilience factor discussed repeatedly through the youth's photos and through critical reflection and dialogue was the beneficial role that youth programs play in the lives of Oakland AAPI youth.

According to Werner and Smith (1992), "Resilience skills" include the ability to form relationships (social competence), problem solve (metacognition), develop a sense of identity (autonomy), and plan and hope (a sense of purpose and future). Youth programs offer an opportunity to build these resilience skills and promote personal growth at the individual and relationship levels. Youth programs raise self-efficacy and offer individual support to cope with stress at the individual level. They also allow a space for expression of concerns and to engage in problem solving through critical reflection and

dialogue with peers. In addition to these individual and relationship-level solutions, youth programs also encompass community-level organizing and outreach, which fuels a sense of civic engagement and community capacity building, and leads to unified efforts towards societal-level change. By reinforcing a sense of hope and giving youth a chance to contribute to meaningful public participation in improving their community, youth and community programs foster a positive sense of optimism for the future.

Limitations

While the Photovoice method offers many strengths, several limitations must be taken into account. As in many qualitative studies, the sample size was limited and thus, the findings may not be generalizable. Moreover, the participants were a self-selected group of youth that had the resources and motivation to participate in this study and thus do not accurately represent the entire Oakland AAPI population. Furthermore, the participants were recruited at a youth health program, and may represent a group of youth who are more likely and socially equipped to seek health resources and support.

Conclusions and Recommendations

Photovoice proved to be an effective assessment method to document the health and contextual factors affecting the health of a hard-to-reach and understudied population that

is rarely asked to contribute to policy decision-making. Through Photovoice, Oakland AAPI youth described the impact of their physical and social environment on their health, focusing on violence, poverty, and social inequality as risk factors, while focusing on youth programs, self-efficacy and political power as protective factors.

Emerging from this study's results is a unique conceptual model that takes into account risk and resilience factors in the lives of Oakland AAPI youth as they fit within the ecological framework. There is an imperative need for further research investigating the risk and protective factors regarding urban AAPI youth health. Utilizing a combined ecological-resilience perspective in future studies will guide health professionals and policy makers to gain further insight into the many salient social, economic, cultural and environmental factors that contribute to, and detract from health and wellbeing.

Policy recommendations emerging from this study include expanding youth and community programs that not only provide health and social support services to foster resilience, but also build social, political and economic power to change the conditions that restrict health and wellbeing for these youth and their communities. Too often, low-income youth are disempowered and overlooked for their abilities to contribute to solutions. Programs should be encouraged to engage their youth in meaningful participation and acknowledge youth as critical thinkers and positive assets to their communities.

We conclude with a participant's apt summary of her experience with meaningful participation in this project:

> "Growing up in Oakland can be very different. The community has a lot of good and bad new experiences that people go through every day. Since I've been taking pictures and bringing life into them, the story of every picture describes something in our teenage community of what we see, feel or experience daily. I believe I can *be the change* in what people think about anything. I learned and cherished this program a lot. It has helped me open my eyes and mind to speak my mind about my community. I can see that every one else in the program has gained some new knowledge."

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