An Apparatus of (In)Difference: Governing Indigenous Food (In)Security through Healthism in Winnipeg, Manitoba

by

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Abstract

Engaging with the fields of critical Indigenous theory, Indigenous STS (Science, Technology, and Society), and governmentality, *An Apparatus of (In)Difference* interrogates how Indigenous food insecurity policy reiterates food insecurity as a matter of poor health choices. I delineate how a power/knowledge nexus of health and nutrition informs how the food insecurity of Indigenous people living in Winnipeg is differentially governed through *healthism*, a governing rationality that disciplines bodies through strategies of self-regulation at the level of the individual. In following Foucauldian governmentality methodologies, this research charts an apparatus of healthism that is constituted by federal, provincial, municipal, not-for-profit intermediaries, and researchers' rationalities, programs, and technologies that includes but is not limited to: population statistics, anti-obesity frameworks, nutrition and dietary programming, food councils, community food assessments, geographic mappings of food deserts, mirages, and swaps, and after school nutrition education. I situate these empirical facets within three conceptual relationalities – the individual and the body politic (settler agents of governmentality), the expert and the expertise (federal policy makers), and the biocitizen (the disciplined Indigenous subject). By connecting these conceptual relationalities to the empirical context of Winnipeg, I demonstrate how governmentality and healthism operate through white possessive securitization and racialized logics, which ultimately leads to the differential governing of Indigenous health and food security. This research identifies liberal, seemingly altruistic, calls for health promotion and regulation that have disciplinary outcomes for Indigenous populations. As such, this analysis disrupts the racialized logics that limit Indigenous health policy approaches to the reiteration of biocolonial ideals.

Preface

This thesis is an original work by Merissa Daborn. No part of this thesis has been previously published.

Dedication

To my Aotearoa triad.

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Chapter One – Introduction

In the winter of 2013, I wrote the essay "Blown to Hell: The Health Legacies of US Nuclear Testing in the Marshall Islands" in a history seminar on war and health that I was taking with Susan L. Smith at the University of Alberta, which would put me on a research trajectory that I have only been able to appreciate with hindsight. A central vein of the Marshall Islands research I completed that winter was the long-lasting health impacts of nuclear testing, particularly through the loss of traditional food sources due to radiation contamination, and an increased reliance on imported foods. This research was formative, and I return to it year after year with new insights, new analytical tools, and new questions. When I began research in Kugaaruk, Nunavut in 2015, I saw connections between these two remote locations through their colonially imposed reliance on imported foods and the negative impacts it has on locals' ability to maintain food security. As I began my doctoral research in 2018, I once again returned to the Marshall Islands as I thought through how health and nutrition dominates discussions of food security.

In the earliest days of my academic research as an undergraduate student, I gravitated towards research on health, medicine, race, and power. Of course, at the time, I did not have all of the language and analytical tools that I have today to grapple with the complexities of these topics, but I kept returning to these areas of research. Indeed, in my research on the Marshall Islands I considered the implications of power relations, policy, and imperialism – albeit without any serious theoretical language to describe these phenomenon – and I was missing analysis of and the language to identify indigeneity, colonialism, and multiple modes of power at play on the Pacific Islands. I shared the essay with a friend at another institution for feedback, and they pointedly remarked, "well, it's good, but what you're really talking about is colonialism and

you're not talking about colonialism." The essay itself was not formative, but the questions it generated, the relations it established, and the directions I went following it were.

As I began to ask new questions of my research contexts and engage in different conversations, I began to transition my academic research to Indigenous Studies following gentle suggestions from professors who indicated my work would be better suited and supported in Indigenous Studies. I tell you this to situate my academic trajectory and relationships, or what Jessica Kolopenuk refers to as "academic kin," who influence our knowledge relations, what theorists we use, what contexts we focus on, and what questions we ask (2020a, 13). Even though I have identified "Blown to Hell" as a research experience that has connected to all of my research since, more than anything, it was a flashpoint that established my "academic kin" (Kolopenuk 2020a, 13). But of course, our relations cannot be separated from our research. As much as my research contexts can be linked to specific relations, so can the questions I ask.

I came to this doctoral research after spending several years researching Indigenous food sovereignty, food security, and colonial health policies, which had taken me (intellectually and/or physically) from the Marshall Islands to Kugaaruk, Nunavut, Aotearoa / New Zealand, and now to Winnipeg, Manitoba.[1] As I carried out this research, I began to identify ties between coconut crabs and strontium 90 radioactive contamination, empty Co-op shelves, basketball courts at Burger King, and food deserts, mirages, and swamps. Indigenous food insecurity was

[1] I do not extensively engage Indigenous food sovereignty literature in this dissertation. While there is some overlap and commonalities between Indigenous food sovereignty and Indigenous food security literature, I see the two fields as distinct intellectual projects. Indigenous food security is much more oriented towards nutrition and health policy interventions. Emerging policy imperatives to focus on Indigenous culture and health will mean that Indigenous food sovereignty will likely become a site of importance for further inquiry in the future. However, if I were to take up that research, I would want to partner with Indigenous communities engaged in Indigenous food sovereignty efforts. For more on Indigenous food sovereignty see: Grey and Patel 2015, Martens et al. 2016, Whyte 2018, Mihesuah and Hoover 2019, and Settee and Shukla 2020.

consistently being framed as a matter of poor health, and efforts to promote food security were equated with the ability to access *healthy* food, not just *any* food.

Nuclear testing in the Marshall Islands left the traditional food supplies of Marshallese, such as coconut crabs, with high levels of radioactive contamination. With food sources being lost to high radiation content, Marshallese had to rely on imported food, resulting in 'fat dumping,' "which refers to the selling of unwanted high fat animal by-products to lower income populations," and an influx of calorically dense processed foods (Gittelsohn et al. 2003; Daborn 2014, 33). High rates of food insecurity in Kugaaruk, Nunavut are further complicated by astronomical food costs, an insufficient federal policy that only subsidizes shipping costs of perishable foods, and unreliable supply chains that will leave store shelves empty for weeks at a time (Daborn 2017). Several Burger King restaurants in Aotearoa / New Zealand have basketball courts for community use – an initiative that is further complicated when placed in the context of high Māori food insecurity rates and anti-obesity interventions.[2] Food deserts, mirages, and swamps in Winnipeg, Manitoba are operationalized in research and policy to mark Indigenous peoples as deficient and in need of health interventions (Wiebe and Distasio 2016; Balcaen and Storie 2018). The cohering logic between these vastly different contexts is one of health, or more specifically, *healthism* (Crawford 1980).

Healthism includes the regulation and disciplining of bodies via normalizing discourses through the strategy of health promotion and self-regulation *at the level of the individual*. In the

[2] It is worth noting that a Burger King location I visited in Auckland had a basketball court but did not provide basketballs. Also see: Burger King. "Sponsorship." *Burger King*. Accessed December 9, 2020. https://www.burgerking.co.nz/partnerships-sponsorship. Parahi, Carmen. "The Stigma of a System that 'Fat Shames' Māori and Pasifika People." *Stuff*. January 31, 2019. https://www.stuff.co.nz/life-style/well-good/110265031/the-stigma-of-a-system-that-fat-shames-mori-and-pasifika-people. Warbrick, Isaac, Heather Came, and Andrew Dickson. 2018. "The Shame of Fat Shaming in Public Health: Moving Past Racism to Embrace Indigenous Solutions." *Public Health*: 1-5.

above contexts, healthism is operationalized when individuals are expected to self-regulate their nutritional intakes because of and in spite of their food insecurity. Adhering to nutritional guidelines is prioritized over safe, dignified, and economic access or preference. I follow the seminal work on Indigenous Studies scholar Brendan Hokowhitu and his theorizations of healthism, racism, and biopower. Hokowhitu connects healthism to colonial pathologizing of Indigenous bodies and posits that healthism is merely a normalized form of madness that determines the unhealthy to be "another form of alterity" (2014, 33). I attune my analysis to how healthism is operationalized differentially for Indigenous populations based on colonial logics of health.

As I began to identify the prevalence of healthism in relation to food insecurity, I turned my attention to contexts where I had yet to interrogate these logics. Whereas I had interrogated the coloniality of food security in the context of Kugaaruk, Nunavut by analyzing one specific federal food security policy, I had yet to bring to bear how healthism and food insecurity cohabitate within an urban context that is subject to a much more complex layering of policy interventions. Winnipeg is an important, albeit specific, power container for the generation of healthism's outputs. The city and its various geographies (social, political, economic) serve as an incubator for nurturing the collisions and co-productions between federal, provincial, municipal, and intermediary colonial healthism and its attempted interventions upon Indigenous lives.

The central aims of my dissertation research are as follows: 1) to render visible the insidious underbelly of "healthism" as a governing rationality of food insecurity in Canadian nutrition and food security policy; 2) to more specifically chart an apparatus of healthism that accounts for how Indigenous health is governed through federal, provincial, municipal, and intermediary programs and technologies; and 3) to demonstrate how Indigenous health is

differentially governed through the operationalization of healthism in response to food insecurity. While I account for federal and provincial governing mechanisms, I situate this research in the context of Winnipeg to identify the points of application of healthism, and to demonstrate how healthism is at odds with the everyday material realities of many urban Indigenous people.

Winnipeg has several intersecting factors that make this research particularly relevant. Manitoba's household food insecurity rates were 14.4% in 2017-2018, which is the highest rate of food insecurity amongst the provinces, with the exception of the Atlantic provinces (Tarasuk and Mitchell 2020, 3). While these rates do not necessarily reflect Winnipeg specifically, they are telling. Moreover, research has shown that the prevalence of household food insecurity is higher for Indigenous people or people of colour – with 28.2% of Indigenous households experiencing food insecurity in 2017-18 (Tarasuk and Mitchell 2020, 13). Winnipeg is home to the largest population of Indigenous people in Canada, with 92,810 calling the city home.[3] Additionally, research on Winnipeg's food deserts and mirages have indicated that one-quarter of the population in high deprivation neighbourhoods (that correlate with severe food deserts and mirages) are Indigenous people (Wiebe and Distasio 2016, 10). I provide these statistics to establish brief context on Indigenous food insecurity in Winnipeg. In the chapters that follow, I am not overly concerned with demonstrating the number of individuals deemed deficient or the size of a food insecurity crisis, but rather with interrogating the disciplinary and differential nature of how food insecurity is intervened upon through health policy.

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[3] Statistics Canada. "Aboriginal Peoples Highlight Tables, 2016 Census." *Statistics Canada*. Accessed December 16, 2020. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/abo-aut/Table.cfm?Lang=Eng&T=102&S=88&O=A&RPP=9999.

Instead of focusing on the numbers of a food insecurity crisis in Winnipeg, I am much more concerned with understanding how a power/knowledge[4] nexus of health and nutrition informs how food insecurity is intervened upon. In order to identify where and how a knowledge/power nexus of health and nutrition operates, there are several corollary theoretical concepts that I engage throughout, including healthism, governmentality, white possessive securitization, and biocitizenship. I have already noted that healthism is the regulation and disciplining of bodies via normalizing discourses through the strategy of health promotion and self-regulation *at the level of the individual*. Healthism is an integral concept and process that I interrogate throughout this research to identify how it informs and structures responses to food insecurity, and also operates as a form of governmentality.

Governmentality, which I introduce in the next chapter, is a mode of exercising power that administers populations through apparatuses that are comprised of institutions, programs, technologies, and knowledge production (Dean and Hindess 1998; Foucault 2009). Governmentality figures as a cohesive analytical and methodological device throughout this research to identify the rationalities that shape how populations are determined, the programs and technologies that delineate 'populations,' and the interventions that are made to administer populations. Governmentality works on the individual to become an agent of governmentality and meet the ends of government through responsibilization and self-regulation (Miller and Rose 1990; Rose and Miller 1992; Lemke 2002). I theorize white possessive securitization as a materialization of individual self-governing subjects in a settler colonial context. I bring together

[4] A power/knowledge nexus can be described as "the power of knowledge of truth and the power to disseminate this knowledge" (Foucault 1980, 34).

relational theorizations of whiteness[5] and white possession with governmentality to delineate how governmentality operates with a rationality and mandate of *security* (Moran 2004; Rose 2004; Lipsitz 2006; Moreton-Robinson 2006; Rose 2007; Moreton-Robinson 2015). White possessive securitization is integral to the operation of governmentality and occurs through individual citizens' efforts to securitize resources.

As I engage these concepts throughout the dissertation, I ultimately argue that healthism, and the governmentality of individual health, operates *differentially* for Indigenous populations by failing to provide necessary resources and expecting Indigenous people to meet the standards of a general population without accounting for inequities or differences. In theorizing the differential governmentality of Indigenous populations, I chart an apparatus of healthism that operates as an apparatus of (in)difference in regard to Indigenous health. An apparatus of (in)difference deploys difference through the differential governmentality of Indigenous populations, which subsequently results in prioritizing the needs of settler government while failing to account for the needs of Indigenous populations. I build on the work of Mary Jane Logan McCallum and Adele Perry who have demonstrated that in Winnipeg healthcare "one effect of anti-Indigenous racism is what we call structures of indifference" (2018, 12). McCallum and Perry indicate that "colonial frames of medicine and health" have produced Indigenous peoples as "special subjects of inquiry, intervention, and discipline" and acknowledge that the racism that informs these practices is not individual, but a "structure of indifference" (2018, 14). In my theorizations, I transition from what McCallum and Perry have identified as structures of

[5] I work with Aileen Moreton-Robinson's definition of whiteness as "the invisible norm against which other races are judged in the construction of identity, representation, decision-making, subjectivity, nationalism, knowledge production and the law" (2006, 388).

indifference, to apparatuses of indifference. I investigate how an entire apparatus operates with persistent racialized indifference.

A final important thread in this research is that of biocitizenship. Given that an integral aspect of governmentality is the self-regulating citizen, the shift of responsibility and risk onto citizens has come to be intertwined with aspects of citizenship (Rose and Miller 1992; Hindess 2001; Lemke 2002). However, as I will argue and demonstrate throughout this research, biocitizenship is often used as an exclusionary and disciplinary device. When individuals fail to meet the expectations of active citizenship for whatever reason – lack of resources or lack of desire – they are subject to judgement and/or neglect. Interventions into food insecurity in Winnipeg that emanate from an apparatus of healthism are preoccupied with intervening in biocitizens, rather than the material realities that cause food insecurity. Education is a common method of biocitizenship interventions because it is meant to shape individuals into being better, or good, biocitizens. However, in the final chapter of this research I demonstrate how educating teens through after school mentoring programs to be better biocitizens is a form of disciplinary and differential governmentality when their access to resources (such as afterschool programming) hinges on appropriate citizenship by learning to be healthy eaters (even if this is not a possibility for them to maintain outside of the program).

In the coming chapters I theoretically weave together governmentality, healthism, white possessive securitization, and biocitizenship to lay bare the effects of healthism as a power/knowledge nexus through which food insecurity in Canadian nutrition and food security policies govern. I engage governmental policy, academic research, and not-for-profit intermediary policy as my primary data to illuminate the pervasiveness of healthism as a response to food insecurity. It is my hope that the theoretical analysis I produce throughout this

research will serve to disrupt dominant power/knowledge approaches to food insecurity that reproduce disciplinary effects which are more concerned with the production of better biocitizens than addressing Indigenous food insecurity or interrogating how Indigenous food insecurity is intervened upon in differential ways.

Indigenous Studies and Indigenous STS

I engage a number of academic fields and draw on a number of theoretical tools throughout this research that are outside of Indigenous Studies – yet I see this research as being firmly anchored in and contributing to Indigenous Studies and the emerging subfield of Indigenous Science, Technology, and Society (I-STS). Aileen Moreton-Robinson has noted that critical Indigenous studies is "where Indigenous-centered approaches to knowledge production are thriving and where the object of study is colonizing power in its multiple forms, whether the gaze is on Indigenous issues or on Western knowledge production" (2016a, 4). My non-Indigenous positionality as a white settler scholar precludes me from producing Indigenous analytics that are from a standpoint grounded in Indigenous epistemologies. I do take direction from critical Indigenous studies scholars throughout this research though and do hold colonizing power as my object of study. I could not do this work without the many Indigenous Studies scholars who have led the way with critical interrogations of and engagements with power/knowledge, settler colonialism, and biopower as it bears on Indigenous lives (Moreton-Robinson 2006; Hokowhitu 2014; Andersen 2016; Warbrick et al. 2016; Murphy 2017; Kolopenuk 2020a; Kolopenuk 2020b). Indigenous Studies values community-based research, research that benefits communities, and Indigenous knowledge production (or co-production), which are missing from this iteration of this research in the sense that I have not partnered with a community or organization (Innes 2010; Moreton-Robinson 2016a; Andersen and O'Brien

2017).[6] However, this research does offer contributions of interrogating colonial power as it operates through healthism and governmentality, which I hope to be of benefit for future research relationships in addition to disrupting dominant power/knowledge discourses of healthism and food insecurity.

As I transitioned from policy research in Kugaaruk, Nunavut to Winnipeg, Manitoba, I began to engage the fields of urban Indigenous studies and urban Indigenous policy to grapple with the complexities of how policy administers Indigenous populations in urban locales. In Kugaaruk, I was concerned with one specific federal policy that had implications for all Northern residents – who are predominately Inuit. In the urban context, issues of jurisdiction, service delivery, and a culmination of federal, provincial, and municipal policies establish a much more complex policy environment to navigate. Decades of scholarship on urban Indigenous policy have accounted for the challenges of how Indigenous populations are administered and served by ineffectively coordinated, overlapping, and deficit-based policies (RCAP 1993; Newhouse and Peters 2003; Peters 2011; Andersen and Strachan 2011; Walker, Moore, and Linklater 2011; Andersen 2013). I have theorized with and alongside urban Indigenous policy scholars to consider how urban Indigenous health and food insecurity is differentially governed through inadequate services, or in a "policy vacuum" (RCAP 1993, 6-7); how federal governments actors, provincial government actors, municipal government actors, social forces, and representative organizations operate in relation (albeit in tension) and in a context of "an uncoordinated jurisdictional quagmire" (Andersen and Strachan 2011, 135); and finally, that

[6] A number of factors contributed to my decision not to undertake community partnered research for this dissertation, including the constraints of the three-year PhD program in the Faculty of Native Studies, securing a tenure-track job shortly after candidacy, and the Covid-19 pandemic. Moreover, given my previous research with community that analyzed the impacts of a single federal policy, I recognized the value in undertaking a more robust policy analysis prior to further community partnered research.

statistical portraits of urban Indigenous populations have a "lack of nuance" and are unable to "account for the complexity" of urban Indigenous life, and are thus "ill-suited" to inform urban policies (Andersen 2013, 279). These three key interventions being made in urban Indigenous studies directed me to consider the complexities of how policy operates – its points of applications, its redundancies, its inefficiencies – and how policy renders populations for intervention in the first place.

As I began identifying Indigenous food insecurity policy recommendations in an urban context, I noticed significant trends that recommended responding to food insecurity with either health or culture. These two interventions are not significantly different when we have an understanding of how whiteness, race, and culture operate in relation. Cultural initiatives relating to food access in urban centres is important – especially if it means accessing traditional foods, reviving governance practices, and creating social relations (Cidro, Peters, Sinclair 2014; Cidro and Martens 2015). I was introduced to the importance of cultural food access in urban centres during a research practicum with the Nihgi Métis Seniors' Lodge during my master's degree. The lodge was unable to serve donated country foods to their residents because of food safety regulations, but as much as this was an issue of cultural programming, it was also an issue of whiteness and colonial logics. Moreover, as a policy recommendation to alleviate food insecurity, we should be wary of how a cultural approach is deployed to avoid addressing social, economic, or political causes of food insecurity, or to merely put a culturally appropriate veneer on existing health and nutrition discursive formations. Measured skepticism of policy recommendations that go all-in on supporting Indigenous cultural practices, rather than

interrogate the colonial logics and systems that maintain Indigenous food insecurity, is a necessary task.[7]

I am critical of how both culture and health are deployed in policy according to logics of whiteness. As Aileen Moreton-Robinson argues, "cultural difference and race become conflated discursively through the invisibility of whiteness" (2016b, 111). This conflation, and indeed collapsing of race into a cultural container, occurred in anthropology following the scientific disproval of 'race,' which Moreton-Robinson indicates led to the designation of "the Indigenous body as the repository of cultural attributes" (2016b, 113). Moreton-Robinson contends that Indigenous scholars have been preoccupied with theorizing cultural difference to inform policy and programs with the aims of making them more culturally aware, appropriate, or competent (2016b, 115). While this is important work, Moreton-Robinson argues that this ultimately "ends up producing cultural difference as an a priori and renders invisible racialized knowledges" that continue to define Indigenous peoples, and thus, "cultural difference is compelled to function discursively to reinscribe race" (2016b, 115). I theorize along these lines to consider how cultural veneers for food and nutrition policies reinscribe race by hypervisiblizing difference, while simultaneously invisiblizing whiteness.

Recognizing how and where culture and race are collapsed and conflated in policy is an integral component of tracing how Indigenous health is differentially governed. In the context of governmental interventions into Indigenous communities in Australia, Moreton-Robinson demonstrated that the state deployed "a discourse of pathology as a means to subjugate and

[7] Michael A. Robidoux at the University of Ottawa is in the process of completing much needed research in this area in response to increased federal government support for Northern Indigenous communities' procurement of country foods to mitigate rates of food insecurity. Robidoux uses community baselines of total dietary energy expenditure rates to determine how much land-based foods could contribute to community food security. This work is essential in light of increased policy efforts to support traditional land-based practices, to determine whether such approaches significantly decrease food insecurity.

discipline Indigenous people to be extra good citizens" but that the tactics and strategies deployed by the state "reveal its own pathology" (2009, 63). According to Moreton-Robinson, biopower operates through race and rights, and "life is conditional on the perceived appropriateness of the individual, the measure of which is the good white citizen" (2009, 77). I argue that these theorizations of power and race need to be carried into analysis of 'cultural' solutions in health, nutrition, and food security policy to ask the following: Is culturally appropriate programming used to discipline Indigenous people into being a particular kind of 'good citizen'? Is culturally aware programming deployed disciplinarily and differentially in lieu of other services? Does 'culture' serve to mask race and whiteness?

I theoretically orient my research alongside and in conversation with Indigenous Studies scholars of indigeneity, race, whiteness, and biopower to demonstrate how these processes and logics are at play in the governmentality of Indigenous health (Andersen 2009; Tuck and Yang 2012; Hokowhitu 2013; Moreton-Robinson 2009; Moreton-Robinson 2016b). Chris Andersen has argued that instead of conceptualizing "*indigeneity-as-different,*" we should turn our attention to Indigenous *density* instead (2009, 88). A shift from difference to density recognizes that Indigenous peoples are "deeply steeped in knowledge about whiteness – how it operates, what it takes for granted and the gaps, silences and illogicalities of its presumptive truths" (Andersen 2009, 93). In the production of Indigenous food insecurity policy recommendations, conceiving of *indigeneity-as-different* shortchanges Indigenous peoples who are not only knowledgeable about whiteness, but are deeply entrenched in whiteness in their everyday lives as well. The inclusion of 'traditional' foods in the First Nations, Inuit and Métis Canada's Food Guide does not change the whiteness embedded in the food guide or alter the fact that many

urban Indigenous people navigate the confluences of whiteness and biopower to meet their health and food needs.[8]

In my research I undertake analysis of what gets left out and negated when there is a focus on culture/tradition, and not race/whiteness. Brendan Hokowhitu's theorization of the production of Indigenous subjectivities through the Māori "Treaty Partner" interrogates how 'tradition' was operationalized to produce a particular Māori citizen (2013, 355). There are correlations here to how healthy Indigenous subjectivities are formed via biocitizenship, but also through cultural food programing that values and emphasizes 'traditional' food practices over contemporary/colonized food sources. While there is absolutely a need for programs that revitalize traditional Indigenous food practices, I exercise caution in offering this as the only appropriate policy recommendation in response to Indigenous food insecurity. Instead, I argue that it is vital to undertake a project of "reframing" (Smith 2012, 154; Duarte 2017, 31) that foregrounds race, whiteness, and biopower in determining how Indigenous health is differentially governed. Otherwise, the constant referral to 'culturally' aware or appropriate policy simply serves as a settler 'move to innocence' that attempts to "reconcile settler guilt and complicity, and rescue settler futurity" (Tuck and Yang 2012, 3). I contend that non-indigenous peoples promoting 'culturally' aware policy responses is similar to the history of non-Indigenous peoples "making moves to alleviate the impacts of colonization" through a "too-easy adoption of decolonizing discourse" (Tuck and Yang 2012, 3). Eve Tuck and K. Wayne Yang argue that such moves to innocence relies on "pre-existing tropes that get in the way of more meaningful

[8] Health Canada. "Eating Well with Canada's Food Guide – First Nations, Inuit and Métis." *Government of Canada*. Accessed December 18, 2020. https://www.canada.ca/en/health-canada/services/food-nutrition/reports-publications/eating-well-canada-food-guide-first-nations-inuit-metis.html.

potential alliances" (2012, 3). There is absolutely room for cultural considerations in policy, but I analyze how, why, and to what ends culture is encouraged as an appropriate policy response.

In this research I actively participate in a *promiscuous* Indigenous Studies when it comes to methodological and theoretical directives. In their introduction to *Sources and Methods in Indigenous Studies* Chris Andersen and O'Brien appeal for methodological promiscuity, yet note that as Indigenous Studies continues to emerge as a discipline, Indigenous Studies has engaged a variety of disciplines and methodologies, but has done so "in a context with little collective strategy or long-term planning – hence our use of 'promiscuity' in the title (referring to its original Latin use, meaning 'mixed, indiscriminate, in common, without discussion') to modify 'methodology'" (2017, 2). Framing promiscuity as being a process that is indiscriminate, rather than strategic, or mixed, rather than in relation is not a sufficient theorizing of promiscuity and its possibilities. Kim TallBear has theorized relations as a theoretical and methodological imperative, which I think takes us further than promiscuity as theorized by Andersen and O'Brien. TallBear posits that Indigenous Studies "needs to be more self-reflexive and more polyamorous in her intellectual-political interventions" (2016, 81). TallBear tells us that she needs Indigenous Studies "to have the courage to conceive theories and projects from a cross-fertilization of radically different fields" (2016, 82). Similarly, Audra Simpson and Andrea Smith have suggested that "intellectual sovereignty requires not isolationism but intellectual promiscuity" (2014, 9). If we centre relationality in our understandings of promiscuity, we not only expand our networks with purpose, we are also required to reconceive how we are relationally accountable to other disciplines, theories, methodologies, and those who are situated in radically different fields (TallBear 2018; Kolopenuk 2020a).

Relations/research of/with promiscuity/polyamory as a cohering logic is made clear in many iterations of Indigenous STS theorizations. Indigenous STS scholars are invested in being in relation with technoscience, an ethic that has emerged in relation to feminist theorists and their ethic of care for the research 'subject' (Liboiron 2016; TallBear 2017; Hernández 2019; Indigenous STS 2019; Kolopenuk 2020a). In describing her Indigenous STS research, Kolopenuk says that "research-doing entails exactly what it is named. It involves becoming a practitioner in technoscientific fields, not studying them; it involves being formative of them even if only among the most seemingly peripheral sets of relations" (2020a, 8). Similarly, TallBear notes that she researches "in concert with diverse thinkers and communities implicated in knowledge constituted at the intersections of technoscience and Indigenous governance" (2017, 78). In my own research, I am in conversation with the fields of political theory, governmentality, health policy, Indigenous health policy, and food studies – just to name a few. Additionally, I am in conversation with the technoscientific and biomedical fields that establish power/knowledge domains of nutrition and health that are reproduced through academic fields and health programs and technologies that intervene in Indigenous health.[9] Andersen has posited that Indigenous Studies should not be preoccupied with difference to the extent that our methodological orientations differ from other disciplines – data collection, statistical profiles, archival research, science studies – are all projects that can be undertaken by "many existing Indigenous studies departments" (2009, 96). Cross disciplinary methodological relationality allows for the production of varying research outcomes that are directed and informed by Indigenous Studies analytics. For me, a promiscuous/poly relational approach to research production has meant that while I may interrogate and critique biomedical and technoscientific

[9] My ability to actually practice "research-doing" (Kolopenuk 2020a, 8), which involves becoming a practitioner of technoscientific fields in a physical capacity has been somewhat limited by the global pandemic.

interventions in Indigenous health, I do so with the aim of producing formative sets of relations and critiques of care.

The emerging subfield of Indigenous STS has shaped the questions and direction of this research. Jessica Kolopenuk notes that "Indigenous STS asks questions like: how do the logics of nature, exploration, and discovery, and the scientific and political technologies that they bring to bear impact bodies, peoples, relationships, relatives, and spaces" (2020a, 5)? I have oriented my research questions and analysis to identify how technologies (scientific and political) of healthism have borne a burden on Indigenous populations through differential governmentality. I draw on Indigenous STS scholars and scholars taking up relational critiques of technoscience to do this work (TallBear 2013; Walter and Andersen 2013; Andersen 2016; Warbrick et al. 2016; Murphy 2017; Kolopenuk 2020a; Kolopenuk 2020b). It is my hope that this research establishes a very modest (and ongoing) contribution to the field of Indigenous STS through analysis of how biomedical technoscientific power/knowledge bears on Indigenous (and non-Indigenous) lives, often to their detriment. Of course, I do this work with the aim of having scientific and policy fields accountable to Indigenous knowledge production, governance, and engagements with science.

A central vein of my research accounts for how Indigenous populations become populations to be intervened upon by technoscientific and biomedical fields. I have come to theorize how populations are iterated in relation to Indigenous STS scholars' theorizations of how Indigenous bodies, populations, and genomic matter are articulated and iterated as indigenous (TallBear 2017; Kolopenuk 2020a). TallBear has extended Foucault's theorizations of biopower and the "biological 'populations' it seeks to regulate" to delineate how population is a key concept of genomic sample and "the (re)articulation of indigenous peoples" according to

genomic knowledge (2017, 183). Similarly, Kolopenuk argues that colonialism involves the "re/iteration and regulation" of bodies based on "racialized/ing-gender/ing bio-symbols . . . that epistemologically and materially pervert and reorder Indigenous peoples' relations to place and to each other" (2020a, 2). I argue that an apparatus of healthism operates to (re)articulate and re/iterate Indigenous peoples into populations of "deficit indigenes" and bad biocitizens (Walter and Andersen 2013, 21). Moreover, when healthism is employed to make health and nutrition related interventions into populations, there are corporeal effects. Tess Lea has noted that "policy particles form decisions made by other people, for other people, bioaccumulate in the present" (2020, 4). The epistemic (re)articulation and re/iteration of Indigenous populations in the administration of health and nutrition has felt effects.

Methodology

Governmentality, while being an integral analytic concept I engage throughout this research, also constitutes a methodological directive. The corollary analytics of power/knowledge (Foucault 1980), discourse analysis (Foucault 1991; Stevenson 2004), and governmental apparatuses (Foucault 1980) have figured centrally in how I have carried out this research. Stuart Hall's influential essay "The West and the Rest: Discourse and Power" establishes a clear rendering of discourse and its implications. Hall notes that a discourse is "a group of statements which provide a language for talking about – i.e., a way of representing – a particular kind of knowledge about a topic," however, a discourse is not merely a singular statement, but several that work together to form what Michel Foucault referred to as a 'discursive formation' (2018, 155). Moreover, discourse is "a form of social practice which both *constitutes* the social world and is *constituted* by other social practice. As social practice, discourse is in a *dialectical* relationship with other social dimensions. It does not just contribute

to the shape and reshaping of social structures but also reflects them" (Jorgensen and Phillips 2002, 61). The important thing to recognize with discursive formations is that they do not exist outside of power, and indeed Foucault argued that discourse needed to be analyzed "in terms of tactics and strategies of power" (1980, 77). Moreover, discourse "is one of the 'systems' through which power circulates. The knowledge which a discourse produces constitutes a kind of power exercised over those who are 'known.' When that knowledge is exercised in practice, those who are 'known' in a particular way will be subject (i.e., subjected) to it . . . Those who produce the discourse also have the power to *make it true* – i.e., to enforce its validity, its scientific status" (Hall 2018, 159).

Healthism is a discursive formation that is operationalized as a strategy of biopower. In my analysis of healthism as a discursive formation throughout this research, I pay particular attention to identifying how the power/knowledge of healthism is embedded within governmental apparatuses that administer and intervene in the health of Indigenous populations. In the chapters that follow – particularly the empirical chapters – I carry out a discourse analysis of the discursive formation of healthism. Critical discourse analysis is concerned with identifying how power is "discursively enacted, produced, reproduced and resisted" and in the context of policy analysis, enables interrogation of "language with other social processes, and of how language *works* within power relations" (Colombo and Quassoli 2016, 325). Critical discourse analysis can be used to identify "the role of discursive practice in the maintenance of unequal power relations" (Jorgensen and Phillips 2002, 64). As Foucault noted, discourse is a strategy of power – so in my discourse analysis, I have focused on how healthism has operated as a strategy of biopower to administer, differentially govern, and discipline Indigenous populations.

Employing critical discourse analysis as a methodological framework has produced a specific set of questions that I use to guide my analysis of the discursive formation of healthism: How does healthism (as governmentality) *constitute* the social world and be *constituted* by social practice? What are the dialectical relations that co-constitute healthism? What can the discursive formation of healthism reveal about power relations? And finally, given that discursive formations are embedded in power relations, what can discursive analysis tell us about the "structures of power" and "embodiment and materialism" that is central to the social co-constitution of healthism?

In addition to carrying out a discourse analysis of the discursive formation of healthism, my methodological approach to this research has resulted from governmental apparatuses as modes of identifying and tracing power relations. Foucault identified apparatuses as "a thoroughly heterogenous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions – in short, the said as much as the unsaid" (1980, 194). Nikolas Rose and Peter Miller have noted that governmentality, and its apparatuses "pertaining to government and a complex body of knowledges and 'know-how' about government, the means of its exercise and the nature of those over whom it was to be exercised" is integral for understanding the operation of political power (1992, 174). Governmentality scholars have theorized apparatuses as "dispersed forms of government" (Hunt 2012, 62), a "tool to think about power in the perpetually dynamic social field" (Bussolini 2010, 90), and as a methodological intervention by Foucault to identify "historically specific totalities of discourses and practices" (Peltonan 2004, 206). In this research, I use the apparatus as a methodological device to chart the 'heterogenous ensemble' of power relations that constitute practices of government.

Understanding how government operates through apparatuses is a necessary analytic endeavour that prevents renderings of power as situated solely in 'the state.' Tania Li posits that moving away from "the image of government as the preserve of a monolithic state operating as a singular source of power . . . enables us to recognize the range of parties involved in attempts to regulate the conditions under which lives are lived" (2007a, 2). Li contends that it is indeed an empirical question and concern to identify "to what extent various governmental initiatives are concentrated in, or coordinated by, the official state apparatus," which ultimately takes analyses away from renderings that "envisage power as a thing stored in the bureaucratic apparatus and the top echelons of the ruling regime" that operates in a top-down manner from government to the population (2007a, 2). Accounting for an apparatus of governmentality that disperses its operation of power is necessary to understand how power operates within and beyond 'the state,' to delineate what and who comprises the apparatuses, and thus to indicate where and how power is applied through governmental interventions on populations.

Governmentality scholars are notably *unempirical*. This trend of non-empiricism results from reiterations and extensions of Foucault, that merely point to one-off examples that illustrate Foucauldian concepts – without a deep empirical engagement to identify how governmentality operates in contemporary society.[10] Li takes Nikolas Rose to task for his failure to pursue empirical study of governmental rationalities (2007a, 5). Li posits that this demonstrates inconsistency in their work, because their interest in "politics as a hypothetical possibility" is not aligned with an interest in "politics as concrete practice" (2007a, 5). To counter this lack of empiricism, Li argues for a methodological approach to governmentality that directs attention to

[10] Like Li (2007a, 5) I have noted the lack of empiricism in Rose (2004; 2006) and Miller and Rose (1990), as well as a number of other governmentality scholars who do not situate their theorizations of governmentality within an empirical context.

the pursual of "sociologies, histories and ethnographies that examine constellations of power in particular times and place" (2007a, 5-6). In my own research, I carry out a decidedly empirical accounting of governmentality to track how healthism is operationalized through an apparatus that is comprised of 'state' institutions, non-governmental institutions and actors, and self-governing citizens in the context of Winnipeg.

The methodological imperatives accounted for here have resulted in discourse analysis of health, nutrition, and food security policies that figure into an apparatus of healthism as a power/knowledge nexus. I use governmentality as a theoretical analytic throughout this research, but I also engage the analytic of the apparatus as a methodological device to chart how healthism is operationalized. I chart the rationalities (reasoning of how and why power is exercised), programs (imagined projects), and technologies (translative devices between the apparatus and populations) of healthism in federal policy, provincial and municipal policy, and in not-for-profit and research intermediaries and the power relations between all of the nodes (Lemke 2002, 55; Rose 2004, 52; Lippert 2005, 4).[11] I then review all relevant governmental policies related to health, nutrition, and food to understand and track how healthism operates as a discursive formation to govern Indigenous health.[12] Beyond governmental policies, I also identify key intermediary actors in Winnipeg.[13] Charting an apparatus of healthism is an integral exercise for identifying the insidiousness of healthism, and accounting for its operation beyond 'the state.'

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[11] See appendices for charts.

[12] I completed a thorough review of all current policies that are publicly accessible in the aims of completing a comprehensive review.

[13] The intermediary agents of an apparatus are a much larger project to track, especially given my chosen empirical context. I could have tracked any number of community-based organization that intervenes in Indigenous food insecurity; however, I chose to select key intermediaries that have a more influential and established presence in the city as also producing and informing discursive formations of healthism as a response to Indigenous food insecurity. Future research could benefit from further charting of intermediaries.

My methodological approach to this research has taken direction from and been influenced by others analyses of governmentality, biopower, and policy (Li 2007b; Murphy 2017; Lea 2020; Kolopenuk 2020a). Tess Lea's method of *policy ecology* accounts for connections between "inhabited worlds that policy emanates form and enters into . . . and the stretches of time and hauntings that help shape the capacious policy category known as 'Indigenous circumstances'" (2020, 11). Lea accounts for policy and its interventions as unruly and incoherent to attempt to delineate how to work within such bounds. Michelle Murphy's *epistemic infrastructures* were formative for my thinking about how "epistemic infrastructures were assemblages of practices of quantification and intervention conducted by multidisciplinary and multisited experts that became consolidated as extensive arrangements of research and governance within state, transnational, and nonprofit organizations" (2017, 6). Murphy's focus on the infrastructural highlighted "the ways knowledge-making can install material supports into the world – such as buildings, bureaucracies, standards, forms, technologies, funding flows, affective orientations, and power relations" (2017, 6). By tracing epistemic infrastructures, Murphy demonstrates the extent to which life is administered and governed through assemblages of quantification and intervention in the context of biopolitical projects of managing reproduction. In my own research, I identify an apparatus of healthism that operates to quantify Indigenous populations (as a risk) to be intervened upon and seek to trace its reaches, which is what I demonstrate in the chapters to come.

Chapter Overviews

Throughout this research I engage governmentality as an analytic and methodological imperative to understand how healthism determines how Indigenous food insecurity is administered and intervened upon. In chapter two I delineate the interconnected concepts and

processes of biopower, biopolitics, and governmentality to identify how populations come to be administered and regulated within the context of a liberal settler colonial state. I propose three specific elements of how governmentality is operationalization through the individual and the body politic, the expert and the expertise, and the biocitizen; all of which anticipate how healthism is operationalized through the same processes. While these elements identify how governmentality operates, they also indicate necessary areas of analysis to interrogate how governmentality operates differentially with regards to Indigenous and racialized populations and bodies. I provide a very cursory introduction to the governmentality of health to preface to how healthism is a form of governmentality.

In chapter three I introduce the field of healthism to extend my theorizations of the governmentality of health. I chart a genealogy of healthism, identify how it is operationalized through the individual and the body politic, the expert and the expertise, and the biocitizen, demonstrate the prevalence of healthism in how Indigenous food insecurity is conceptualized, and interrogate the limits of healthism literature in relation to race, indigeneity, and colonialism. This chapter largely responds to how Indigenous food security is conceptualized in Canadian food policy and research – namely, that there is a preoccupation with individuals eating *healthy* foods and self-regulating their diets, with little to no attention to barriers or choices that would prevent this. I make the necessary argument here that healthism does not equate to food security, and the two projects need to be decoupled.

I turn to Winnipeg in chapter four to demonstrate how governmentality operates through the individual and the body politic. I theorize how white possessive securitization operates through the individual as a form of governmentality. With succinct vignettes of securitized grocery stores, austerity city budgets, and over policing, I demonstrate how white possessive

securitization operates through vigilantism, securitization of food resources, and multiple modes of policing and surveillance. I argue that the empirical context of Winnipeg, and the everyday materiality of grocery stores, city budgets, and policing, determine how Indigenous people in the city experience food security/insecurity. I highlight the surveillance, policing, and securitization Indigenous people in Winnipeg have to navigate to draw attention to the fact that healthism is incongruous with the everyday realities many people face. The deployment of healthism as a response to food insecurity is a mode of differential governance for Indigenous populations in Winnipeg.

In chapter five I shift my empirical focus to the federal government to identify how governmentality operates through the expert and expertise. I situate this chapter alongside the fields of health policy and Indigenous health policy to demonstrate key rationalities of Canadian health policy. I identify key interventions and approaches to health policy and services, and how such approaches are determined and limited by the political and economic contexts of liberalism. I demonstrate how federal experts quantify Indigenous populations, and how they are often quantified as a risk to the security of the settler colonial state. I chart an apparatus of healthism of federal rationalities, programs, and technologies that contribute to the governmentality (and differential governmentality) of Indigenous health.

In chapter six I return to Winnipeg to demonstrate how healthism is operationalized through a focus on the biocitizen. I demonstrate how the governing rationalities identified in chapter five were distilled down into provincial, municipal, and non-governmental intermediaries that implement food insecurity programming in Winnipeg. I once again chart an apparatus of healthism to account for how healthism operates through provincial, municipal, not-for-profit intermediaries, and research to identify how the programs and technologies produced connect

and refract the federal apparatus. I identify three points of application of healthism interventions that operated to make individuals into better biocitizens. The three points of application include: 1) research that imagines food insecurity; 2) education of biocitizens; and 3) the rezoning of bad biocitizens. I argue that when food insecurity is conflated with bad biocitizenship, programs and technologies that intervene to make better biocitizens result in disciplinary and differential governmentality. In my concluding chapter, I propose a 'post-healthism' that would require a reorientation away from biocitizenship and a turn toward *bad* biocitizenship to disrupt the capitalistic, racialized, and colonial logics that determine what constitutes good or bad health (Kolopenuk 2020b).

Chapter Two – Biopower and Governmentality

[C]onstructing indigenous peoples as essentially fragile or inferior leads to narrow health care policies and bio-medical practices that target the supposedly pathological indigenous body, rather than the pathological colonial conditions which shape the political, socio-economic, ecological, and biological forces through which healthy and unhealthy bodies are produced.
– Jessica Kolopenuk[14]

In this chapter I introduce the concepts of biopower, biopolitics, and governmentality to analyze how governmentality is relevant for understanding Indigenous health and how it is governed through Canadian health policy. Governmentality operates at the confluence of biopower and biopolitics, and for Indigenous people, governmentality does not operate outside of differential governance, or what Kolopenuk refers to in the provocation above as pathological colonial conditions.[15] The pathological colonial conditions that produce and sustain the conceptual and material landscape of health policy for Indigenous people in Canada are at the forefront of my interrogation throughout this research. This chapter is composed of three major sections – first, I delineate governmentality and situate it as an overarching theoretical lens that is employed throughout the dissertation; second, I consider key interventions and modes of operation of governmentality relevant for the analysis I carry out in subsequent chapters; and third, I identify how governmentality operates in relation to *health* and *healthism*.[16] In the chapters that follow I connect healthism, whiteness, nutrition and food security related policies to the overarching colonial governmentality of Indigenous bodies and communities. I argue that governmentality operates through networks of power relations that sustain biomedical

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[14] Cited in: McCallum, Mary Jane Logan and Adele Perry. 2018. *Structures of Indifference: An Indigenous Life and Death in a Canadian City*. Winnipeg: University of Manitoba Press, 98.

[15] Differential governance occurs as a result of asymmetrical relations of biopower that results in the differential governance (both intended or unintended) of sub-populations through technologies of governmentality that result in differential outcomes from the population as a whole.

[16] Healthism is a mode of governing health that situates responsibility for health at the level of the individual by requiring the individual to self-regulate their health.

hegemonic nutrition, narrow interventions into health, and colonialism writ large. Employing governmentality as a theoretical lens provides useful conceptual tools to trace not only the operation of the governance of Winnipeg Indigenous residents through healthism, but governmental and non-governmental nutrition and food insecurity interventions more generally.

Governmentality

In this section I delineate the interconnected concepts and processes of biopower, biopolitics, and governmentality to introduce governmentality as a key theoretical lens for analyzing healthism, food insecurity interventions, and the conditions of existence in Winnipeg, where these processes of governmentality of health are implemented for Indigenous residents. Governmentality is an exercise of power that administers populations through apparatuses comprised of institutions, programs, technologies, and knowledge production, all of which operate to secure the state (Dean and Hindess 1998; Foucault 2009). I begin this section by briefly introducing these concepts as they were originally theorized by Michel Foucault, before connecting them to their socio-historical context of liberalism, welfarism, and neo-liberalism[17] and situating them within the field of governmentality studies that has burgeoned in the decades following Foucault's initial theorizations.

Foucault introduced three integral iterations of power in his *Security, Territory, Population* lectures at the Collège de France – sovereign power, pastoral power, and biopower

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[17] Liberalism can be defined as "a normative political doctrine or theory that treats the maintenance of individual liberty as an end in itself and therefore views liberty as setting limits of principle both to the legitimate objectives of government and to the manner in which those objectives may be pursued" (Hindess 2001, 93). Here I draw on the work of Barry Hindess, which recognizes no singular unity of liberalism but rather "many liberalisms" (Hindess 2004, 36). Moreover, Hindess situates welfare as an ethos of liberalism (2001, 106). For this research, the preoccupation of liberalism with non-interference and freedom corresponds to *how* government is structured and operationalized to seemingly limit governmental interference through the capacity building and regulation of citizens. However, Hindess notes that liberalism does not preclude the use of *illiberal* techniques – namely technologies of governmentality that do intervene in *some* populations e.g. "policing of immigrant communities, the urban poor and indigenous peoples" (2004, 28).

(Foucault 2009). These iterations of power have transitioned from one to the other in some contexts, but they are not necessarily mutually exclusive either – their effects linger. I focus most closely on biopower here, but because of the lingering effects of sovereign power and pastoral power, it is necessary to identify these iterations of power to recognize their influence in biopower. Sovereign power is characterized by the sovereign's right to decide life and death (Foucault 1978, 135). Foucault notes that the sovereign "exercised his right of life only by exercising his right to kill, or by refraining from killing," which meant sovereign power culminated in "the right to *take* life or *let* live" (1978, 136). Sovereign power references a form of power and rule that operated through accumulation, seizure, and power to take and suppress life through war and public capital punishment (Foucault 1978, 136). Foucault identifies pastoral power in distinction from bloody sovereign forms of power found in the West, connecting pastoral power to the Mediterranean East (2009, 123). Pastoral power is a "beneficent power," that has an essential objective of salvation of the flock (Foucault 2009, 126). Foucault contends that "pastoral power is a power of care" that is effectively carried out through a duty to care for individuals of the flock (2009, 127). One of the key distinguishing factors of this iteration of power is that it is "exercised on a multiplicity rather than on a territory," which situates it as a power "with a purpose for those on whom it is exercised, and not a purpose for some kind of superior unit like the city, territory, state, or sovereign" (Foucault 2009, 129). Pastoral power is a precursor to modern forms of power – yet it remains important to identify how it operated to secure the population through *care*.

Biopower, while concerned with life, is not as beneficent as pastoral power and at its most basic, it may be understood as the power to administer life. Biopower operates around two poles of power – regulatory power and disciplinary power. Of course, as we will see throughout

this research regulatory power can produce disciplinary outcomes when it is employed differentially. Administration of life is inextricably connected to territory through the rendering of populations to be administered through biopower. Foucault (2003) theorized the transition of sovereign power to biopower by noting that ancient sovereign power was replaced by "a power to *foster* life or *disallow* it to the point of death" (Foucault 2009, 138). Biopower is a "technology of power over 'the' population as such, over men [sic] insofar as they are living beings. It is continuous, scientific, and it is the power to make live" (Foucault 2003, 247). Biopower relies on regulatory and security mechanisms to "optimize a state of life" (Foucault 2003, 246). Foucault argues that biopower is thus "a matter of taking control of life and the biological processes of man-as-species and of ensuring that they are not disciplined, but regularized" (2003, 246-247). Biopower is engrossed with shaping the conditions of life – which results in optimal conditions for some, and not so optimal conditions for others, but both of which are largely by design.

If we understand biopower as the power to administer and regulate life, then we can understand biopolitics in terms of the techniques and technologies of biopower. Foucault (1997) describes biopolitics as the endeavour "to rationalize the problems presented to governmental practice by the phenomena characteristic of a group of living human beings constituted as a population: health, sanitation, birthrate, longevity, [and] race" (73). Further, biopolitics deals with the population "as a problem that is at once scientific and political, as a biological problem and as power's problem" (Foucault 2003, 245). Foucault notes that biopolitics introduces mechanisms such as "forecasts, statistical estimates, and overall measures . . . to intervene at the level at which these general phenomena are determined, to intervene at the level of their generality" (2003, 246). It is such characteristics and generality that is always reflected in policy.

Moreover, "biopolitics will derive its knowledge from, and define its power's field of intervention in terms of, the birth rate, the mortality rate, various biological disabilities, and the effects of the environment" (Foucault 2003, 245). Biopolitics thus consists of the techniques and technologies to optimize and regulate the life biopower has a vested interest in.

Biopolitics do not simply intervene in and regulate a 'conglomerate life.' Foucault argues that the target of "this new technology of power is not exactly society . . . nor is it the individual-as-body" (2003, 245). Rather, "it is a new body, a multiple body, a body with so many heads that, while they might not be infinite in number, cannot necessarily be counted. Biopolitics deals with the population, with the population as political problem, as a problem that is at once scientific and political, as a biological problem and as power's problem" (2003, 245). Biopower and racism render not only a population as a political problem, but population(s) that are scientific and political in vastly different ways. Given the biopolitical preoccupation with population(s), it is of the utmost importance to interrogate how such preoccupations unfold in a settler colonial context. Interrogating biopolitics in settler colonial contexts is generative for elucidating how biopower works to establish a scientific/political/biological problem of racialized and Indigenous populations.

To recap – biopower is the power over the life of a population and the power to regulate it, while biopolitics includes the techniques and technologies of biopower that aim to administer life of the population, and governmentality is the confluence of the two as the rationalities, technologies, and programs of governmental regimes of biopower. Governmentality is a project of biopower. Foucault defines governmentality as: "the ensemble formed by institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has the population as its target, political economy as its

major form of knowledge, and apparatuses of security as its essential technical instrument" (2009, 108). Power in the form of government has "led to the development of a series of specific governmental apparatuses," as well as "the development of a series of knowledges" (Foucault 2009, 108). The rationalities, technologies, and programs embedded in the reaches of governmentality are biopolitical and exist because of biopower. Foucault further argues that "the survival and limits of the state should be understood on the basis of the general tactics of governmentality" (2009, 109). The survival of government requires the operationalization of the ensemble of apparatuses of governmentality – and its limits are made clear through the threshold of which bodies are incorporated into the population, and which are meted into a sub-population through racial logics. Healthism *is* a form of governmentality and it operates to maintain security of the government rather than provide care for the population. Although the population is the target, as healthism is individualized and distilled at the level of the body, individual investment in the security of government is expected through the practices of health, rather than government investment in the health of the population.[18] In later chapters I delineate the governmental apparatuses of healthism that differentially govern Indigenous health in Canada, and in Winnipeg more specifically.

In the decades following Foucault's initial theorizations of governmentality, the field of governmentality studies has flourished to develop an analytic of the rationalities, technologies, and regimes of government (Gordon 1991; Rose and Miller 1992; Lemke 2002; Dean 2015). Scholars have extended Foucault's theorizations to specifically account for how such rationalities and technologies of government are situated in changing economic and political

[18] Healthism is an essential form of governmentality is realized as the "conduct of conduct," in which the individual, and thus the population, becomes a central mechanism of government by governing the self. See: Gordon (1991) and Foucault, Michel, Daniel Defert, François Ewald, and Jacques Lagrange. 1994. *Dits Et Écrits, 1954-1988.* Paris: Gallimard.

contexts of liberalism, welfarism, and neo-liberalism (Rose and Miller 1992; Lemke 2002; Dean 2015). However, Mitchell Dean has urged governmentality scholars drawing on Foucault to read him with an understanding of his relationship to neoliberalism and "the intellectual and political field in which he operated," while simultaneously learning from him and going beyond him to extend the conceptual tools he left into our contemporary contexts (2015, 389).

Foucault theorized governmentality – "the conduct of conduct"[19] – as an inherently *liberal* form of governance that governed through rationalities and technologies that promoted the governing of the self. Colin Gordon explained that Foucault and his co-researchers of the time conveyed how "liberalism has functioned historically not so much as a web of inveterate contradiction (reverie of a minimal state, as background music to a real state that ceaselessly grows), but as a prodigiously fertile problematic, a continuing vector of political invention" (1991, 18). Similarly, Thomas Lemke has contended that neoliberal governmentality is "not a diminishment or reduction of state sovereignty and planning capacities but a displacement from formal to informal techniques of government and the appearance of new actors on the scene of government (e.g., nongovernmental organizations) that indicate fundamental transformations in statehood and a new relation between state and civil society actors" (2002, 58). These extensions of governmentality that have considered its operation in changing economic and political contexts are effective for grasping how governmentality undergoes reconfigurations of its rationalities, technologies, and programs according to overarching political and economic rationalities such as welfarism and neoliberalism. In Winnipeg, we see that liberal rationalities of governing the self are evident in programs such as the Health Equity and Prevention Unit of the Manitoba Department of Health, Seniors and Active Living. The unit supports Manitobans "to

[19] See: Gordon (1991) and Foucault, Michel, Daniel Defert, François Ewald, and Jacques Lagrange. 1994. *Dits Et Écrits, 1954-1988.* Paris: Gallimard.

make healthier choices," and thus prioritizes individual self-regulation of health over the provision of health care services and supports.[20]

Given that governmentality operates as a vector of political invention reconfigured to the political and economic aims of the modern nation-state at any given time, governmentality studies have sought to situate governmentality as an integral component of how states govern and wield biopower. Nikolas Rose and Peter Miller sought to re-locate "the state" in governmentality by focusing on its "governmentalization" (1992, 174-175). Rose and Miller note that Foucault cautioned against giving too much attention or gravitas to the state as a dominating force, but they argue that understanding the *governmentalization* of the state is necessary for understanding power in modern societies (Rose and Miller 1992, 174). They argue that it is no longer about determining the power *of* the state but "how, and to what extent, the state is articulated into the activity of government: what relations are established between political and other authorities; what funds, forces, persons, knowledge or legitimacy are utilised; and by means of what devices and techniques are these different tactics made operable" (1992, 177). Identifying the extent of the modern state's governmentalization is necessary for simultaneously identifying where and how (e.g., unequally) biopower operates in contemporary settler states.

Locating governmentality as integral to the governmentalization of the state requires attending to its diverse technologies. Dean argues that "it is up to us to reclaim the political from its economic neutralization by neoliberalism and to reconnect what Foucault called the 'technologies of governmentality' and 'pragmatics of the self,' to an analysis of state and sovereignty, of changing forms of capital, and their consequent modes of domination and hegemony" (2015, 403). Interrogating contemporary operations of governmentality and its

[20] Health, Seniors and Active Living. "Health Equity and Prevention." *Government of Manitoba*. Accessed November 9, 2020. https://www.gov.mb.ca/health/hep/index.html.

technologies is a particularly generative task for identifying how power operates through the state, the population, and individuals.

An analytic of governmentality is a critical tool for tracing how biopower operates through regulatory and disciplinary power – and for identifying how previous forms of power continue to linger in biopower, sovereign power in particular (Scott 1995; Lemke 2002; Dean 2015). Lemke argues that with governmentality Foucault introduced a way to differentiate between power and domination (2002, 53), explaining that power does not always result in "a removal of liberty or options available to individuals" and instead, power could result in "an 'empowerment' or 'responsibilization' of subjects" (2002, 53). Moreover, Lemke ultimately argues that government "refers to more or less systematized, regulated and reflected modes of power (a 'technology') that go beyond the spontaneous exercise of power over others, following a specific form of reasoning (a 'rationality') [that] defines the telos of action or the adequate means to achieve it" (2002, 53). Given this, "disciplinary or sovereign power are reinterpreted not as opposite forms of power but as different technologies of government" (Lemke 2002, 53). In a settler colonial context, tracing how power operates differentially through the state, the population, and the individual through regulatory and disciplinary power in the aim of security becomes crucial. Attuning to how settler colonialism operates through shapeshifting strategies, alteration of tactics, and the reiteration of peoples, places, and modes of governing to further the ends of settler security is a necessary endeavour to trace the ongoing exercise of power as productive, and not merely eliminatory.[21]

[21] I see governmentality as a key analytic for better identifying how settler colonialism continues to operate through what Patrick Wolfe called a "repertoire of strategies" (2006, 404), which often works in tandem with what Jessica Kolopenuk has theorized as the "re/iteration and regulation" (2020, 2) of Indigenous bodies. Additionally, Wolfe's (2006) theorization of settler colonialism operating according to a "logic of elimination" (387) remains relevant in many contexts. However, I argue that further attention to the *productive* aspects of biopower and governmentality are necessary for understanding strategies of settler colonialism that have a veneer of benevolence but ultimately operate towards the ends of settler colonizers.

Existing literature in governmentality studies is limited when it comes to addressing the areas of Indigeneity and settler colonialism. The extent to which governmentality studies have engaged with governmentality of Indigenous people in settler colonial states is limited to descriptions of colonial governmentality (Rose and Miller 1992; Scott 1995; Rose 2004) and the brief accounting for differing modes of governmentality that rely on coercion and paternalism for poor, racialized, or Indigenous people (Hindess 2001, 94; Andersen 2014, 30; Dean 2015, 402). To bridge these limitations, I turn to Indigenous Studies scholars who have further theorized the relationship between biopower, race, and colonialism. Governmentality *should* be able to conceptualize robust renderings of differential biopower in settler colonial states. In this research I aim to extend governmentality to specifically account for how governmentality of Indigenous health operates within the empirical context of settler colonial institutions (both state and non-state).

Indigenous Studies scholars have further theorized the relationship between biopower and race to account specifically for the colonial context (Moreton-Robinson 2006; Hokowhitu 2014; Moreton-Robinson 2015; Kolopenuk 2020a). Aileen Moreton-Robinson notes that while Foucault "acknowledges a relationship between biopower and colonization," he fails to extend his analysis "to the colonial context" (2015, 129). Moreton-Robinson notes further that "the use of Foucault's idea of biopower to explicitly address the context of a 'postcolonizing' nation will produce a new understanding of how whiteness operates through the racialized application of disciplinary knowledges and regulatory mechanisms" (2015, 129). Moreover, Moreton-Robinson notes that Foucault "does not account for the Whiteness of sovereignty, without which biopower could not function" (2006, 390). I want to draw attention to two integral aspects of Moreton-Robinson's argument – racialized disciplinary knowledges and regulatory mechanisms, and

whiteness. In the colonial context, governmentality of health relies on racialized knowledges and mechanisms – which are always in operation to *maintain* whiteness.

Brendan Hokowhitu has extended Foucault's theorizations of biopower to the realm of healthism and the immediacy of Indigenous bodies. Hokowhitu argues that "underpinning racism and colonialism is biopower; in this context, the power to colonise justified upon the uncleanliness of the savage body" (2014, 33). Here Hokowhitu's argument resonates with Foucault's elucidation of biopower and racism as working to eliminate what has been deemed abnormal. In the colonial context, the Indigenous body is always rendered abnormal against the norm of the white body. Hokowhitu argues that biopower "is useful for interpreting healthism because it understands the body as a material site where discursive formations are fleshed out; where discourse, as a 'border concept', operates between ethereal knowledge and material conditions" (34). Racism – the marginalization and oppression of people who have been racialized through interpersonal and institutional relations – is an integral factor in determining how the Indigenous body is rendered healthy or unhealthy through rationalities of biopower and technologies of governmentality. It is thus necessary to attend to the colonial context of biopower, in which biopower and racism already operate in unison, to grasp how the prerogative of biopower to "make live" comes with a long list of exceptions for anyone in a non-white body. In the colonial context, biopower *is* racist.

If we consider the way biopower plays out in health policy in Canada, we can see beyond the immediate generalities and characteristics of population that have been siloed for the sake of population management. Foucault urges us to "understand power by looking at its extremities, at its outer limits at the point where it becomes capillary," and to study power at the point and "the places where it implants itself and produces its real effects" (2003, 27-28). In studying such

power, Foucault argues that we must "begin with its infinitesimal mechanisms, which have their own history, their own trajectory, their own techniques and tactics" (30), and in addition, we should orient our analysis of power "toward material operations, forms of subjugation, and the connections among and the uses made of the local systems of subjugation on the one hand, and apparatuses of knowledge on the other" (2003, 34). Governmentality scholars have expanded upon Foucault's prompt to orient analyses of power toward techniques and material operations to further theorize the differential use of technologies in liberal governmentality (Dean 2015, 402), the role of government and the self (Hindess 2001, 97), and the extent of power as a technology of government (Lemke 2002, 53). Governmentality is ultimately a tool for identifying the multitude of forms and functions through which biopower operates to govern Indigenous health.

Biopower is not as explicit in taking life as sovereign power, but it can and does function to "let die" through what I will term here manufactured neglect, and in the colonial context, we can additionally see the lingering effects of sovereign power through the manufactured neglect of biopower. The extremes of biopower have been theorized as *necropolitics* – biopower's process of "letting die" (Mbembe 2019). Foucault theorized that "the ancient right to *take* life or *let* live was replaced by a power to *foster* life or *disallow* it to the point of death" (1984, 261). Necropolitics exists when biopower operates to let die, or disallow life, for particular populations. Necropolitics does not preclude the operation of biopower – the two can exist alongside each other, particularly when biopolitical interventions are being made to foster life for some of the population, but not all.

The neglect and subsequent death of Indigenous people has been theorized with a framework of necropolitics (Morgensen 2010; Hokowhitu 2014, 36; Belcourt 2018). However, when it comes to health and nutrition, I am much more interested in the biopolitics at play. If

Indigenous peoples are being conceptualized as (more) susceptible to death, diabetes, and other 'diet-related diseases,' but there are biopolitical interventions being made into the health of those populations, it is not enough to merely theorize how those populations die, but there is a need to understand how they are being intervened upon by experts wielding technologies of governmentality. By looking at how life is managed (however poorly) we can see the colonial operation of biopower – where it is productive and where is flounders between death and life. Biopolitics will highlight how it wants to produce healthy biocitizens, and where it has little vested interest in providing the necessary resources to make that fully happen – and thus demonstrating how health is governed in differential and insufficient ways for Indigenous people.

Attending to the colonial imperatives of governmentality is necessary to understand how the pathologizing of Indigenous bodies becomes an *economic endeavour* to maintain the sovereignty of the settler colonial state and their governments through the production of an industry of expertise and intervention. Moreton-Robinson argues that the differential governance of Indigenous peoples is always in the best interest of the white sovereign, and that "the Indigenous industry is an income-generating service for predominately white professionals, tradespeople, and public servants" (2015, 151). Similarly, Tess Lea refers to the flow of funding supporting the Indigenous industry as "legitimated interventionary overload" (2020, 13).[22] An example that illustrates this is current diabetes policy that is less about addressing health inequities or 'closing the gap,' and more about asking individuals to be good biocitizens to help

[22] Lea (2020) notes that the Northern Territory National Emergency Response of 2007 that was largely meant to intervene in alleged child sexual abuse in Aboriginal communities and resulted in increased funds to support existing and new interventions in the form of "more police, more truancy officers, more teachers, more departmental data collectors . . . [and] more training for imagined jobs, more enforced school attendance, more housing, and more jailings" (13).

reduce economic expenditures on health – and thus secure the state's economic health.[23] Such initiatives require experts in the form of statisticians, data coders, and policy analysts – a lucrative economic industry, while community based front line organizations that deal with the ins and outs of community health suffer from underfunding, high turnover, and even abandonment (RCAP 1993, 16-17; Andersen and Strachan 2011, 127; Richmond and Cook 2016, 7; Lea 2020, 38). However, community based organizations are not exempt from investments in liberal governmentality, whether it is because of choice or need, just as not all community based organizations are exempt from reproducing an Indigenous industry that serves as an income generating service for expert interventionists.

Experts of intervention are sustained professionally by a pathologized Indigenous body in constant need of repair – and this is particularly true of the health policy field. Moreover, Moreton-Robinson contends that 'knowledge' of pathology "circulates as strategic truth . . . to rationalize the continuing subjugation of the Indigenous population and encourage non-Indigenous investment in patriarchal white sovereignty" (2015, 168). Ultimately, the patriarchal white sovereign deploys a "discourse of Indigenous pathology as a weapon to circulate a strategic truth: if Indigenous people behaved properly as *good citizens*, then their poverty would disappear" (2015, 172). The rationalities, programs, and technologies of governmentality are meant to establish self-regulating biocitizens – but when subjects do not conform to these standards for whatever reasons, such interventions are no longer solely regulatory but disciplinary as well. I return to the concept of good citizenship throughout much of this research – but here I want to focus on the use of citizenship standards as a disciplinary tool to encourage

[23] Winnipeg Food Atlas. "Winnipeg Food Atlas." *Manitoba Collaborative Data Portal*. Accessed May 2, 2020. http://www.mbcdp.ca/fns.html. See: diabetes dashboard.

subjects to adhere to normalized behaviours, and to justify limits of investment when citizens have failed to be good enough.

This research analyzes the operation and reproduction of governmentalities' and healthism's larger structures of rationalities, technologies, and programs at the levels of federal, provincial, and municipal government to regulate specific populations (Lippert 2005, 4). In the coming chapters I chart out an apparatus of healthism to identify its governing rationalities, and the programs and technologies it produces, as well as its points of application in Winnipeg, and how it serves to differentially govern Indigenous health and food insecurity. If we use Canada's Food Guide as an example, we can see how it is informed by and reproduces scientific and governmental rationalities as a program that administers and regulates the nutrition of the population.[24] This predominantly occurs through scientific data on the relationship between nutrients or foods and health, and the priorities of a liberal government.[25] Moreover, it results in specific technologies within its material programming that reinforce its guiding rationalities.[26]

[24] The production of Canada's Food Guide is informed by scientific and governmental rationalities, specifically in relation to the evidence used to establish appropriate nutritional guidelines. Canada's Food Guide utilizes an evidence review for dietary guidance that gathers, assesses, and analyzes scientific data relevant to nutrition guidelines. The evidence review process accounts for three factors: 1) scientific basis, which accounts for nutrient standards and the relationship between food and health; 2) a Canadian context, which accounts for characteristics of the population that determine eating behaviours and food environments; and 3) existing guidance, which assesses uptake of existing guidelines (Health Canada 2016, 2). As new scientific studies emerge, the evidence review process determines whether the evidence is relevant for Canadian nutritional guidelines and reassess previous data that may no longer be relevant e.g., the relationship between dietary fibre and decreased risk of colorectal cancer is "no longer convincing evidence" (Health Canada 2018, 3).

[25] The evidence and scientific data that informs Canada's Food Guide is not wholly objective and disconnected from governing rationalities. Canada's Food Guide has operated according to industry objectives (dominant Canadian industries such as dairy and agriculture) for decades. Unfortunately, scientific evidence is often presented as objective and non-political, but science, the production of food, and the rationalities of government are far from non-political. For further discussion of Canada's Food Guide and industry influence see: Grant and Jenkins 2018; Crowe 2019; and Vandenbrink, Pauzé, and Kent 2020.

[26] The latest version of Canada's Food Guide directs consumers to be aware of how marketing can influence food choices, which marks the resistance to industry influence in the latest guide. However, the marketing mediums identified, and the prompts provided to encourage consumers to reflect on food marketing do not significantly change how science or governmental rationalities influence consumer food choice. Food marketing undergoes constant revision to reflect the changing scientific and governmental rationalities of nutrition (e.g., fast food companies alter marketing to reflect sustainability, whole foods, or being preservative free). See: Health Canada.

The rationalities of nutrition science and medicine that inform Canada's Food Guide operate as a "power-knowledge" nexus that has both disciplinary and regulatory effects (Foucault 2003, 252). Food is often intertwined with medicine due to its centrality in nutrition and medicalized dietary needs, thus is often reflected in policy with disciplinary and regulatory effects. How such programs are deployed with the aim of governing the health of a population is the crux of biopower, which is "continuous, scientific, and it is the power to make live" (2003, 247). However, Foucault notes that when racism intervenes, biopower's objective to make live can also let die when it functions differently on racialized populations (2003, 254). At the very least, the differential governmentality that ensues under racism does not 'make live' in the same capacity as it does for the white settler population. In the following section, I detail how governmentality is operationalized – its targets, its rationalities, and its points of application.

Operationalizing Governmentality

In this section I identify three specific elements of the ways in which governmentality operates that shape my theoretical analysis throughout this research and that inform the empirical evidence I draw on in later chapters. The three elements I delineate are: the individual and the body politic, the expert and expertise, and the biocitizen. These elements each illuminate that when it comes to biopower, "individuals are not merely subjects of power but play a part in its operations" (Rose and Miller 1992, 174). Focussing on these three elements likewise provides an opportunity to empirically situate and chart the material realities of how governmentality has theorized power as technologies of government (Lemke 2002), to understand how liberal governmentality has gravitated towards regulatory technologies of the self (Hindess 2001; Dean

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"Marketing Can Influence Your Food Choices." *Government of Canada.* Accessed February 14, 2021. https://food-guide.canada.ca/en/healthy-eating-recommendations/marketing-can-influence-your-food-choices/.

2015), and to interrogate how governmentality operates in terms of health outcomes for Indigenous people living in a settler colonial state.

I thus unpack how each of these elements is integral to the operation of governmentality, while simultaneously representing areas of intervention for scholars interrogating how governmentality operates to regulate and discipline the population. These elements anticipate and align with my analysis of healthism in the next chapter. As a form of governmentality, healthism operates through many of the same mechanisms identified in the governmentality literature, but specifically targets individual health. Each of the three elements below are an integral element of my theoretical analysis throughout this research, but they also specifically anticipate the following chapters: *the individual and the body politic* informs chapter four and how the conditions of existence in Winnipeg are antithetical to Indigenous people being able to meet the expectations of healthism; *the expert and expertise* informs chapter five and how Indigenous people are governed as a population in Canadian health policy; and *the biocitizen* informs chapter six, where we return to Winnipeg to delineate how food security programming for Indigenous people is tied to unnecessary expectations of biocitizenship.

An analytic of governmentality provides direction to begin to identify the material outputs of biopower. Nikolas Rose contends that "to analyse political power through the analytics of governmentality is not to start from the apparently obvious historical or sociological question: what happened and why? It is to start by asking what authorities of various sorts wanted to happen, in relation to problems defined how, in pursuit of what objectives, through what strategies and techniques" (2004, 20). Randy Lippert asserts similarly that analytics of governmentality continue to "deploy three major concepts – programs, rationalities, and technologies of government" (2005, 4). Governmentality thus provides a conceptual base for

moving away from understanding power solely through 'the state' and instead looking to identify how power operates through "dispersed forms of government" and "dispersed forms of technical expertise" in non-state actors, individuals, and the population (Hunt 2012, 74). In the context of this research, governmentality as a theoretical analytic is a useful tool for thinking through health policy – and more specifically healthism – for Indigenous populations to identify how Indigenous bodies are regulated and disciplined, according to particular rationalities, objectives, problems, and through the operation of specific technologies and programs.

Analysis of how, where, and why governmentality operates lends itself to much more complex renderings of power beyond a monolithic state regulating a monolithic social body. Examining the reaches of governmentality allows us to "examine constellations of power" (Li 2007a, 5). Tania Li specifically theorizes *interventions* of governmentality noting that they "may operate on population in the aggregate, or on subgroups divided by gender, location, age, income, or race, each with characteristic deficiencies that serve as points of entry for corrective interventions" (2007a, 1). In Canadian health policy we often see populations rendered and demarcated according to specific sets of disaggregated and reaggregated data as a technology to cohere social portraits for the purpose of administrating life – these populations include: Indigenous people, Indigenous children, low-income Indigenous people –each population is saddled with specific or overlapping deficiencies (general poor health outcomes, obesity, diabetes, and others). Indigenous health policy scholars have argued for better statistical engagements to better serve Indigenous populations (Lavoie 2013; Andersen 2016; Smylie et al. 2018). Interventions of governmentality thus "engage with a particular ensemble of population, a definite set of relations that is to be directed and improved," and such interventions are often at odds with how Indigenous peoples and communities envision health care (Li 2007a, 7).

Further to this, Li argues that "understanding governmental interventions as assemblages" moves us away from 'the state' as a singular power and to instead "recognize the range of parties involved in attempts to regulate the conditions under which lives are lived" (2007a, 2). Scholars have addressed at length how governmentality operates through ongoing interventions, and that government itself is "a *problematizing* activity" that operates on a continuum of expert intervention (Rose and Miller 1992, 181; Lemke 2002, 59; Coyte and Holmes 2006, 156; Lea 2020). Understanding that governmentality intervention extends beyond 'the state,' Li contends that "to what extent various governmental initiatives are concentrated in, or coordinated by, the official state apparatus, is an empirical question" (2). Li argues that "rather than envisage power as a thing stored in the bureaucratic apparatus and the top echelons of the ruling regime from which it spreads outwards across the nation, and downwards into the lives of the populace," an analytic of governmentality is instead concerned with who/where authority and power lies, and how differing areas of life become governable (2007a, 2-3). An analytic of governmentality is useful for determining how government does not merely govern from the top-down – indeed, it relies on interventions that cohere technologies of the self to have citizens become part of the process of governing through responsibilization (Lemke 2002, 59). The ensemble of apparatuses that governmentality operates through is bureaucratic, non-governmental, and personal.

Governmentality is thus not a singular 'state' power, nor merely state apparatuses – it relies on and is sustained by the population. Li explains that "at the level of population, it is not possible to coerce every individual and regulate their actions in minute detail. Rather, government operates by educating desires and configuring habits, aspirations and beliefs" (2007a, 1). Governmentality shapes subjects to have a vested interest in conforming to the

regulatory standards they are meant to meet (Lemke 2002, 59). Rose and Miller argue that "self regulatory techniques can be installed in citizens that will align their personal choices with the ends of government" (Rose and Miller 1992, 188-189). Analysis of how individuals become agents of governmentality requires identifying the points of application of governmentality. Li notes that "an explicit, calculated program of intervention is not invented *ab initio*. It is traversed by the will to govern, but it is not the product of a singular intention or will. It draws upon, and is situated within a heterogeneous assemblage or *dispositif*" (2007a, 2).[27] Given that individual subjects are essentially meant to become self-perpetuating agents of governmentality, it is essential to consider what components of the assemblage or *dispositif* that they reinforce and maintain through their own subjectivity.

The Individual and the Body Politic

Governmentality/biopower operates through rationalities, technologies, and programs that are specifically seated in state governance apparatuses – but governmentality also requires the individualization of subjects within a population to enact governmentality. Programs of governmentality "induce a whole series of effects . . . they crystallize into institutions, they inform individual behaviour, they act as grids for the perception and evaluation of things" (Foucault 1991, 81). Peter Miller and Nikolas Rose contend that governmentality "draws attention to the diversity of forces and groups that have, in heterogeneous ways, sought to regulate the lives of individuals and the conditions within particular national territories in pursuit of various goals" (1990, 3). With such an analytic "the state becomes a particular form that government has taken, and one that does not exhaust the field of calculations and interventions

[27] Foucault defines *dispositif* as "a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions — in short, the said as much as the unsaid" (Foucault 1980, 194). The *dispositif* is an *analytic of power*.

that constitute it" (Miller and Rose 1990, 3). Miller and Rose go on to argue that "governing involves not just the ordering of activities and processes. Governing operates through subjects. . . Government to that extent is a 'personal' matter, and many programmes have sought the key to their effectives in enrolling individuals as allies in the pursuit of political, economic and social objectives" (1990, 18). The individual subject is meant to govern themselves, while also playing a vital role in governing their peers.

Governmentality scholars have theorized the self-governing individual as operating through both regulatory and disciplinary power (Miller and Rose 1990; Rose and Miller 1992; Lemke 2002; Rose 2004; Li 2007a). The individualization of governmentality relies on "the particular persuasive role of expertise," which I delve into further in the following section but here it suffices to say that there exists an entire assemblage of experts and programs that are meant to design self-regulating and disciplined individual subjects (Miller and Rose 1990, 26). Miller and Rose contend that individuals can be "mobilized in alliance with political objectives" through programs of governmentality that "utilize and rely upon a complex net of technologies . . . for educating citizens in techniques for governing themselves" (1990, 28). Modern political power "has come to depend upon a web of technologies for fabricating and maintaining self-government" (Miller and Rose 1990, 28). Government is invested in the production of self-regulating subjects to carry out the objectives of liberal governments.

It is thus necessary to attend to this mode of political power to both understand its technologies and reaches, but also to understand how its uneven relations of power and discipline vary depending on its target. In a similar vein, Li argues that at the level of the population, mass coercion and regulation is not possible. However, through the operation of governmentality, individuals can be shaped through "educating desires and configuring habits, aspirations and

beliefs" through conditions that are engineered to ensure individuals take it upon themselves to act in their interest, and the states' (Li 2007a, 1). The individualization of the body(politic) through governmentality is by design – and those who fail to be appropriately educated will be penalized, surveilled, and disciplined.

When it comes to individualization and the body politic within governmentality, two integral processes are at play. First, that through the many programs and technologies of governmentality, self-governing subjects are produced; second, individualizing subjects within a population works to differentially govern a population and ultimately operates as a form of social control. In the next chapter I attend to this second process more thoroughly through healthism literature on the *individualization of health*. Both of these processes are inherently at once regulatory and disciplinary. Rose argues that disciplinary techniques for health, hygiene, and civility are no longer required because "the project of responsible citizenship has been fused with individuals' projects for themselves" (2004, 88) and contends further that "individuals act upon themselves and their families in terms of the languages, values and techniques" made available through apparatuses of expertise, and as such, "it has become possible to govern without governing *society* – to govern through the 'responsibilized' and 'educated' anxieties and aspirations of individuals and their families" (2004, 88). So, while the apparatuses of expertise set the guidelines of regulation, Rose disconnects this governmentality from an explicit form of disciplinary power. When applied differentially, regulatory power and interventions implementing technologies of the self do result in felt disciplinary effects.

The individualization of health through governmentality often results in *differential* governance that transforms regulatory power into disciplinary power. Elyse Amend has argued that biopolitical administration "over the population as a whole" is done through "regulatory

mechanisms that promote healthy, fortified, and able-bodied populations in the service of state power" such as Canada's Food Guide (2018, 720). In this context, Amend argues that nutrition and health expertise are a technology of power that work "to discipline bodies and create subjects viewed as at risk, and who need to monitor and work on themselves in order to become healthy, responsible eaters" (2018, 730). Both Rose and Amend have missed the nuance of disciplinary power in the context of the responsibilized individual who self-regulates. When regulatory power is employed differentially, it can result in disciplinary outcomes. Canada's Food Guide is a technology that employs regulatory power to responsibilize individuals to self-regulate their nutrition – however, when individuals do not have the resources to meet these nutrition guidelines, the food guide produces disciplinarily and differential effects – particularly through "biopedagogical missions" that assume increased education will lead individuals to attain better health, without any consideration of "historical, social, environmental, cultural, political, and economic issues" (Rail and Jette 2015, 331). Technologies of governmentality may intervene at the level of the – whole population – but this results in differential outcomes, or what Peter C. Coyte and Dave Holmes have identified as 'exclusionary' health policies that are meant to offer "universal benefit, despite yielding adverse effects for significant groups of people in society" (2006, 154). In the next chapter, I draw on healthism literature that has specifically situated the individualization of health as a mode of differential governance with a multitude of disciplinary outcomes when individuals fail to regulate their health, and when populations lack the resources to self-govern.

The Expert and Expertise

The role of the expert (and their expertise) is integral to the operation of governmentality. The expert plays a key role in educating subjects to be self-governing subjects, while

simultaneously comprising the structural apparatuses of governmentality. Miller and Rose argue that "the self-regulating capacities of subjects, shaped and normalized in large part through the powers of expertise, have become key resources for modern forms of government" (1990, 2). Moreover, Miller and Rose contend that "the existence of experts has made it possible for self-regulation to operate in a way that minimizes the need for direct political intervention" (1990, 15). Of course, non-intervention in matters of health could shift power relations from biopower to necropolitics. Self-regulating citizens and non-intervention are both technologies of governmentality that are designed to secure the health of the state, not necessarily its populations. Li notes that experts intervene in relations to adjust them: "they aim to foster beneficial processes and mitigate destructive ones. They may operate on population in the aggregate, or on subgroups divided by gender, location, age, income, or race, each with characteristic deficiencies that serve as points of entry for corrective interventions" (Li 2007a, 1). Experts intervene in perceived deficiencies of populations (Coyte and Holmes 2006, 156; Li 2007a, 1; Rail and Jette 2015, 330-331). Such interventions rarely come with material resources for individuals to implement the changes desired by experts. Geneviève Rail and Shannon Jette argue that such interventions, which they call rescue missions, result in the insistence "that bio-Others "do it" by themselves and for themselves" (2015, 331).[28] However, in the settler colonial context it is necessary to understand that interventions on the population in the aggregate will invariably result in *differential governance*. Interventions based on perceived Indigenous deficiencies are still often rooted in racist biopower, contributing to the ongoing pathological conditions of governmentality (Lea 2020, 12).

[28] Rail and Jette (2015) define bio-Others as biocitizens who are "dangerously undisciplined and in great need of policing" (330).

Identifying where experts are seated within networks of biopower is useful for indicating the extent of apparatuses of governmentality, and how pervasive their projects of intervention are. Li argues that "understanding governmental interventions as assemblages helps to break down the image of government as the preserve of a monolithic state operating as a singular source of power and enables us to recognize the range of parties involved in attempts to regulate the conditions under which lives are lived" (2007a, 2). In the governmentality of health, health promotion, expertise, and interventions are not solely contained to the field of medical science – instead, there are a multitude of social interveners as well, including politicians, teachers, and social service providers (Miller and Rose 1990, 21; Murphy 2017, 6; Lea 2020, 13).

Michelle Murphy theorizes what she refers to as *epistemic infrastructures*, a concept that resonates here. Murphy explains that "epistemic infrastructures were assemblages of practices of quantification and intervention conducted by multidisciplinary and multisited experts that became consolidated as extensive arrangements of research and governance within state, transnational, and nonprofit organizations" (2017, 6). Murphy further notes that she calls them "*infrastructural* to underline the ways knowledge-making can install material supports into the world — such as buildings, bureaucracies, standards, forms, technologies, funding flows, affective orientations, and power relations" (2017, 6). Murphy's theorizations are generative in relation to governmentality of health and healthism in particular. When it comes to Indigenous health, the experts and interventions designed in response to Indigenous deficiencies is infrastructural and multi-sited. Indigenous health policy is invariably infrastructural and multi-sited, which is well demonstrated in Lea's (2020) ethnography of 'wild policy' and logics of intervention with Indigenous health policy in Australia, as well as in the work of Gabel, DeMaio, and Powell (2017) that addresses the 'labyrinth' of Indigenous health policy in Canada.

Epistemic infrastructures and multi-sited experts sustain apparatuses of healthism and occupy an integral role in the design and implementation of interventions. Li explains that "the analytic of governmentality draws our attention to the ways in which subjects are differently formed and differently *positioned* in relation to governmental programmes (as experts, as targets), with particular capacities for action and critique" (Li 2007a, 3). Interrogating the infrastructures of experts and how such infrastructures are meant to *sustain* expertise as a reigning form of governmentality is an imperative task – especially with the aim of being able to delineate how such infrastructures and expertise operate at the expense of Indigenous well-being (Rail and Jette 2015, 330; Lea 2020, 157). Moreover, if we take seriously governmentality as an endeavour of governing the population in an economical manner (Miller and Rose 1990; Burchell 1991; Li 2007a), then the assemblage of experts that exist to intervene in Indigenous health are part and parcel of the settler colonial epistemic and economic infrastructure.

The role of experts and expertise prove useful for identifying generative conceptual and methodological interventions of governmentality. Miller and Rose have noted that experts have "problematized new aspects of existence," while at the same time offering their expertise to "overcome the problems that they have discovered" (1990, 19). Experts and expertise are meant to establish enclosure, to establish the boundaries of problematization, and to set the terms of intervention. Further, experts have "acted as powerful translation devices between 'authorities' and 'individuals', shaping conduct not through compulsion but through the power of truth, the potency of rationality and the alluring promises of effectivity" (1990, 19). Analysing the power of experts and expertise is a crucial project to be able to conceptualize how governmentality operates through both governmental and non-governmental processes. Li takes Foucault, Rose, and others to task for their reluctance to empirically study governmental rationalities, which

positions politics as a "hypothetical" and not as a "concrete practice" (2007a, 5). I return to Li's call for empirical analysis of governmentality in chapter five when I anchor my conceptual framework of governmentality to the empirical reality of Indigenous health policy in Canada. Li ultimately directs us to ask empirical questions to identify what the "implementers or targets" of expertise are actually doing, "how are their practices understood," and what are the "*effects* of governmental interventions" (2007a, 9). Being tuned in to where and how experts maintain governmentality of health will lead to empirical sites of governmentality that may not have been recognizable as such if we limited power and governance to solely the state and its direct apparatuses.

An analytic of governmentality proves useful for understanding how Indigenous health and food security is governed by the state, experts, and citizens alike. The governmentality of health – what I identify in the following chapter as healthism – requires not only the acceptance of a dominant ideology of health, but biopolitical interventions that can be made in the name of health *improvement*. Despite the aim of improvement, Amend posits in her research on nutritional expertise via Canada's Food Guide that experts who "know 'the truth' about nutrition and body weight . . . possess the authority to advise non-experts on how to live in order to avoid obesity," yet critical obesity research has shown that nutrition interventions by experts "have not been effective at reducing rates of obesity, but have rather increased the number of people who self-identify as 'abnormal' and 'irresponsible' 'fat subjects'" (2018, 720). In her theorizations of improvement (which are situated within a field of power) Li argues that improvement requires two key mechanisms — problematization and "rendering technical" (2007, 7). Problematization identifies deficiencies in need of being rectified, whereas "rendering technical" involves "the bounding and characterization of an 'intelligible field' appropriate for intervention," which

subsequently "confirms expertise and constitutes the boundary between those who are positioned as trustees, with the capacity to diagnose deficiencies in others, and those who are subject to expert direction" (2007b, 7). When it comes to healthism, problematization and rendering technical are key strategies used by experts to govern Indigenous health.

This practice of improvement is quite apparent in responses to food insecurity, especially when food insecurity gets framed in terms of nutrition deficiencies that need to be rectified through expert diagnoses. Li notes that the task of improvement is frequently rendered non-political by experts who fail to account for social, political, or economic relations and instead "focus more on the capacities of the poor than on the practices through which one social group impoverishes another" (7). When it comes to dominant approaches to food insecurity, this process occurs when "solutions" to food insecurity focus on individuals to implement self-regulation and discipline to change their circumstances. As a technique of governmentality, healthism is employed in policy and programming to activate citizens to promote their own health, without accounting for political and economic forces that rely on biocitizens to consume the directives of healthism and medicalization with little to no materialization of "health."

The Biocitizen

A key driver of governmentality is the individual – the citizen – which I briefly grappled with in the earlier section on the individual and the body politic but will delve into further here. Governmentality studies has addressed the role of the citizen via self-regulation and shifting of responsibility of social risks onto citizen subjects (Rose and Miller 1992; Hindess 2001; Lemke 2002). Rose has theorized how "advanced liberal forms of government" require "activation of the powers of the citizen" (2004, 166). Citizenship is a relation with the state that occurs through a variety of practices of 'active citizenship.' Rose contends that "the citizen as consumer is to

become an active agent in the regulation of professional expertise; the citizen as prudent is to become an active agent in the provision of security; the citizen as employee is to become an active agent in the regeneration of industry and much more" (2004, 166). Active citizenship is a means to an end for governmental security and while it operates through individual active citizens, these citizens culminate in a community setting.

In this context, Rose explains that "community is not simply the territory within which crime is to be controlled; it is itself a *means* of government: its ties, bonds, forces and affiliations are to be celebrated, encouraged, nurtured, shaped and instrumentalized in the hope of enhancing the security of each and of all" (2004, 250). Within the matrix of communal active citizenship "those who refuse to become responsible, to govern themselves ethically, have also refused the offer to become members of our moral community. Hence, for them, harsh measures are entirely appropriate. Three strikes and you are out: citizenship becomes conditional upon conduct" (2004, 267). Rose broadly conceives of citizenship here but goes on to narrow his theorizations of citizenship to biological notions of citizenship that result in *biocitizens*. The biocitizen becomes a technology of the governmentality of health, and the operation of healthism.

The connections between biopower, biopolitics, governmentality, and healthism come full circle with Nikolas Rose's theorization of health and citizenship. Rose refers back to biopolitics of the 20th century in Germany and the United States noting:

> To be a citizen was not merely to be a passive recipient of social rights: it carried obligations to tend one's own body and, for women, those of one's spouse and offspring. The state would engage in measures for preserving and managing the collective health of the population, but individuals themselves must exercise biological prudence, for their own sake, that of their families, their own lineage, and their nation as a whole (2007, 12).

The pressure to conform to biological notions of citizenship around health and illness and to partake in active citizenship creates circumstances in which "negative judgements are directed

towards those who will not, for whatever reason, adopt an active, informed, positive and prudent relation to the future" (2007, 13). Once again, those who deviate from dominant social norms of health are subject to technologies of discipline.

Critical health scholars have taken up theorizations of biocitizenship as resulting in invariably disciplinary interventions in health (Greenhalgh and Carney 2014; Rail and Jette 2015; Amend 2018, Johnson, Happe, and Levina 2018). Elyse Amend notes that "health and healthy living become intrinsically linked to ideas of citizenship" (729) and that 'good citizens' must partake in healthy lifestyles to meet civic duties and that by doing so, they "socially and economically benefit the whole citizenry and the state" (730). Citizens who fail to do so by neglecting their health, not only harm their personal well-being but the well-being of "the population and state as a whole" (730). Similarly, Jenell Johnson, Kelly E. Happe and Marina Levina contend that the "model biocitizen is rational, autonomous, healthy, able-bodied, or *endeavors to be so*" (2018, 8). Johnson, Happe, and Levina go on to importantly note that such a model of biocitizenship "is thoroughly anchored in a privileged, liberal subject, for whom norms of embodiment, livelihood, and affect are both intelligible and accessible" (2018, 9). It is then troubling when health policies are oriented towards biocitizenship, especially educating biocitizens, when target populations are not privileged and do not have the resources (or desires) to be model biocitizens – which ultimately results in differential and disciplinary outcomes.

Efforts to shape biocitizens require education – along with the necessary experts and expertise – which often takes the place of any other significant health resources because biocitizens are expected to generate health for themselves (Greenhalgh and Carney 2014; Rail and Jette 2015; Amend 2018). Rail and Jette argue that in contrast to good and virtuous biocitizens are "bio-Others" who have been deemed risky, non-citizens, undisciplined, lacking

willpower, and in need of policing (2015, 330). Rail and Jette identify five "rescue missions to save bio-others," all of which "insist that bio-Others 'do it' by themselves and for themselves" (2015, 330-331). One of the key 'rescue missions' outlined by Rail and Jette is the biopedagogical mission that assumes "knowledge necessarily leads to desired behavior and therefore that, as this subject becomes more informed about health and how to attain it, he or she will behave in ways that lead to such health" (2015, 331). Such interventions do not account for structural determinants that prevent individuals from changing behaviours (let alone desire to change behaviour by adhering to colonial and hegemonic ideals of health). In their research on Latinos and the 'obesity epidemic,' Susan Greenhalgh and Megan A. Carney highlight the limits of such biopedagogical missions. In their interviews with Latino youth, Greenhalgh and Carney found that youth "were so knowledgeable about weight and health because their social worlds were full of dutiful biocitizens who readily informed them of their weight problem if they carried extra pounds and what they must do to fix it" (2014, 270). Indeed, youth were bombarded with biopedagogical missions through media, education, health care, and social relations (Greenhalgh and Carney 2014, 270-271). As we will see in the context of Winnipeg in later chapters, educating biocitizens does nothing to change structural barriers to health, or account for alternative ideas of what it means to be healthy.

All of these processes work to form biocitizens – or, what is really an attempt to have citizens self-govern aspects of their health as an integral aspect of their citizenship. However, it is absolutely crucial to recognize that the type of biocitizenship that healthism fosters works unevenly on different populations. Such differential citizenship is actually a cornerstone of biopolitics, in which biopower and state racism work in conjunction to differentially govern the health of populations. Jessica Kolopenuk argues that "any articulation of good (and bad for that

matter) biocitizenship has been, at least, partly shaped by colonial thinking" (2020b, S28). Biocitizenship is always in reference to and in service of settler colonial investments in sovereignty, capitalism, and the political rationalities of liberalism and neoliberalism. When it comes to healthism, we can see that it is essential to management of populations and is a specific technique and/or tactic of governments to urge biocitizens to manage their health. In this sense, healthism is a rationality of biopower. Through biopower, healthism is deployed to activate the disciplining and self-regulation of health through the dispositif, or rather, biopolitical networks comprised of institutions, regulations, administration, and scientific discourses that do different things for different populations.

Biocitizenship is an inherently disciplinary process when citizens invariably fail to live up to the expectations of active citizenship. Julie Guthman links the disciplinary processes of healthism and biocitizenship, arguing that healthism "allows neglect of those not enrolled in such ethics and exaltation of those who are" (2011, 47). Guthman further argues that "by coupling health efficacy with notions of rights, responsibilities, and good citizenship, those not captured by its purse seines are afforded little basis on which to make claims for health care and other resources" (2011, 62). Ultimately, connecting healthism to expectations of biocitizenship "provides a protective veneer for neglect or exclusion" (Guthman 2011, 62). In chapter six, I interrogate how healthism and biocitizenship occupy a central role within Indigenous food security policy in Winnipeg, and instead of providing urban Indigenous people with the means to become more food secure, serve as an attempt to discipline them into better biocitizens of the settler colonial state.

Governmentality and Healthism

Governmentality provides us with the tools to recognize how technologies of health and nutrition operate under a much larger rationale of state security. While early theorizations of healthism were concerned with how governments deployed healthism as a form of social control, the focus has largely shifted towards how individuals undertake their roles as self-regulating subjects, without consideration of how government fosters the conditions for subjects to self-govern according the aims of the state (Zola 1972; Rose and Miller 1992; Lemke 2002). Governmentality provides the analytic and methodological tools to trace the rationalities (reasoning of how and why power is exercised), programs (imagined projects), and technologies (translative devices between the apparatus and populations) in the settler colonial context (Lemke 2002, 55; Rose 2004, 52; Lippert 2005, 4). Healthism is but one rationality of the governmentality of health – it results in the output of specific programs and operates through a technology of biopower, which is specifically troubling given how biopower operates differentially for Indigenous populations. Moreover, in chapter 5, I identify liberalism as a dominant governing rationality that determines the operationalization of healthism in Canada policy. Liberal rationalities of non-interference, market values, and citizen self-regulation correlate with the aims of governmentality (and thus healthism) which operate through individualization, expertise, and biocitizenship. Analyzing how governmentality, and thus healthism, operate is crucial for understanding how Indigenous health and nutrition has been regulated and disciplined through food insecurity policy and programming.

Literature on the governmentality of health has focused on many of the processes of governmentality I have outlined in this chapter – particularly individualization and citizenship (Greenhalgh and Carney 2014; Rail and Jette 2015; Williams and Fullagar 2019). Scholars have

taken up a range of interventions including how self-governing individuals promote health and nutrition through policing and preaching (Warin, 2011); how families implement techniques of self-governmentality and regulation of nutrition (Ristovski-Slijepcevic, Chapman, Beagan 2010); how bio-pedagogies and governmentality operate through individualization, rationalization, and sanitization of food and consumption (Leahy and Wright 2016, 243; Rail and Jette 2015; Amend 2018); how students in a politics of obesity course respond to course content through tropes of neoliberal governmentality (Guthman 2009); and how public health campaigns employ tactics of governmentality and bio-power to incite fear for poorly regulated health (Gagnon, Jacob, and Holmes 2010, 251). While these scholars extend key theorizations of governmentality to the specific realm of health, the focus tends to gravitate towards how individuals are subjectified through governmentality, rather than how and where governmentality operates from its seat in biopower and the apparatuses that administer and intervene in health.

Given the field of governmentality of health, in the next chapter I narrow my focus to the field of healthism given its preoccupation with the individuals' capacity to regulate their health through diet and exercise. While healthism resonates with many of the governmentality of health sources above, it almost always focuses on diet and nutrition – which often inform policy and programming for food insecurity. More importantly, however, healthism is first and foremost a form of governmentality – it operates through the same strategies of governmentality and is embedded in many of the same apparatuses. Moreover, healthism stemmed from early literature on medicalization that critiqued the medicalization of social issues as a form of social control of deviance and behaviour. In the next chapter I chart the genealogy of healthism, which proves useful for understanding how the self-regulation of health through biomedical hegemonic nutrition promoted through healthism has been employed as a technique of social control,

undergone de-politicization, and become a pervasive component of health policy and food insecurity programming in Canada.

Conclusion

I have provided a very cursory introduction to how governmentality operates in relation to health in this chapter. I introduced biopower, biopolitics, and governmentality and situated governmentality as a conceptual analytic that I use throughout this research. I specifically focused on how governmentality operates in relation to the individual and the body politic, the expert, and the biocitizen. In chapter 3 I turn to healthism to identify how these same modes of operation occur within healthism and argue that while identifying how healthism (and thus the governmentality of health) operates through these avenues, there is a recurring failure to empirically situate such analysis in relation to the larger structures (and apparatuses) that maintain it. In chapter four I conceptually draw on *the individual and the body(politic)*, and thus the governmentality prerogative of establishing a body politic of self-governing subjects, to interrogate how discipline and surveillance operate in relation to the governmentality of Indigenous health to demonstrate how the individual self-regulating governmental subject implements securitization – a process which constrains the possibilities of health for Indigenous people living in Winnipeg. As a result, disciplinary power occurs through regulatory governmentality in which the individual is trained to conduct the conduct of the self and others. However, it will be important to hold room for agency within these theorizations – subjects often resist and refuse. In chapter five I turn to *the expert and expertise* to identify an apparatus of healthism at the federal level. I focus specifically on the rationalities, programs, and technologies that comprise the apparatus to analyze how Indigenous bodies and populations are administered through federal expertise, and how Indigenous populations become quantified by experts as a

risk to the settler colonial state. In chapter six, I turn to the *biocitizen* to identify the points of application of the apparatus of health to demonstrate how efforts to address food insecurity in Winnipeg are conflated with notions of biocitizenship that result in regulatory, disciplinary, and differential governance of Indigenous populations who fail to be appropriate biocitizens.

Chapter Three – Healthism

In early 2019, Health Canada published the latest revised edition of Canada's Food Guide that marked a departure from earlier versions of the guide[29] that relied on primary colours and illustrations to contemporary editorial photographs depicting scenes of healthy eating and images of foods and food marketing to beware. The photograph that is front and center of the latest guide is a plate divided in three sections – half of the plate contains fruits and vegetables, a quarter of the plate contains protein, and the final quarter contains whole grains. Despite the aesthetic marketing efforts, the guide has been on the receiving end of sharp criticisms – including that "the divided plate could well be a metaphor for fundamental divisions in Canadian society" (Baranyai 2019, para 4), or that the guide is only "easy to follow if you're wealthy or middle class" (Hamann and Pannu 2019), and that the guide "highlights the biggest obstacle to healthy eating – poverty" (Saul 2019).

These critiques hone in on the fact that the healthy foods and standards of nutrition being promoted through the guide are out of reach for those who experience varying degrees of food insecurity. However, these criticisms of the guide fail to connect the project of nutritional intervention to food insecurity interventions and thus rely on a set of assumptions, including that addressing the affordability of food would result in individuals drastically changing eating habits, or that poverty necessitates that they are already eating unhealthy, or that they hold drastically different epistemologies of food that do not correspond with dominant nutrition guidelines.

[29] Health Canada. 2019. *History of Canada's Food Guides: From 1942 to 2007.* Ottawa: Health Canada. Canada's first food guide was introduced in 1942 and has undergone subsequent revisions in 1944, 1949, 1961, 1977, 1982, 2007, and 2019.

I begin this chapter with a vignette of Canada's Food Guide to provide empirical context for what healthism looks like in practice in Canadian policy. Canada's Food Guide "underpins policies, programs, and initiatives to promote healthy eating throughout the country," and while it has "strong brand recognition," Health Canada has found that "consumers are not following the advice" in the guide (Health Canada 2016, 6). Health Canada has taken the position that consumers need both guidance and food environments to enable them to make healthy choices. To support these efforts, they have undertaken new approaches to communicating guidance, which is evident in the latest guide, and have indicated that it is critical to "reinforce and leverage the role that intermediaries play in helping consumers apply dietary guidance" (Health Canada 2016, 6).

The food guide uses evidence review cycles during revisions that consider scientific basis of recommendations, the Canadian context, and use of existing guidance – thus, it draws on existing scientific and medical rationalities while subsequently reproducing them in the field of nutrition (Health Canada 2016, 2). The food guide is one of many technologies that comprises what I refer to as a biomedicalized hegemonic nutrition conglomerate and operates within an apparatus of healthism. The guide then informs programming and technologies employed through programs – such as education programming offered to teachers through the Winnipeg School Division, educational booklets on healthy eating that are distributed to families with children in grades K-8, and even parent education sessions (Food Matters Manitoba 2013, 34). The food guide operates on the premise that individual deficiency must be ameliorated through healthy eating by adhering to the nutritional guidelines established by Health Canada experts. Later in the chapter I further review how healthism operates through individualization, expertise, and citizenship expectations. I hope that throughout the chapter returning to Canada's Food

Guide will prove useful for thinking through conceptualizations of healthism and linking them back to recognize what healthism looks like *in practice* in Canadian policy.

In this chapter I introduce the field of *healthism* as a way to unpack some of the central concerns I have about how Indigenous food security is currently conceptualized in both policy and academic research. The analysis of healthism I undertake here stems out of my frustrations with the limitations of policy meant to address food insecurity and the preoccupation of such policy with ensuring individuals ate *healthy* foods and not *any* foods. I outline key thinkers of healthism, identify how healthism is operationalized, demonstrate the prevalence of healthism in renderings of Indigenous food insecurity, and interrogate the limits of healthism when it comes to understanding its relationship to race, indigeneity, and colonialism. I extend and connect healthism to the previous chapter's theorizations of governmentality. I identify three key operationalizations of healthism that mirror how governmentality operates – *the individual and body politic, the expert and expertise, and the biocitizen*.

What is Healthism?

Robert Crawford's 1980 article "Healthism and the Medicalization of Everyday Life" is widely recognized as being the seminal text of healthism literature. Crawford (1980) was writing in response to late 1970s U.S. health movements concerned with personal health and ultimately situated "the problem of health and disease at the level of the individual" (365). The practice of healthism — most notably, the self-regulation of health, was widely underway in medical fields through discourses of self-help, self-care, holistic health. Moreover, the medicalization of health was already being theorized by Michel Foucault (1994), Irving Kenneth Zola (1972), Ivan Illich (1976), and Thomas Szasz (2007). Healthism has become a convenient body of literature to refer to, especially as it relates to self-regulated health in the areas of diet and exercise. Crawford

continues to be extensively engaged in the corollary fields of public health and nutrition (Guthman 2011; LeBesco 2011; Kimura et al. 2014). However, those who have carefully read the endnotes in Crawford's text know that the genealogy of healthism can be traced to Irving Kenneth Zola's 1977 essay "Healthism and Disabling Medicalization" (Turrini 2015). Zola's essay considers how medicalization specifically operates by individualizing social/health issues as a form of social control. Crawford has consistently been misattributed as the progenitor of healthism with most scholars relying on his conceptualization of healthism rather than Zola's (Cheek 2008; Hendersen, Epp-Koop, and Slater 2009; LeBesco 2011; Guthman 2011; Kimura et al. 2014; Sharon 2015; Brown 2018). Regardless of how essential Crawford's theorizations have been to the field of healthism, the reliance on his contribution as the be-all-end-all of healthism has shaped the trajectory of healthism literature in troubling ways over the past several decades. In this section I chart how healthism has unfolded since the late 1970s and in doing so I identify the trend towards focusing on how individuals engage with self-regulation of health, rather than how healthism is ultimately employed as a technique of social control or what we could also call differential governmentality.

Early healthism literature (including both Crawford and Zola) connected healthism to the well-established phenomenon and literature of medicalization. Medicalization was the process by which a number of 'ills' of both the body and social context came to be defined and treated as a medical problem by medical experts. Early scholars of medicalization identified integral aspects of medicalization as including increased individualization (Foucault 2004; Zola 1972) and complex technological and bureaucratic systems (Zola 1972) that require specific expertise (Zola 1972; Illich 1976; Zola 1977). Through these processes, scholars consistently argued that medicalization worked as a form of social control – particularly by individualizing the 'ill'

subject from their greater social context, intervening with increased expertise, and shifting responsibility for larger social issues to the realm of individual illness (Zola 1972; Illich 1976; Zola 1977; Crawford 1977). I will return to these provocations later in this section to delineate how healthism has largely departed from its roots in medicalization. For now, I want to turn to some of these early conceptions of healthism and medicalization.

Crawford's rendering of healthism provides a useful starting point for thinking critically about how health has materialized at the level of the individual, but current theorizations of healthism still leave much to be desired. Crawford theorized healthism through the health movements of "holistic health" and "self care," but since then healthism has seeped into any and all aspects of health that require the individual to practice self-regulation or self-discipline (1980, 366). Crawford delineates healthism as the "preoccupation with personal health" as the sole focus for maintaining health and well-being, which "is to be attained primarily through the modification of life styles, with or without therapeutic help" (1980, 368).

Regardless of the disease or health issue of concern, "healthism treats individual behaviour, attitudes, and emotions as the relevant symptoms needing attention," and indeed, healthism has targeted these areas of individuals when responding to diabetes, obesity, and even food insecurity (1980, 368). Those who implement the practice of healthism may acknowledge that there are external factors for health problems (Crawford uses the example of the American diet), but above all else such factors are simultaneously identified as behavioural (Conrad 1992). Individual responsibility to change or adapt to external factors is then a cornerstone of healthism. Crawford notes that with healthism solutions lie with "the individual's determination to resist culture, advertising, institutional and environmental constraints, disease agents, or, simply, lazy or poor personal habits" (1980, 368). Healthism requires individuals to self-intervene in their

own health through discipline and regulation, despite external factors that can very well result in self-interventions being done in vain.

Healthism functions beyond the individual through the twinned processes of dominant ideologies of health and medicalization. As a dominant ideology, healthism requires depoliticization, which works to ensure health remains an individual problem, while also undermining “social effort to improve health and well-being” (Crawford 1980, 368). As healthism functions as a dominant ideology, Crawford argues that it contributes “to the protection of the social order from the examination, critique, and restructuring which would threaten those who benefit from the malaise, misery, and deaths of others” (1980, 369). In short — individuals are burdened with their ill health, rather than the external actors who often exacerbate ill health in populations.[30] Crawford’s theorization of healthism tied into existing literatures on medicalization, especially through a framing of medicalization as a process in which professional power of wider spheres of life is positioned to enact some form of social control (1980, 369).

Medicalization, for example, is particularly focused on deviancy (deviant behaviours) and the moral duty of individuals to meet “the obligation to correct unhealthy habits” (1980, 380). Medical authority is then extended through the practices of self-regulation and self-care, ensuring that individuals are correcting what medical authorities have defined as their deviant behaviours. Crawford argues that “in the absence of a clear societal responsibility for (commitment to) health promotion, individual responsibility comes to be seen as a necessity” (1980, 383). Unfortunately, Crawford did not account for what happens when “societal

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[30] Even when structural and social determinants of health are accounted for, individuals are often expected to change their behaviour. For example, food insecure residents of food swamps (geographic locales with a high number of fast food or convenience store food access points) are expected to change their diets in spite of environmental determinants of health. I address this example more in-depth in chapter six.

responsibility for health promotion" is actually just the promotion of healthism. Throughout this chapter, we will see how healthism, while still very concerned with the individual, is used in state public health policy to promote self-regulations of entire populations to negate any amount of political responsibility for healthy citizens.

The connection between healthism and medicalization go far beyond the centrality of medical authority influencing a movement of individuals to self-regulate health. Crawford grounded his conceptualizations of healthism in the existing field and theorizations of medicalization, extending the work of sociologist Irving Zola and philosopher Ivan Illich (1980, 369). While Crawford engages medicalization as an ideology, he stopped short of engaging with the serious political consequences of medicalization that previous scholars had well established. Crawford cited Illich's theorizations of medicalization which focused on "understanding the social control of deviance" (1980, 370). Illich argued that the health care system had grown "beyond critical bounds" and sharply criticized it because: "it must produce clinical damage that outweighs its potential benefits; it cannot but enhance even as it obscures the political conditions that render society unhealthy; and it tends to mystify and to expropriate the power of the individual to heal himself and to shape his or her environment" (1976, 9). Illich contended that "such medicine is but a device to convince those who are sick and tired of society that it is they who are ill, impotent, and in need of technical repair" (1976, 9). Illich connected industrialism, capitalism, and political power to medicalization and ultimately argued that the "medical monopoly over health care has expanded without checks and has encroached on our liberty with regard to our own bodies" (6).

The healthism that Zola conceptualized is radically different from Crawford's self-help, self-care, white middle-class healthism. Crawford's empirical context considered how subjects

bought into healthism to take charge of their own health. Zola on the other hand was more concerned with how healthism was a means of off-loading responsibility for social problems onto individuals as personal health failings. Zola (1977) argued that "medicine is becoming a major institution of social control," not by an increase in doctors' political power but through "an insidious and often undramatic phenomenon, accomplished by 'medicalizing' much of daily living, by making medicine and the labels "healthy" and "ill" *relevant* to an ever increasing part of human existence" (41-42). Zola identified an increasing number of instances in which social problems such as poverty, behavior, black power, race riots, and children in care were being conceptualized as "health problems" (1977, 61-62). Zola was concerned about the process of individuals being rendered ill and he noted that "while this may have a pragmatic basis in the handling of a specific organic ailment when a social problem is located primarily in the individual or his immediate circle, it has the additional function of blinding us to larger and discomfiting truths" (62). Lack of perception has proved to be a central component of healthism – healthism works best when we decide to regulate our own health without considering how social, political, economic, and environmental factors impact the efficacy of any self-regulation we undertake.

In addition to narrowing in on the problems with connecting social issues to illness, Zola criticizes how the logics of "health" and "illness" are circulated and employed. Not only was illness to be diagnosed and treated through the "assumed moral neutrality" of the medical model (Zola 1977, 63) but doing so meant a rise in the need for expertise. Zola's analysis revealed how healthism could become institutionalized, and he ultimately argued that "the danger is greater for not only is the process masked as a technical, scientific objective one but one done for our own good. In short, the road to a healthist society may well be paved with supposedly good

intentions" (67). This will be an important point to return to throughout this chapter when we think about how healthism is often employed to encourage individuals to eat healthier, or according to set nutritional guidelines – which seems innocent enough, and done with good intentions and the motive of improving individuals' access to healthy food. But if we consider how promoting healthy eating simultaneously functions to prevent understanding of larger issues such as systemic poverty and structural inequities, it seems unlikely that healthism is 'done for our own good.'

The departure of healthism literature from its early ties to medicalization ignores the political processes and structures that medicalization scholars were so adamant to attend to (Blaxter 2005; Cheek 2008; Brown 2018). Such a departure is a fault and rift that must be attended to in order to identify the structural materializations of healthism, especially amongst differing populations. Petr Skrabanek's *The Death of Humane Medicine and the Rise of Coercive Healthism* (1998) is an under cited text that bridges healthism and medicalization, extending Illich's earlier works (11). Skrabanek divides his analysis into three key interventions: first, he outlines how "health" is exploited for "professional, political and economic purposes," particularly through the ideology of healthism, which he considers a main component of the "totalitarian ideologies in Nazi Germany and Communist Russia" (11); second, he considers "lifestylism," which he contends "proceeds from historical examples of individual pursuit of the chimera of health to the collective normalisation of behaviour as state policy" (11); and third, he argues that the twinned processes of healthism and medicalization result in "the tyranny of normalisation, the rise of Big Brothers in the surveillance of 'lifestyles', and other manifestations of coercive medicine" (12).

Throughout his work, Skrabanek never loses sight of the investment of the state or governing bodies in the process of individual self-regulation of health. Moreover, Skrabanek maintains that when there has been widespread buy-in to discourses of healthy nations and citizens, "without understanding the means by which this end is to be achieved, healthism and lifestylism get universal support" (12). Skrabanek notes that "the perversion of language obscures the power motive behind the seemingly altruistic pursuit of health for all" (12). I aim to trouble precisely this, "the seemingly altruistic pursuit of health," throughout this research, particularly the seemingly altruistic pursuit of healthy eating for all. Healthism has maintained a preoccupation with the self rather than how medicalization and healthism run unregulated throughout biopolitical structures.

Now that I have charted the origins of healthism, it is necessary that I contextualize what is often thought to be the ideal subject of healthism. At the time of Crawford's writing he noted that the phenomenon of healthism was "overwhelmingly middle class" (1980, 365). Middle class healthism works in two distinct, important ways. Healthism for the middle class has been characterized by extreme health awareness, self-reflection, high expectations, and access to an abundance of "different demographic, economic, technological, scientific and ideological forces" (Greenhalgh and Wessely 2004, 210). Middle class healthism can be distinguished by not only the personal investment in healthism by practicing subjects, but by the resources middle class subjects have at their fingertips to initiate and maintain the practice of healthism. The role of morality in healthism has meant that middle class subjects engaging in healthism can set themselves apart from the unhealthy lower class who have failed to be responsible and healthy citizens (Crawford 1994; Kimura et al. 2014). In rendering the middle class subject of healthism, it is generally left unsaid that such a middle class subject is almost always white. Being attuned

to the role of whiteness and middle classness in analysis of healthism is crucial because the subject of healthism matters in understanding how it operates.

Even though we know that white middle class people have a long standing infatuation with healthism, it is necessary to ask whether they are really the ideal subject of healthism. Throughout this chapter I demonstrate that contemporary healthism actually works to target non-white, non-middle class subjects to work to discipline them to be more like white middle class subjects. Healthism has been determined by white morality, and throughout the years as it has shifted from holistic health and self-care to areas of nutrition and exercise, to a technique of biopolitical governmentality. Of course, had the trajectory of healthism literature stemmed from Zola's (1977) renderings of healthism, it is likely the subject in question would be entirely different. Zola was well attuned to how medicalization was being employed as a form of social control on racialized and other marginalized populations through the transition to healthism (1977, 65-66). The transition of healthism to a disciplinary technology of governmentality is rooted in understandings of deviance, and the moral duty individuals have to rectify their deviance. Moreover, deviance can be traced back to race science and the inscription of deviance onto "the other." Thus, racialized populations can come to be viewed as doubly-deviant under the logics of healthism. Healthism as a technology of biopolitical governmentality operates through state racism and the logics of differential citizenship — I will elaborate on specific examples of how healthism operates in this way throughout the remainder of the chapter. Here it suffices to say that healthism gets employed in troubling ways when used as a technology of governmentality to manage populations (particularly racialized populations) and is no longer solely an interesting phenomenon of white middle class subjects.

I have tried to narrow my focus to healthism literature that intervenes in the areas of increased medicalization and social control of health (namely, biopower). The strengths of these analyses lie in how they provide the basis for questioning how public health policies individualize social issues as issues of individual illness, create the conditions for increased expertise to ensure regulation, and set standards for ideal citizenship. In a post-Crawford era, in many takes on healthism there has been a gradual but marked shift where scholars have narrowed their inquiries to, namely, individual interactions with healthism, rather than healthism as a form of social control. This shift is marked by analysis of an emerging public health focus on lifestyle (Blaxter 2005), individual behavior (Cheek 2008; Brown 2018), and new forms of health expertise (Petersen and Lupton 1997; Cheek 2008; LeBesco 2010; Mayes and Thompson 2014; Brady, Gingras, and LeBesco 2019). Crawford undoubtedly situated healthism as a process of individual vested interest in self-regulating health, which has invariably shaped the literature that has followed. While I do not think a total shift to focusing on individual lifestyles is ideal for considering how healthism and biopower operate, these literatures are useful for delineating how health policy has continued to rely on both medicalization and healthism and for understanding how expertise (now professional and non-professional) is wielded to shape ideal biocitizens.

The trajectory of healthism literature has followed public health trends. In Canada in particular, the 1970s through the 1990s saw public health efforts in the realm of health promotion that were often concerned with individual lifestyle (Raphael 2008, 485). Lifestyle was framed as a cause of poor health, and a path to good health through health promotion. There was some attention to broader determinants of health in the mid to late-1980s and 1990s, but such causation was not engaged seriously, and public health efforts consistently turned to promotion and

lifestyle interventions (Raphael 2008, 486-487). It was not until the 2000s that Canadian public health policy makers began to seriously identify social determinants of health (SDOH) as a significant factor of population health (Raphael 2008, 490). By 2012 Canada pledged to improve health equity under the Rio Political Declaration on Social Determinants of Health.[31]

I flag the transition to SDOH here as a preface to chapter 5 where I more thoroughly delineate how SDOH policy shapes the current public health environment in Canada. I interrogate how even with SDOH policy frameworks, with healthism still looming large, interventions are still largely situated at the level of the individual. Healthism scholars have not taken up SDOH literature to respond to the shortcomings of healthism. Instead, several scholars have noted the shortcomings of SDOH approaches due to policies still largely situating interventions at the level of individuals, rather than structural or social determinants (Raphael 2008, 490; Mayes and Thompson 2014, 164; Brown 2018, 1005; Brady, Gingras, and LeBesco 2019, 111). The confluence between SDOH and healthism in response to the "obesity epidemic" highlights the limitations of SDOH approaches, and the societal entrenchment of healthism as a logic of health. A focus on lifestyle approaches and individual behaviours rules policy responses (Raphael 2008, 490; Brady, Gingras, and LeBesco 2019, 111). Even when responses consider structural, social, or environmental determinants such as making "changes to the built environment, improved urban planning and neighbourhood walkability, reduced availability and advertising of junk food, greater access to retailers of 'healthy' food, and banning or taxing high-calorie foods and drinks," these approaches "expect that with the correct policy measures, populations will be shepherded into making healthy choices" (Brady, Gingras, and LeBesco

[31] Health Canada. "Social Determinants of Health and Health Inequalities." *Government of Canada.* Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html.

2019, 111). Even though SDOH has undertaken remedial work to attempt to shift the focus of health from the individual to the structural, healthism and rationalities of liberal governmentality restrain the possibilities of such analyses and approaches to health.

Operationalizing Healthism

From here on out I specifically consider how individualization, expertise, and citizenship are key components of the operation of healthism. I focus on these areas specifically because when we look to how individualization, expertise, and citizenship operate through healthism, we can begin to trace healthism back to the particular apparatuses it is embedded within. I argue that these avenues of analysis are critical to the charting of how healthism has developed over the years, particularly in relation to the regulation of nutrition through health policies. Where possible I will narrow in on literature that specifically accounts for how these circulate in relation to nutrition and food, which will lead us to discussion of how healthism has become imagined and deployed as a solution to food insecurity. I limit the discussion here to how scholars working in the area of healthism engage these three components of how healthism operates, but in the coming chapters I empirically situate individualization, expertise, and citizenship in relation to how Indigenous food security is governed in Winnipeg.

The Individual and the Body Politic

Healthism operates in a few crucial ways — through individualization, expertise, or the process of "rendering technical" (Li 2007b, 7; Rose 2004, 26), and biocitizenship. I have chosen to specifically delineate these areas because when it comes to nutrition and food insecurity, many public health and policy approaches rely on these processes and modes of operation. Moreover, it will be necessary to understand the way in which healthism operates through these processes

later in this chapter to identify the limits of the productivity of healthism when it is used as a technology to govern racialized populations.

I will begin this section by considering the process of individualization, as well as what I will refer to as individual deficiency. Peter Conrad (1992) argued that "with medicalization, medical definitions and treatments are offered for previous social problems or natural events" and with healthism, "behavioral and social definitions are advanced for previously biomedically defined events" (223). Conrad (1992) contends that medicalization "proposes biomedical causes and interventions," while healthism "proposes lifestyle and behavioral causes and interventions" (223). Despite the differentiations Conrad is making between the two, both medicalization and healthism intervene in the *individual body*. In doing so, individualization works to establish a subject with *individual deficiency*. Intervening at the level of the individual serves to abstract what has been identified as an individual deficiency from its larger social context. Zola (1972) argued that "by locating the source and the treatment of problems in an individual, other levels of intervention are effectively closed" (500). It is imperative to interrogate how individualization divorces individuals from their larger communities and populations, placing deficiency or illness on the individual subject, as a specific mode of biopolitics that invariably works to differentially govern the health of populations that have been rendered ill or deficient.

The promotion of individualization via healthism works in two intertwined ways – through the individualization of health, and the off-loading of responsibility of health (both economic and corporeal) from the state to the individual. When health becomes an individual responsibility, it simultaneously becomes a behavioural deficiency when individuals fail to find solutions to their health problems through their own doing (Cheek 2008; Brown 2018; Kimura et al. 2014; LeBesco 2011). Crawford noted that solutions rest "within the individual's

determination to resist culture, advertising, institutional and environmental constraints, disease agents, or, simply, lazy or poor personal habits" (368). The off-loading of health responsibility onto individuals has rendered nutrition as a matter of discipline that encourages "dietary self-regulation" (Kimura et al. 2014, 37), "voting with your fork," (Guthman 2011), or more education because if only people *knew* how to eat in a particular way then they would (Kimura et al. 2014). While none of these activities are inherently problematic, they undeniably work to create the conditions in which larger environmental, structural, economic, and societal causes for nutritional inequity are left uninterrogated. The off-loading of responsibility has not left a vacuum or void – rather, it has generated the need for experts to define, regulate, and aid individuals in the attainment of health.

The off-loading of responsibility for well-being onto individuals is a central driver of how biopolitical endeavours are materialized within societies. In later chapters I will analyze how healthism operates in Winnipeg through an apparatus of healthism. With the empirical context of Winnipeg, we can trace how biopower operationalizes healthism as a white middle class effort to regulate health, and as a technology of state racism that employs healthism to differentially govern racialized populations. Petr Skrabanek (1998) has written on the explicit connection between healthism and public health campaigns rooted in racism and eugenics. The more insidious form of healthism may be the version that operates through the nurturing of biocitizens who *should* regulate their health, thus establishing that when they do not, governments do not hold responsibility for their health outcomes, which "profoundly marginalizes those who 'opt out' of health" (LeBesco 2011, 160).

The role of individual behavior and deficiency has been a key theme in the literature reviewed thus far and has proved to be a central facet of nutritional healthism as well. Brown

(2018) has argued that the "behavioural turn" (998) of healthism and health promotion should be avoided because of the direct and indirect harms it causes. Brown argues that the stigmatization that results with moralization reinforces "the idea that people *can and should* alter their behaviour" and thus it distracts from "more effective ways of promoting health" (1008). Jennifer Brady, Jacqui Gingras, and Katie LeBesco (2019) take a feminist approach to critical obesity studies and note that even when scholars look for environmental and structural factors to account for obesity, these analyses are still "tinged with moralizing but also classist, racializing, and sexist ideas about what makes a neighbourhood 'healthy' or 'good,' and that ignore the embodied experiences of fat bodies" (112). I will not go in depth here into the connections between obesity, healthism, and food insecurity but I will note Brady, Gingras, and LeBesco's (2019) argument that "the persistence of fat bias is rooted in several erroneous beliefs about body weight and health, including that an 'obesity epidemic' is real; that fat people can and should lose weight to become healthier; and that weight conformity will save already stretched health care dollars" (104). The off-loading of responsibility of health (both economic and corporeal) onto the individual is a significant marker of how healthism is used to regulate and discipline individuals with diet-related diseases and health outcomes.

Overcoming individual deficiency is a key objective of nutrition interventions by both governments and not-for-profit intermediaries. Nutrition promotion projects that rely on an educated subject to regulate their health by making calculated choices about their nutrition are merely "policies and technologies that aim to facilitate the amelioration of the self, through quantitative management" (Mudry in Kimura et al. 2014, 37). In their collaborative article addressing nutrition *as a project*, Aya H. Kimura, Charlotte Biltekoff, Jessica Mudry, and Jessica Hayes-Conry (2014) each author contributes short articles on the subject at hand. Mudry argues

that "the quantitative program of knowing what and how to eat, with the promise of health as the end goal, presents governmental policies as benevolent, well-meaning, and unobjectionable" (38). Mudry ultimately finds that "governmentality turns nutrition into an administrative goal" that will never manifest for subjects trying to achieve health (and citizenship) in food through constantly changing metrics and expectations (Kimura et al. 2014, 38).

Moreover, in Kimura et al. (2014), Hayes-Conroy has argued that "interveners assume that a lack of knowledge and/or motivation is the main problem, rather than, for example, examining how cultural differences, structural inequalities, and material relationships might produce much more varied and contradictory mechanisms of bodily nourishment" (39). In nutrition interventions, it is always the subject who is framed in terms of a deficiency whether a nutritional deficiency, a moral deficiency, or an educational deficiency. Perhaps not surprisingly, the interveners/interventions are rarely deficient. When it comes to food insecurity for Indigenous people, interveners consistently frame food insecurity in reference to at least one, if not all, of these deficiencies.

Nutrition is a key figure in critical engagements with healthism because it has become one of the first aspects of health individuals are expected to self-regulate. In the Kimura et al. (2014) introduction, Guthman has argued that it is "vital to defamiliarize nutrition, to undo its taken-for-grantedness" (3). In this vein, I think there are many projects required to undo nutrition as common sense, which includes conceptualizing nutrition beyond eating healthy. Brady, Gingras, and LeBesco (2019) have criticized *big nutrition* – they cite a forthcoming definition of big nutrition from Brady, Parker, and Hite as including the "conglomerate of research, public health, health promotion, and nutrition experts that have biomedicalized food and eating and therein redefined food and eating primarily as health practices" (115). Similarly, in Kimura et al.

(2014), Hayes-Conroy would refer to the nutritional advice that emerges from the medicalized nutrition conglomerate as “hegemonic nutrition” (39). In their analysis of the ethical implications of moralistic nutritional interventions, Christopher Mayes and Donald B. Thompson push back against the medicalization of food choice through nutrition science (2014, 159). Mayes and Thompson argue that “those who use nutrition evidence to command individual food choices have an ethical burden to articulate why the biomedical value of food should be prioritized over and perhaps to the exclusion of values such as pleasure, comfort, belonging or well-being” (159). In chapters to come, the question of why the biomedical value of food is prioritized over any number of other factors (pleasure, well-being, community connection, economic reasons) is one I will return to especially when considering urban Indigenous food insecurity.

The use of biomedicalized hegemonic nutrition as a response to food insecurity in policy is a phenomenon I aim to disrupt throughout this research. Whether we are talking about biomedicalization, healthism, or hegemonic nutrition through interventions, they all serve to individualize subjects. The continuous efforts to individualize are especially problematic when these technologies and techniques are used to effectively shift interventions to the individual rather than to the larger social context. If an entire community (e.g. a specific geographic boundary) or population (e.g. urban Indigenous people) is disproportionately affected by food insecurity, yet policy interventions are only concerned with changing the individual and not the larger environmental structures within which food insecurity propagates, then any solution is likely to fail. However, it is not likely that these policy approaches are *actually* meant to abolish food insecurity; rather, they are meant to govern differentially and to give the illusion that health promotion efforts have taken place when in reality, all efforts have just contributed to the disciplining of biocitizens.

In the previous chapter, you will recall that I identified how governmentality operates through the *individual and the body politic*. While I have predominately focused on how healthism operates through individualization (and individual deficiency) in this chapter, it is necessary to note that such processes also serve to establish a body politic of governing subjects that meet the aims of government through their own self-regulation and regulation of others (Miller and Rose 1990; Rose 2004; Li 2007a, 1). Individuals become responsibilized as agents of governmentality who regulate their own deficiencies, and the deficiencies of others.

The Expert and Expertise

The role of experts and expertise are integral to the operation of healthism. In my introductory chapter, I discussed the integral role of expertise in the actualization of governmentality. While the focus of healthism has often been on the individual and how they take up self-regulation practices, it is important not to forget the role of the expert in advising individuals and creating programs of healthism. Zola (1972) noted that medicalization was "becoming the new repository of truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts" (487). Zola (1977) also argued that such expertise is not only depoliticizing, but exclusionary as well (65). Such expertise that is rendered non-political, objective, and neutral carries through to healthism as well. Expertise eventually moves solely from the realm of medicine and into new fields of expertise (Skrabanek 1998; Cheek 2008) to include a wider variety of health professionals (physical trainers and nutritionists). Attending to how expertise is employed through healthism is necessary to understand how experts adhere to governing rationalities of liberalism that overly determine the programs and technologies used to intervene in health.

The power of healthism lies in its acceptance as a dominant ideology by experts (nutritionist, academics, policy makers) and non-experts alike. Interrogating the benevolence and unquestioned merit to living a healthy life is fraught with contention – but this is precisely how healthism operates as a dominant ideology and thus contributes "to the protection of the social order from the examination, critique, and restructuring which would threaten those who benefit from the malaise, misery, and deaths of others" (Crawford 1980, 369). The expert knowledge that shapes the fields of nutrition and healthism is ultimately a claim to expertise with countering technical solutions. However, anthropologist Tania Li eloquently notes that "the claim to expertise in optimizing the lives of others is a claim to power, one that merits careful scrutiny" (2007b, 5). Attempts at optimizing the lives of others without their consent and input especially warrants scrutiny, and as Kimura et al. note, "beneficiaries of nutrition interventions are rarely invited to discuss their experiences and actually work with nutrition experts and development practitioners" who aim to 'optimize' their lives (43).

The role of expertise and 'rendering technical' in healthism is well outlined in relation to the latest technologies and tactics to promote self-regulation of health, and policies that serve to offset responsibility while simultaneously educating individuals on how to be better biocitizens. A stark example of this is Julianne Cheek's (2008) "Healthism: A New Conservatism?" in which she analyses a set of lifestyle choices and technologies grounded in healthism that have changed the boundaries of "what health care actually is" (975). The choices and technologies reviewed include fitness assessments in gyms; health audit tests, including "The Mortality Index" test that claims to reveal how long individuals will live (977); and "Lifescripts," which is a "lifestyle prescription" initiated by the Australian federal government as a mode of health prevention (978). Cheek is never explicit about the subject of these technologies of intervention, but it is

clearly a subject who can access private gyms, has the leisure time to take health audit quizzes, and has access to family healthcare. Cheek sought to critique aspects of health care that are taken for granted or unchallenged, but left issues of class, race, and colonization unchallenged – and in doing so, left how healthism operates to differentially govern biocitizens uninterrogated. In a similar vein, Rebecca Brown (2018) criticizes health promotion efforts that rely on individualized interventions focused on behavioural responsibility. Brown argues that while health promotion strategies that focus on individual education seem to be a "benign" use of educational strategies, such efforts work to "reinforce (misconceived) beliefs regarding people's responsibility for their health-related behaviour and subsequent (ill) health" (999). Brown's analysis provides a starting point but misses how these strategies specifically target populations that have often been rendered ill, immoral, or deficient through racialization.

Aya H. Kimura's writing on "nutrition as a project" responds to the prompt to "reflect on what happens when nutrition goes to work: what kinds of subjects it attempts to make, does make, and how the project of nutrition works in class/race differentiation as well as capital accumulation" (Guthman in Kimura et al. 2014, 34). In her response to this provocation, Kimura contended that "when we discuss nutrition as project, the tendency is to obfuscate the subject of the project" (43). The preoccupation with the individual in healthism serves the process of obfuscation — it masks the unwieldy operationalization on entire populations and communities — and in effect, serves to erase the expertise of these individuals and communities in favour of nutritional expertise. In her critique of micronutrient nutritional interventions in West Africa that were led by white men (doctors and aid workers), Kimura notes that "supposed beneficiaries of nutrition interventions are rarely invited to discuss their experiences and actually work with nutrition experts and development practitioners" (43). Fortification in particular (rather than

supporting food production capacities, for instance) "gives greater control to experts" (43). Kimura's analysis of this one case highlights a number of issues that are replicated around the world in nutritional interventions. The two most important facets of Kimura's analysis that I want to narrow in on are: 1) those who are intervened upon are never understood to be subjects with expertise of their own circumstances and 2) nutrition interventions work to correct individual deficits, not structural deficits.

The Biocitizen

Citizenship has developed in healthism literature as a key area of intervention (Petersen and Lupton 1997). Citizenship – or biocitizenship – is closely connected to both individualization and expertise. Individualization often targets individual deficiencies with the aim of having individuals take responsibility for their health to be a better citizen. Expertise contributes here as well when it comes to rationalizing how citizens are expected to regulate their health and why – here I think of diabetes programs that expect individuals to engage in approved diet and exercise to reduce economic expenditures on health care. Skrabanek (1998) noted that governments had substantial investment in healthism and that "nations have become patients. To be healthy is a citizen's duty" (152). Government investment in healthism proves to be both ideological and economic. Interrogating how healthy citizenship is defined is useful for understanding how biopower works differentially here for producing biocitizens.

Medicalization (and subsequently healthism) has focused on correcting deviant behaviours by emphasizing the moral duty of individuals to correct deviant, unhealthy habits (Crawford 1980, 1994; Kimura et al. 2014; Brown 2018). The intertwining of morality and "health" has also meant that "healthy" citizens (usually middle class) can set themselves apart from citizens who fail to be active citizens, thus deviating from social norms of health (Rose

2007). Interventions in the areas of both deficiency and citizenship will focus on individual efforts to correct deviant behaviours, but will also call on individuals to be better biocitizens by taking all precautions against ill-health — which ultimately means ill-health for the nation when health care systems require excess economic expenditure. Individual deficiency will be a frequent target in interventions because healthism has situated the individual as being the be-all and end-all of health and illness. Individuals must change behaviours and resist all external factors impacting health. Delineating these all too common areas of intervention can tell us a lot about how health is differentially governed, particularly for Indigenous populations in Canada. Moreover, when health policy foregrounds expertise, citizenship, and individual deficiency in its approaches to health, it is a strong indicator that much has been left un-interrogated such as structural inequities, economic imperatives, and unchecked political power.

In healthism, individual deficiency is almost always intertwined with notions of citizenship and what is required of individuals to be healthy or good citizens. Julie Guthman (in Kimura et al. 2014) has argued that healthism has "aided the devolution of health responsibility from the public sphere to individual action and thus made the failure to achieve health a moral problem, deserving of social disapprobation" (34). Public health efforts that have employed healthism as a technique of health promotion have come to rely on "empowering those who appeared not to be self-actualized with health knowledge to make them better citizen-subjects as defined through neoliberal notions of personal responsibility" (34). Similarly, Kathleen LeBesco (2011) has argued that "the healthy body has come to signify the morally worthy citizen — one who exercises discipline over his or her own body, extends the reach of the state and shares the burden of governance" (154). Ultimately, the processes of biomedicalization and healthism have resulted in "health as a responsibility, rather than a right" which unfortunately, "repositions

subjects as at fault if they are deemed unhealthy, particularly if they had the information about how to achieve health" (156). In this type of scenario, the burden of health and responsibility has already been off-loaded onto the individual, and if they fail to achieve health they are still deemed as "at fault" because they were given the resources to self-regulate. But being educated into self-regulation cannot change the material circumstances of health.

In order to understand the implications of tying a moralized ideal of health to citizenship, we must move beyond solely focusing on the off-loading of responsibility and move towards thinking deeper about what it means to be a biocitizen under colonialism. Hayes-Conroy prompts us in such a direction:

> Thus, we need to ask, who benefits and who loses when the definition of a nourished body becomes limited to certain individualized health behaviors? And, what happens when differently nourished bodies are read as deviant? More importantly, how does the standardization and depoliticization of nutrition preclude us from understanding and practicing bodily health in ways that are more attentive to the complex realities of material life (2014, 41)?

I think these questions can lead us to further explicate whose bodies are read as deviant and in need of improvement under colonialism, and how biocitizenship requires a specific materiality (healthy food, access to health care, economic and educational resources) that often precludes non-white populations.

Expectations of biocitizenship such as individual responsibility for individual corporeal health and the economic health of the nation are echoed in Rebecca de Souza's (2019) *Feeding the Other: Whiteness, Privilege, and Neoliberal Stigma in Food Pantries*. de Souza has demonstrated how in an environment of top-down policy efforts and stigmatizing discourses "food insecure citizens navigate food choices and perform health citizenship amid material constraint" (191). de Souza's analysis is powerful for understanding how biocitizens are stigmatized by essentially failing to conform to healthism and the necessary health standards for

being an appropriate biocitizen. When biopower drives the operation of healthism it is used to shift responsibility onto marginalized and racialized individuals that are up against structures that deny access to health resources, while simultaneously creating the conditions to be left behind, ungoverned, or 'drain resources' because they have failed to meet the standards of biocitizenship.

Despite the breadth of the foundation of both healthism and medicalization literature, there has been little attention to how these processes are specifically enacted differentially on different populations within a single nation — namely, racialized or classed populations. In the next section I will turn to more contemporary theorizations of healthism that have engaged with race, indigeneity, and colonization in their analyses. Analyses that engage race, indigeneity, and colonization are absolutely necessary if we truly want to understand the brunt of healthism on populations in colonized countries that have been rendered non-normative, non-white, or non-middle class. Healthism and medicalization operate in service of social, economic, and political power, and while it necessary to interrogate those modes of operation beyond an altruistic process of improving health, without tending to the structures that form to allow its operation, or the processes by which it operates inequitably there will be an absolute failure to understand its ramifications beyond the white middle class.

Missing Links: Race, Indigeneity, and Colonialism

In the field of healthism, scholars who account for how healthism is used to regulate racialized populations are outliers. Some scholars admittedly attend to race more substantially than others. Kathleen LeBesco's (2011) "Neoliberalism, Public Health, and The Moral Perils of Fatness" begins with a news story of a missing 555-pound teenager, and a mother facing charges for fleeing the state with her son rather than face charges for medical neglect. LeBesco notes that

"their unsmiling, fleshy African-American faces peer out from dark backgrounds in grainy, unflattering pictures just off to the side of the article" (153). LeBesco connects this news story to anti-obesity school interventions (158) and forcible removal of fat children from their parents' care (154) as being indicative of neoliberal state interventions in obesity, and thus health and nutrition as well. When LeBesco returns to the news story later in the article, she notes that the mother and teen have been effectively rendered as Other through phrases like "medical neglect" and "fugitive," which alongside the images provided invoke imagery of the welfare queen and dangerous black male youth (156-157). Moreover, the idea of medical neglect connects back to how healthism operates through both medical expertise and by targeting individual deficiencies. State interventions in obesity, such as interventions in child welfare due to "medical neglect" of obesity, could tell us much more about the biopolitical structures of healthism if further care was taken to additionally interrogate how child welfare systems disproportionately affect Indigenous people and people of colour.

Scholars studying at the intersections of critical nutrition and healthism have captured the limits of seemingly altruistic nutritional healthism for Indigenous people or people of colour. In Kimura et al. (2014), Jessica Hayes-Conroy has argued that nutrition is a colonial practice that often occurs through a missionary approach that utilizes educational interventions in "at risk" populations and "trend toward 'culturally appropriate' dietary advice" (39). Hayes-Conroy notes that culturally appropriate dietary advice "often works to tokenize and co-opt diversity in ways that outwardly appear to celebrate difference, while in reality perpetuating hegemonic nutrition as a colonial project" (39). These programs have a mere veneer of cultural diversity "after the facts of nutrition science have already been stabilized and depoliticized" (39). These programs, like many healthism programs, rely on depoliticized and objective expertise to intervene in

individual nutritional deficiencies. An example Hayes-Conroy provides is USDA's food pyramids, which have been translated for a variety of "cultural traditions — including Native American, Latino, and Japanese" (39). Like the First Nations, Inuit and Métis Canada Food Guide, "'culture' is employed as a translation tool in an effort to promote Western dietary guidelines, while other health knowledges remain silent" (39). Putting a veneer of cultural diversification on existing nutritional programming does not alter the hegemonic nutrition at the base.

The Canadian context has a long history of state sanctioned nutrition interventions, especially for Indigenous populations, as demonstrated by historian Ian Mosby (Mosby 2013). Nutrition and biomedical experimentation in Indigenous communities and residential schools between 1942 and 1952 was an explicit intervention, but in the years since, nutritional interventions for Indigenous people still exist in federal biopolitical structures; they are just less explicit in their coercion (Mosby 2013). While some experiments were undertaken to assess scientific theories around caloric consumption (152), some of the interventions were also done with the aim of determining how Indigenous people could take part in their own improvement (Mosby 2013, 154). Mosby's accounting for the administration of colonial science through nutrition experimentation in Canadian residential schools illuminates essential history of nutritional intervention in Indigenous communities in Canada and in doing so, gleans insights for contemporary colonial interventions in nutrition, and the structures that exist to perpetrate them.

Nutrition as a colonial technology has replicated its modes of operation in different time periods, countries, and populations. In her section of Kimura et al. (2014), "Nutrition as a Colonial Project," Hayes-Conroy has highlighted that nutrition becomes a colonial practice by "teach[ing] others how to conform to appropriate forms of citizenship" through the rectification

of individual deviant behaviours through education on the need to eat healthy and correctly (38). As previously mentioned, Hayes-Conroy refers to colonial nutrition as missionary in its nature and notes that "those who take up this missionary approach first identify 'the other' by way of target populations — most often disenfranchised peoples: the poor, racial/ethnic minorities, single mothers, etc. — and then seek to 'educate' such populations on the importance and how-to's of eating well" (39). Hayes-Conroy ultimately posits that "the issue at stake seems to be one regarding nutrition as a (bio)political project, where citizenship and 'goodness' is determined by correct bodily behaviour" (41). The implementation of nutrition interventions that require self-regulation and education for populations that face inequities and marginalization is needlessly disciplinary, redundant, and coercive in nature. Such policies are presented with a humanitarian or altruistic facade, yet without attending to the material realities of those who are being intervened upon, healthism has little to offer. The colonial logics of nutrition and healthism interventions operate by individualizing collective issues — namely, turning community level food insecurity, inequitable access to foods, or high rates of "diet related diseases" into an issue of individuals needing to merely change their eating behaviours or educate themselves into better health.

Nutrition (and thus, healthism) has been well accounted for as a colonial concept and technique of biopolitical management but the structures it inhabits have been examined to a lesser extent. LeBesco (2011) acknowledged the intertwining of healthism and racism, yet failed to connect her case study of forced removal of children with obesity due to medical neglect to larger structural histories — particularly those of Indigenous people who have been targeted for child removal for decades — resulting in Stolen Generations, forced removal, and the Sixties Scoop (Haderer 2013; Haskins and Jacobs 2002). Connecting these histories can direct our

analysis to how existing structures of colonialism continue to disconnect families, coercively discipline morality and food consumption, and operate through new and innovative avenues. Here it is more important than ever to acknowledge the disservice of healthism literature that takes for granted who the subject of healthism is and to instead interrogate how healthism operates to individualize subjects from their greater communities that are being regulated en masse.

Analysis of healthism with an Indigenous subject in mind is absolutely necessary for robust interrogations of the limits of healthism. In regard to health and the practice of healthism, Brendan Hokowhitu (2014) contends that "underpinning racism and colonialism is biopower; in this context, the power to colonise justified upon the uncleanliness of the savage body," and thus "pathologizing Māori serves the allegorical function of describing the desired healthy body" (33). Hokowhitu goes on to argue that "during colonialism's cleanse, ambivalence sprung forth as the dutiful and domesticated colonised subject's tempered abhorrence for the unclean. To this end, 'rational society', including the morality of healthism, is plagued by *dis*ease" (33). This *dis*ease is "produced via the myth of universal knowledge," and "produces *invalids* . . . with invalid ontologies." Hokowhitu unpacks the intertwinement of *dis*ease and healthism:

> Healthism is sustained by the fact that being healthy signifies power as "ableness"; being able to afford the right foods; being able to afford the time to exercise; being able to afford the right education; being able to afford the time, land and resources to grow an organic garden; being *able*. These statements of power help enunciate the dialectic between healthy and unhealthy, able and *dis*abled. The biopolitical terrain that has produced healthism, therefore, demands alterity. The flipside of healthism is the allegorical figure of the *dis*abled, the monstrous unclean other, whose madness must be kept beyond the pale, cast adrift upon the *ship of fools*. The impossibility of "health," of being *able* as defined here suggests such abjection not only springs forth in the imagined distance between the Self and Other, but also just beneath the surface, in the liminal space where the failures to attain healthiness mount and mount (2014, 38).

*Dis*ease and healthism run rampant in theorizations of food security (Burnett, Hay, and Chambers 2015, 5; Balcaen and Storie 2018; Woodruff 2019). *Dis*ease is present in the way Indigenous peoples are subjected to colonial ontologies and notions of health when they are included in policy and research. Moreover, food must meet standards of healthism. Food security never includes unhealthy foods, they are relegated to an abject status, reserved for the unhealthy, or *dis*abled. I will return to Hokowhitu's further theorizations of how to get out from under the grips of *dis*ease later — for now I simply want to bring these theorizations into the fold as a beacon of the possibilities of engaging with healthism from an Indigenous Studies standpoint.

Given the obvious connections between healthism and biopower, it is puzzling to see such a lack of robust theorization of the interconnectedness of biopower, healthism, and Indigeneity. However, the way in which biopower bears on the lives of Indigenous peoples has been taken up by several scholars to theorize the intersections between biopower, whiteness, settler states, and Indigenous health — their insights bridge the gap that exists in healthism literature. Stefan Haderer (2013), for example, delineates how Foucault's "genealogy of the development of racism and biopower are useful for understanding how whiteness became an arbitrary marker of biopolitical health in Australia and how the very notion of whiteness came to be used as a tool of power to consolidate the positions of the historically privileged and marginalised" (8). While Haderer focusses on the biopower associated with the "biological and cultural assimilation policy in Australia" which resulted in "more than 100,000 members of the Stolen Generation," the larger ideas of how whiteness shapes, regulates, and decides health to the boundaries of life and death, is connected and in conversation with other researchers as well (2013, 15-16).

Similarly, Isaac Warbrick, Andrew Dickson, Russell Prince, and Ihirangi Heke (2016) indicate that biopolitics link how populations are "imagined and understood as a problem – for example as overweight, unhealthy, unequal and so on – and the seemingly mundane techniques through which that reality is constructed – for example with statistical tables, diagrams and graphs – and performed – such as through public health programmes that target the problems being imagined and displayed" (397). When such understandings are filtered through whiteness, it is no surprise that "problematic subpopulations emerge through particular biopolitical techniques," and thus "we need to ask what these consequences might be for how people in those subpopulations will be subjectified and disciplined" (Warbrick et al. 2016, 397). Regulation of health according to whiteness, and subsequently the individualization of health, will fall short of actually meeting health needs of Indigenous peoples (Warbrick et al. 2016, 398). For food security policy this will require interrogation of how food is framed in relation to whiteness, to health, and to discipline and regulation of populations. In Canada, there has been next to no Indigenous designed federal food policy; whiteness[32] therefore continues to serve as a filter for what foods are deemed healthy and acceptable, and discipline and regulation is employed on Indigenous populations that have been identified as having high rates of obesity, diabetes, and other nutrition related concerns.

Those who have engaged the field of healthism have laid a sufficient foundation for theorizing critical components of how healthism operates. Given the genealogy of healthism as an academic avenue of inquiry, and the history of healthism as a practice in the world, it is disappointing to see how race has been so marginally attended to. Perhaps it is precisely the lack

[32] Here I draw on Aileen Moreton-Robinson's (2006) definition of whiteness as "the invisible norm against which other races are judged in the construction of identity, representation, decision-making, subjectivity, nationalism, knowledge production and the law" (388).

of attention to race that has also led to an under theorization of how healthism operates through structures and apparatus — the mechanisms through which biopower flows and state racism is carried out in the name of managing the health of populations – resulting in what I have identified previously as *differential governmentality*. Without interrogating how and where healthism operates through apparatuses of governmentality, we miss the opportunity to identify how healthism is implemented to off-load responsibility for population wide health issues. As it stands, the bulk of healthism literature is theoretical in nature, but not empirically robust — if scholars actually begin to empirically trace how and where healthism operates through apparatuses of governmentality it would be much harder to only conceptualize healthism within the limits of whiteness.

Healthism's Entanglement with Food Security

In the final sections of this chapter, I will transition to the empirical context of how healthism has become entangled with food security to begin to identify how individualization, expertise, and expectations of appropriate citizenship flow through framings of food security. The conceptual affinity between healthism and food security that I am making in this chapter warrants brief discussion as it pertains to how I theorize the flow between the two. Healthism provides a conceptual framework for thinking about medicalization, self-regulation, discipline, and hegemonic nutrition as it relates to health at the level of the individual. If we look to food security (in policy and research) we can see what healthism looks like in practice. Approaches to food security carry forward the very practices that scholars of healthism have been attempting to intervene in such as moralizing food, relying on hegemonic nutrition, focusing on individual deficiencies, and tying correct and healthy food choices to promote good biocitizenship. Interrogating the coupling of food security and healthism is a necessary venture because while

healthism often bases its analysis in health interventions at the level of the individual, it often fails to address how it works beyond the individual. Food security is a community level issue and thus provides a remarkable case study to understand how healthism is operationalized to govern the health of a population.

Nutrition is a flash point for the professionalization and technical expertise of health interventions in which experts such as doctors, nutritionists, food scientists, and policy makers (to name a few) exercise a will to improve (Kimura et al. 2014, 37; Li 2007b). Nutrition is the tie that binds healthism and food security. In her analysis in Kimura et al. (2014), Hayes-Conroy argues that hegemonic nutrition relies on three central assumptions — first, “that the food-body relationship can be standardized (as in through the standard of calorie);” second, “that nourishment can be reduced to macro- and micro-nutrients;” and third, “that nourishment is universally equivalent and thus can be decontextualized from the political-economic, socio-spatial, and cultural locations in which it takes place” (39). It takes a countless number of experts to maintain these assumptions — to define them, to regulate them, to enact them. Mayes and Thompson (2014) have put forward the important argument that “non-nutritional features of food are valuable for ontological security and flourishing . . . [but] in the current biopolitical context, such arguments are rarely put forward. Instead, it is assumed that individuals are obligated to choose for health, as defined by biomedical and nutritional sciences” (166). The governmentality of nutrition and its administrative goals seeks accountability from individual subjects yet offers no such reciprocity in its promises.

Food security has become intimately intertwined with nutrition promotion — some reasons for this connection make sense, while others are more bewildering. Having the right to access quality food is a pinnacle of food security, whereas being educated into counting calories

or choosing foods that fit within hegemonic nutrition guidelines makes less sense when the primary concern of food insecurity is not having sufficient access to meet your needs. However, when food security policies specifically define food as healthy or nutritious, it makes it easier to transition policy to narrow in on issues of health or nutrition, rather than the bigger issues at hand such as sufficient and safe access or cultural preference.

To back up for a moment, any discussion of healthism and its intersections with food security must be prefaced by a brief discussion of what exactly constitutes *food security,* to distinguish why it cannot be achieved through the processes of healthism. Existing research on food security tends to be aligned with some version of the World Health Organization's (WHO) definition which defines food security as including access to sufficient, safe, and nutritious food that also meets the individuals' food preferences.[33] It is worth noting that the United Nations Food and Agricultural Organization (FAO) envisioned food security as being "based on universal human rights, including food as a right, [but this] was replaced in 1986 when the World Bank redefined food security as the ability to buy food" (Constance et al. 2014, 28). However, there have been many changes to the definition of food security over the past several decades, and one study identified 32 different definitions between 1975 and 1991 (Maxwell and Frankenberger 1992, 68-70). The definition used by Health Canada is relevant to understand the policy context in which advocates appeal for solutions to food insecurity. The current Health Canada definition is:

> Food security exists "when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life." Household food insecurity is "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the

[33] FAO, IFAD, UNICEF, WFP, and WHO. 2019. *The State of Food Security and Nutrition in the World 2019: Safeguarding Against Economic Slowdowns and Downturns*. Rome: FAO.

> uncertainty that one will be able to do so." It is often associated with the household's financial ability to access adequate food.[34]

While some definitions of food security are more reflexive of the social context in which food injustice (and thus food insecurity) occurs, and account for a broader physical, social, and economic context in which individuals access sufficient, safe, and nutritious food, it is rare to see food security conceptualized beyond the individual.[35]

Food security holds a multitude of meanings for a multitude of people, and while we can begin from general understandings such as having access to food, communities need to be able to determine what food security means for themselves. The individualization that has occurred through conceptualizations of food security — particularly the tracking of *household* food insecurity — has been criticized in the nutrition and public health field due to the limitations of thinking of food insecurity as a phenomenon that happens within the confines of individual households (Engler-Stringer 2011, 136). In the late 1990s, scholars in nutrition and public health began to use the term "community food security," which built upon existing definitions of food security to be inclusive of community food security goals in which all residents access safe, nutritious, and culturally acceptable foods in a way that maximizes self-reliance and social justice (Engler-Stringer 2011, 136-137). This is a particularly necessary intervention because what we see from food security data in Canada is not that household food insecurity is a sparse

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[34] Health Canada. "Household Food Insecurity in Canada: Overview." *Government of Canada*. Accessed September 19, 2019. https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/household-food-insecurity-canada-overview.html. Health Canada cites the following sources in their definition of food security and food insecurity: Food and Agriculture Organization. *Rome Declaration on World Food Security and World Food Summit Plan of Action*. Rome, Italy: FAO, 1996. Available at: www.fao.org/docrep/003/w3613e/w3613e00.htm and Davis B, Tarasuk V. "Hunger in Canada." *Agriculture and Human Values* 1994;11(4):50-57. Website has since been modified and cited information is no longer available but can be found on a web archive dating back to September 26, 2019.

[35] Food and Agriculture Organization (FAO). 2003. *Trade Reforms and Food Security: Conceptualizing the Linkages.* Rome: United Nations. See chapter 2 on concepts and measurements of food security.

phenomenon affecting individuals, but that food insecurity largely impacts entire communities of people such as Indigenous people, newcomers, and low income neighbourhoods.[36]

When entire communities are disproportionately affected by food insecurity, it indicates that food insecurity is not merely an *individual household* problem. Framings of community food security seem to have gone to the wayside in favour of more status quo analytics of food security and nutrition. If research were to approach food security from a community perspective that grounded analysis in local experiences, while still looking to broader macro-level political, economic, and social structures that contribute to food insecurity, status quo solutions to food insecurity that only account for individual experience could be avoided. In the next section I outline how healthism has been taken up in food security research, and why healthism should not be equated with food security.

Healthism ≠ Food Security

In this section I want to return to the themes of individual deficiency, expertise, and citizenship to consider how food security policy and researchers have continued to perpetuate healthism as an adequate response to food insecurity. The goal here is to demonstrate the way in which the line between adhering to hegemonic nutrition and food security has been blurred. In this section it will be necessary to reflect back on Canada's food guide and its role as a technology of the biomedicalized hegemonic nutrition conglomerate. The food guide is an established source of nutrition guidelines that are reiterated through food security research when experts invariably comment on how the food insecure should eat.

[36] Tarasuk, Valerie and A. Mitchell. 2020. *Household Food Insecurity in Canada, 2017-18.* Toronto: Research to Identify Policy Options to Reduce Food Insecurity (PROOF), 13.

Healthism permeates research of food insecurity across Canada whether the focus is on Indigenous or non-Indigenous populations, rural or urban communities, or community-based or policy oriented inquiry. In their analysis of federal policy and media accounts of food insecurity in Canada, Sarah Wakefield, Kaylen R. Fredrickson, and Tim Brown (2015) have importantly outlined how national narratives of food insecurity rely on geographic imaginaries of Canada as a place of abundance, while simultaneously socially excluding some populations from that abundance, particularly Indigenous peoples. Such a vision of Canada as abundant has often led to "a distinction between 'real' hunger (experienced elsewhere) and what is experienced in Canada, which is apparently less real or meaningful" (2015, 88).

Moreover, when food insecurity and hunger is conceptualized as "not in my backyard," it works to void the experiences of the food insecure (of which a large percentage is Indigenous peoples, proportionately speaking) as a non-issue. At the same time, renderings of Canada as a place of abundance has resulted in emphasizing education, opportunities for individuals to improve circumstances, and the "responsibility of individuals to adopt appropriate self-care measures" in regards to health — all of which fall short when people have inequitable access to food (2015, 87). Such a prominent framing of Canada as a place of abundance, in which citizens have the opportunities to implement self-care while living amongst the resources to not be hungry, proves to be entirely ignorant of any structural, racial, or colonial determinants of health. No amount of self-care or self-regulation can ameliorate the biopolitical structures of Canadian colonialism and whiteness that have consistently worked to regulate and discipline Indigenous life.

Food security research that relies on healthism to understand and to resolve food insecurity has commonalities in its definitions of nutrition and health, how food insecurity

equates to poor health, and what the necessary solutions to food insecurity are. In their article on food security community interventions in Montreal, Federico Roncarolo, Caroline Adam, Sherri Bisset, and Louise Potvin (2015) compared traditional interventions in food insecurity such as food banks and food redistribution to alternative interventions such as capacity and skill building programming. The authors found that individuals using traditional interventions had lower food and nutrition quality compared to those who participated in alternative interventions (Roncarolo et al. 2015, 883). However, they also noted that participants using traditional interventions were more preoccupied with survival and easily accessible resources. In this case, being food insecure has been understood as having poor health and interventions in food insecurity further entrench poor health. It seems that interventions that would provide greater equity in access could be more appealing than interventions that promote individual knowledge capacities of health and nutrition (Roncarolo et al. 2015, 880). Joyce Slater and Fiona Yeudall (2015) have proposed expanding food security to include nutrition security, which would require individuals to have "adequate nutritional status in terms of macro- and micronutrients" (1). Slater and Yeudall (2015) argue that neither individual, household, nor community food security acknowledge that individuals may not have the knowledge, or live in appropriate environs, to achieve acceptable nutrition (2). Slater and Yeudall merge these two approaches to "achieve public health nutrition goals" (2015, 1). They recommend interventions to improve food and nutrition security alongside consideration of the "context of people's chosen livelihood strategies" and to reinforce positive aspects by "promoting opportunities and mitigating constraints" (Slater and Yeudall 2015, 12). The food insecure are thus morally obliged as biocitizens to improve not only their food security, but their nutrition security as well.

What these approaches have in common are their baseline definitions of health and nutrition, which are invariably determined by Health Canada guidelines. In relying on dominant understandings and renderings of health and nutrition science distilled via the Canadian government, food insecurity becomes equated to poor health through inadequate readings of nutrition science that fail to distinguish a difference between correlation and causation, and fail to grasp the impact of social, economic, and racial structures on food insecure communities. Interventions that rely on individual self-regulation and knowledge, even if they follow chosen livelihood strategies and promote opportunities such as Slater and Yeudall suggest, will fall flat if they do not provide agency for people in making their own health and nutrition choices, and if they do not begin to grasp food insecurity as a phenomenon beyond a failure to eat nutritious food.

The laser focus on health and nutrition in food security research with Indigenous populations is frequently taken up in worrisome ways. Food insecurity is frequently directly tied to, and conflated with, poor nutrition, obesity, and diet related diseases. Treating food insecurity as an individual failing of health results in proposed nutrition interventions, even for children (Genuis et al. 2014), as well as a focus on "eating behaviour" (Willows 2005, S33), both of which serve to establish food insecurity as an outcome of unhealthy eating, and not the other way around. Noreen Willows has noted that dietary practices of Indigenous people "pose significant health risks" (Willows 2005, S32), and has noted elsewhere that "the conditions of food insecurity and obesity overlap" (Willows, Hanley, and Delormier 2012, 5).

It is thus troubling that populations who face high rates of food insecurity due to socio-economic barriers, often exacerbated for Indigenous populations, have larger issues of inequity rendered down to an issue of self-regulation. One of the more baffling conflations of food

insecurity and nutrition that I have come across has compared household food security status for an Indigenous population aged 18+ based on fruit/vegetable intake. Insecure and secure households were compared for measures of whether they consumed fruit/vegetables at least five times a day, or less than five times a day. 91% of food insecure households consumed fruit/vegetables less than five times a day, whereas 83% of food secure households consumed fruit/vegetables less than five times a day (Willows et al. 2011, 17). While these statistics do show a difference in fruit/vegetable consumption between households, the rate of food secure households who indicated less than the standard nutrition guidelines for fruit and vegetable consumption indicates that adhering to nutrition standards is not necessarily indicative of how individuals understand their food security status.

Using nutrition to intervene in food insecurity also closes off possibilities for other understandings of what constitutes health and nutrition, and closes off opportunities for agency in food choice. Policy recommendations that are based in healthism result in interventions based at the individual level in which the food insecure individual is expected to make dietary and lifestyle changes within a social context that is entirely unchanged and still has long term economic, social, racial, and environmental barriers that restrict the capabilities of food insecure populations to have equitable access to food. For Indigenous people, this means that colonialism sometimes figures as an event that occurred and shifted dietary patterns, but is rarely engaged with as an ongoing process with material and structural realities that shape the everyday experiences of food security.

I cannot emphasize enough how important it is to understand how food security operates through apparatuses of biopower. Common improvements upon food insecure populations include supporting access to healthy foods through the creation of a new grocery outlet to bring

appropriate, 'healthy' food to neighbourhoods that are rendered deficient or incapable of making healthy choices with the available options or through the education of individuals to make better food and purchasing choices with their limited resources. These improvements These are not non-political solutions that meet the needs of the food insecure. These solutions exist within networks of biopower that draw on technologies such as discourses of healthism grounded in self-regulation, biopolitical governance that produces policies and institutions invested in the disciplining and regulation of populations, all while producing asymmetrical power relations. Rebecca de Souza (2019) has theorized approaches to food insecurity such as food banks, food stamps, and welfare as neoliberal enclosures that employ techniques of governance that transform and exert control over individuals "not by direct coercion but by creating self-regulating bodies through procedures of supervision, assessment, and evaluation" (221). It is within apparatuses that solutions to food insecurity (supporting access to healthy foods, eating healthy to rectify diet related diseases, promoting hegemonic nutrition with a "culturally appropriate" facade, nutritional education interventions) serve to reproduce forms of colonial citizenship that require self- discipline and regulation with no real resources to achieve "health" or "food security."

Food insecurity in Winnipeg, for example, has been geographically imagined according to such terms as a "food desert," "food mirage," and "food swamp."[37] Research that is occupied with spatially placing food insecurity seems to be much more oriented towards policy recommendations than other literature, perhaps because of the close ties to city planning and

[37] In addition to the interrogation of Winnipeg's inner-city being imagined as a food desert, mirage, or swamp and how Indigenous people are rendered as bad biocitizens within these spaces, it is also necessary to note the troubling ecological metaphors that are employed with these imaginings. The colonial logics at work with these ecological metaphors situate deserts as devoid of life, and swamps as places of danger. However, both deserts and swamps are vital ecosystems and scholars have been calling for a halt to such metaphors that only serve to further misunderstandings of urban food environments and ecosystems, and further "colonial settler subjective understanding" of racialized ecologies (Snorton 2019). Also see: Elton 2018.

geography, and the types of policy recommendations being made are cause for concern. Within these geographical imaginings and spatial reasonings of food insecurity, there is also a variance in why individuals need access to "healthy foods" — spoiler alert, flooding environments with "healthy foods" as determined by dominant (white) nutrition guidelines is deemed the only respectable response to food insecurity. One study on food deserts in Winnipeg noted that food deserts are concentrated in the downtown core (Slater et al. 2017, 353). The methods for determining availability of food only accounted for full-service grocers and national chains (not convenience stores, ethnic food stores, small food shops, or bargain stores) because their metrics for grocers required "a good selection of self-serve fresh fruits and vegetables (i.e. more than potatoes, onions and bananas, and not prepackaged), fresh meat and dairy products at reasonable prices (i.e. close to national chain prices)" (Slater et al. 2017, 352). Not only does this limit what constitutes access to food, and healthy food, but it also limits our understandings of food deserts to the ability to economically access foods sold through particular modes of capitalism.

Similar limits are apparent in research that has named Winnipeg's inner-city a food mirage (Wiebe and Distasio 2016) — a space in which healthy foods are available but individuals do not have the economic means to go into those spaces and come out with the food they need. The authors of the food mirage study posit that their research "helps local organizations make informed policy and program decisions on urban food issues by identifying key neighbourhoods at risk of health problems related to a lack of access or inability to purchase healthy food" (Wiebe and Distasio 2016, 3). We should be asking what kind of policy outcomes could result from knowing that people have physical and economic barriers to accessing food — does this information support the building of a mega grocery store, or will it result in advocating for basic income, better housing, and less policing? Critical questions need to be asked about

what this data will do when used for policy recommendations, and whether the onus of responsibility will be put back on individuals to learn how to stretch their dollar, or to make more health-conscious buying decisions from their available retailers.

The classification of Winnipeg's inner-city as a food swamp is insidious. Martine Balcaen and Joni Storie (2018) sought to evaluate nutrition environments by measuring "geographic food access in combination with the socio-demographic factors associated with eating patterns" (15). Their study comprised of "a geographic assessment of food swamps using (1) a Socioeconomic Deprivation Index (SDI) based on seven Census variables, (2) distance to restaurants, and (3) clustering of restaurants, to identify at-risk locations and populations" (Balcaen and Storie 2018, 15). I want to belabour the metrics of assessment for a moment and note that "the seven census variables used to create the SDI were taken from Wiebe et al. (2016) and include low education (no certificate or diploma), low income families (less than median after taxes), walking as main transportation, unemployment rate, total recent immigrants, total lone parent families and Aboriginal-identified population" (Balcaen and Storie 2018, 17).

Using these variables situates being Indigenous as an indicator of socioeconomic deprivation, and thus, ultimately in need of intervention and improvement. Balcaen and Storie are incredibly oriented towards policy outcomes of their findings, noting: "If an area is a food desert, then policy focus should be on accessibility and affordability. In comparison, if an area is a food swamp, the policy should be on deterrents to unhealthy food choices" (2018, 15). Policy resulting from the different framings of desert, mirage, and swamp could result in wildly different outcomes. The underlying insidious nature of healthism within conceptualizations of food swamps and the need to merely "deter" unhealthy food choices could result in real harm if a severely food insecure environment is reimagined as a food swamp that merely requires

individuals to self-regulate their food choices better, instead of receiving material support to remediate food insecurity. Balcaen and Storie argue that "policies need to address zoning restrictions on restaurants, establish tax incentives to grocery stores, provide grants and loans to service high-risk populations, offer alternative strategies to curb poor dietary consumption patterns or further refine initiatives to support retail food projects in underserved areas" (2018, 21). These interventions are troubling because they seem to favour dietary self-regulation and cushioning capitalist ventures. The absolute preoccupation with the nutritious foods touted by moralizing hegemonic nutrition does an additional disservice by failing to account for the non-nutritional features of food that are so essential to urban inner-city communities.

One of the most concerning gaps I have identified is the lack of attention to the misuse of nutrition through framings of food security. Healthism literature recognizes nutrition as both hegemonic and missionary, but does not specifically account for how nutrition is used against the food insecure for failing to be good biocitizens through their moral and nutritional deficiencies. The few renderings of food security covered thus far have demonstrated how subjects do not get to be transformed from food insecure to food secure without going through a process of becoming healthy. Much like the other shortcomings of healthism, it is likely that this gap in the literature can be traced back to the lack of accounting for intersections of race, Indigeneity, and colonialism to any serious extent. If race, Indigeneity, and colonialism are taken seriously as both key drivers of healthism, as well as key compounding factors of how healthism operates, then it will be much harder to ignore the misuse of nutrition through food security research and policy.

Conclusion

I want to bring us back to the limits and bounds of healthism as a concept to make sense of biopolitical interventions in health. Healthism literature has varied widely since its inception in the 1970s. In this chapter I have focused on several main arguments that have remained fairly consistent over the decades – 1) healthism operates through the individualization of health and off-loading of responsibility onto the individual to ameliorate their deviance/deficiency; 2) expert definitions of health and illness (amongst other areas of 'expertise') have established the rationale and technological interventions to be carried out in programs of healthism; and 3) self-regulation of health has been linked to citizenship expectations. I have remained focused on these three areas because they demonstrate the strengths of healthism literature, while also proving useful for identifying how it operates in an apparatus of healthism in later chapters. Healthism literature has no shortage of limitations – the literature has never substantially engaged with race, biopower, or deep empirical contexts. The fact that in the decades since Zola and Crawford theorized healthism the focus has moved towards middle-class white people and not how healthism is taken up to differentially govern health is an unacceptable fault. My research addresses these shortcomings through both my theoretical framing and empirical context. This research undertakes a thorough analysis of how an apparatus of healthism sustains processes of healthism that operate in inequitable and differential ways for Indigenous people in Winnipeg, particularly in the area of food security. In the next chapter I begin this analysis by focusing on *the individual and the body politic* in Winnipeg to delineate how self-regulating subjects of governmentality foreclose opportunities of food security (and opportunities to be the biocitizens expected by proponents of healthism) through white possessive securitization. The individual and the body politic is a productive framing both theoretically and empirically to

delineate how race and whiteness operate in tandem with governmentality. Attending to the individual, the body politic, and how individuals and the body politic are co-constituted and interact in a multitude of formations is a necessary endeavour to understand how governmentality results in differential governance, and how these formations and relations materialize in a specific empirical locale.

Chapter Four – The Individual and The Body Politic

What feels illegal, but isn't?
Shopping in Winnipeg businesses as an Indigenous person.
– @lovelyjess and @LenardMonkman1[38]

White people are not simply "protected" by the police, they *are* the police.
– Frank B. Wilderson III[39]

I begin with these two epigraphs – they feel fitting as they evoke many of the everyday realities and immediacies of life in Winnipeg. Food security and healthism in Winnipeg must be examined within the context that Indigenous people are subject to multiple forms of policing when carrying out the most basic and essential everyday processes such as grocery shopping. In this chapter I connect the rationalities of whiteness and governmentality to the material points of application of apparatuses of healthism – including grocery stores, city budgets, and policing. In the governmentality of health, individuals are meant to become part of an apparatus of governmentality by self-regulating their own health and behaviour – but also by taking up a form of citizen governmentality in which citizens have become those who govern themselves and others. The methodological imperative of governmentality requires that I not only look to government policies and institutions that rationalize and intervene in health through programs and technologies of healthism, but to all corners of the apparatus of healthism, which includes other biocitizens who have been institutionalized into the apparatus or not. In this chapter I focus on *the individual and the body politic* to illustrate the pathology of whiteness as governmentality.

[38] Monkman, Lenard (@LenardMonkman1). 2020. "Shopping in Winnipeg businesses as an Indigenous person." Twitter, February 3, 2020, 1:02 p.m. https://twitter.com/LenardMonkman1/status/1224407841278054400. Monkman responded to a tweet by @lovelyjess that asked, "What feels illegal, but isn't?" and is no longer available on Twitter.
[39] Frank B. Wilderson III. 2010. *Red, White & Black: Cinema and the Structure of U.S. Antagonisms.* Durham: Duke University Press, 82.

In the previous chapter I introduced healthism and argued that it often gets employed as a tool of differential governance for Indigenous people and other non-white populations. I criticized analyses from the field of healthism for their failure to engage with race, biopower, and empirical contexts that demonstrate where and how healthism operates. In this chapter I begin to bridge these gaps by situating the incongruity of healthism for Indigenous residents in the context of Winnipeg. It may seem like a conceptual leap to link the biomedicalized hegemonic nutrition and the self-regulation of health that is promoted through governmental, not-for-profit intermediary, and research approaches to food security that perpetuate healthism to racism, white possession, securitization, and what some have called the police state of Winnipeg (Wilt 2019). However, the expectations of healthism in the context of food security that require individual initiative to correct deficiencies, adherence to expert knowledge about appropriate foods, and deeply flawed colonial measures of citizenship cannot be divorced from the social context and experiences of Indigenous people in Winnipeg. In this chapter I consider how white possessive securitization of food, resources, and spaces in Winnipeg renders any policy solution entrenched in healthism inadequate for meeting individuals' food needs and is ultimately disciplinary. I argue that prescriptive programs of 'health' that govern food insecurity with apathy and policing should be abandoned in favour of more transformative approaches to food security that are grounded in *community care*.

Being differentially governed through the operationalization of healthism and not having access to the material resources required to be a successful subject of healthism is not merely an oversight – it is intentional. Differential governing of health requires and banks on inequity (Skrabanek 1998; Coyte and Holmes 2006; Williams and Fullagar 2019; Lea 2020). Mary Jane Logan McCallum and Adele Perry have written on the structures of indifference, such as

biomedical facilities, which shape Indigenous life (and death) in Winnipeg (McCallum and Perry, 2018). McCallum and Perry remark that an "insult of colonization is that the myths of our settler society hold that ill health and early deaths of Indigenous people are their own fault, bearing no relation to the historical context of social, economic, and cultural oppression stemming from colonialism, white supremacy, and racism right here at home" (2018, 102). The differential governing and off-loading of responsibility, and thus blame, onto Indigenous people for their health when structural realities work to make achieving health as required and envisioned by colonial logics near impossible is precisely why understanding the links between healthism and white possessive securitization is so important. Interrogating these structures that have remained largely invisible to those entrenched in their own whiteness is of the utmost importance to begin to disrupt and alter the conceptual landscape of Indigenous food security.

In this chapter I theorize the concepts and processes of white possession, securitization, and policy/policy to demonstrate how *white possessive securitization* operates through the individual as a form of governmentality. White possessive securitization operates through vigilantism, securitization of food resources, and multiple modes of policing and surveillance. I provide three vignettes to demonstrate how these theoretical concepts come to life in Winnipeg via grocery stores, austerity budgets, and policing. I argue grocery stores, city budgets, and policing exist within an apparatus of security that operates alongside an apparatus of healthism, which results in the inability for Indigenous people to access 'healthism approved' forms of food security and the differential governmentality of Indigenous health.

White Possessive Securitization

White Possession

Whiteness and white possession underlie and structure the rationalities, programs, and technologies of colonial governmentality. Critical Indigenous studies scholar Aileen Moreton-Robinson (2006) has defined "whiteness as the invisible norm against which other races are judged in the construction of identity, representation, decision-making, subjectivity, nationalism, knowledge production and the law" (388). White possession operates to maintain these constructions. Black studies scholar George Lipsitz has theorized how a possessive investment in whiteness operates through logics of capital. Lipsitz uses the framing of possession to connect the relationship between "whiteness and asset accumulation in our society, to connect attitudes to interests, to demonstrate that white supremacy is usually less a matter of direct, referential, and snarling contempt and more a system for protecting the privileges of whites by denying communities of colour opportunities for asset accumulation and upward mobility" (2006, viii). Moreover, "whiteness is invested in, like property, but it is also a means of accumulating property and keeping it from others" (2006, viii). Of course, white possession extends beyond mere property ownership – it is essential to the ongoing operation of colonialism and operates in "white people's daily lives" through "racialising discourses the reproduction of inequality" (Moran 2004, para. 6).

Moreton-Robinson (2015) theorizes how the regulatory mechanisms of colonial nation-states work to reaffirm and reproduce "possessiveness through a process of perpetual Indigenous dispossession, ranging from the refusal of Indigenous sovereignty to overregulated piecemeal concessions" (xi). Moreton-Robinson's conceptualization of *possessive logics* indicate:

> a mode of rationalization, rather than a set of positions that produce a more or less inevitable answer, that is underpinned by an excessive desire to invest in reproducing and

> reaffirming the nation-state's ownership, control, and domination. As such, white possessive logics are operationalized within discourses to circulate sets of meanings about ownership of the nation, as part of commonsense knowledge, decision making, and socially produced conventions (2015, xii).

Moreton-Robinson makes it clear that possessive logics extend beyond possession of property. Perhaps most importantly, "subjects embody white possessive logics" (Moreton-Robinson 2015, xii). Possessive logics occupy a central role in liberal governmentality, especially when it comes to reaffirming and *securing* the state's economic position by investing in forms of health governance that require citizens to become better biocitizens by self-regulating health and reducing economic expenditures that the state needs to make to maintain a healthy population (Rose 2004; Rose 2007). In Winnipeg, we see the rationalization of such possessive logics, and their subsequent embodiment, in the efforts of individual citizens to retain and securitize their possession over resources.

I will return to this later in the chapter with examples that elucidate how the criminalization and policing of Indigenous people in inner-city Winnipeg is directly connected to white possession and the embodiment of white possessive logics by subjects who act at the behest of the white possessive logics of colonial governmentality. I will briefly note that one mechanism through which this occurs is citizen policing such as the Downtown Winnipeg Biz patrol – a private citizen run patrol that is meant to make a "safer and friendlier downtown."[40] The patrol is for the benefit of business owners in the city, and for the safety of white inner-city goers – not for the benefit of the Indigenous people who live, work, and move through the inner-city every day. For white settlers, it is likely that they think the patrol does just this, keeps

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[40] Downtown Winnipeg BIZ. n.d. "Volunteer Watch Ambassador." Downtown Winnipeg BIZ. Accessed May 15, 2020. Downtown Winnipeg BIZ. n.d. "Watch Ambassadors." Downtown Winnipeg BIZ. Accessed May 15, 2020. http://www.downtownwinnipegbiz.com/wp-content/uploads/2013/05/Volunteer-Watch-Ambassador-Job-Description.pdf.

downtown "safe" without giving thought to this extra mechanism of white possession. Yet as Moreton-Robinson notes, "for Indigenous people, white possession is not unmarked, un-named, or invisible; it is hypervisible" (Moreton-Robinson 2015, xiii). Similarly, Sara Ahmed posits that "whiteness is only invisible for those who inhabit it" (2004, para. 1). Simeon Moran has demonstrated how whiteness "manifests through the ordinary social praxis of white subjects" through the example of how whiteness can lead to "white individual's [sic] feeling uncomfortable in the presence of racialised difference, which can impact upon their personal behaviour in such contexts" (2004, para 21). Moran argues that "whiteness shapes the social worlds and communal spaces" of everyday life, and as such, race may influence "where a subject chooses to go to shop," or "the assumptions some policing power makes as it approaches a non-white subject," and that ultimately, "being classed as non-white in such contexts can impact directly and negatively on the experience of daily life and the range of opportunities that it presents" (2004, para 21). In the context of Downtown Winnipeg Biz patrol, we can consider how whiteness influences the securitization of everyday spaces for individuals who are made hypervisible in distinction from whiteness.

White possessive logics resonate productively with theorizations of racial capitalism. When I speak of racial capitalism, I draw particularly from Owen Toews' *Stolen City: Racial Capitalism and the Making of Winnipeg*. Toews delineates capitalism as always/already *also* racial capitalism, in that it has always used racial structures to justify the thefts, attacks, and inequalities inherent to it, while simultaneously making them appear proper, inevitable, and just (2018, 18). Toews argues that, "as Winnipeg's past and present demonstrate, racist thinking is used to excuse capitalist inequality in many different ways, from straight-up vilification of oppressed groups to more cunning ways of feeling that promote the sense that oppressed groups,

perhaps through no fault of their own, are not quite ready to enjoy self-determination or a humane standard of living" (2018, 18). Toews contends that "while capitalist structures are not solely responsible for racism in our society, neither are they passive inheritors of it, as if racism was simply human nature. Rather, capitalist structures . . . actively renew, renovate, and entrench racial hierarchies, feelings, and practices" (2018, 18). Racial capitalism and white possession renovate racism through differential governmentality that seeks to produce consumer biocitizens who buy and regulate themselves to better health, while simultaneously rationalizing securitization of resources from those deemed unworthy.

Maintaining the *security* of the white possession is an integral undertaking of white possessive logics (Harris 1993; TallBear 2013; Moreton-Robinson 2015; Leroux 2019). Moreton-Robinson argues that as a regime of power "patriarchal white sovereignty operates ideologically, materially, and discursively to reproduce and maintain its investment in the nation as a white possession. One of the ways in which the possessive investment manifests itself is through a discourse of security, which supports the existence, protection, and maintenance of patriarchal white sovereignty" (139). Moreover, the colonial nation-state undergoes a constant remaking through various forms of security – it must constantly secure its possession (Moreton-Robinson 2015, 144-145). In the Australian context, Moreton-Robinson has argued that discourse of security is "inextricably linked to an anxiety about dispossession shaped by a refusal of Indigenous sovereignty with clear roots in white supremacy" (2015, 152). White possessive logics have been well theorized as operating to secure white possession, whether it is through property and white supremacist premises racial exclusion (Harris 1993, 1737), or through the possession of Indigenous lands, lives, and biomatter (TallBear 2013; Leroux 2019), or simply through the hoarding of resources required for health to the exclusion of others (Rail and Jette

2015, 331). Securitization in all of its forms is inevitably at odds with Indigenous sovereignty and is a manifestation of white possession and white supremacy.

In the context of Winnipeg, it is essential to understand how *white possessive securitization* operates individually, structurally, and systemically. Lipsitz (2006) reminds us that if we only consider "conscious and deliberative individual activities, we will be able to discern as racist only *individual* manifestations of personal prejudice and hostility" but it is necessary not to lose sight of "systemic, collective, and coordinated group behaviour" (20). In the remainder of this chapter, we will see examples of both individual manifestations of racism, as well as that which is systemic and collective. Individually, citizens buy-in to logics of white possession and operate as agents of governmentality in the regulation of themselves and others; structurally and systemically, the everyday material interfaces citizens engage with operate white possessive securitization in ways that foreclose access for those deemed non-white. However, Lipsitz is careful to note that

> group interests are not monolithic, and aggregate figures can obscure serious differences within racial groups. All whites do not benefit from the possessive investment in whiteness in precisely the same ways; the experiences of members of minority groups are not interchangeable. But the possessive investment in whiteness always affects individual and collective life chances and opportunities (2006, 22).

In the following section I connect individual actions to larger systemic and collective operations of white possessive logics. Moreover, I argue that governmentality of health relies on a collective buy-in of white possession to maintain the health and economic security of the nation.

Securitization (and Surveillance)

I build on white possessive securitization where it resonates with the conceptualization of *immunitas.* Political philosopher Roberto Esposito has theorized the dual concepts of *communitas* and *immunitas*. Esposito situates immunity (or *immunitas*) as the opposite of

communitas – he notes that both words derive from the Latin root word of *munus*, "which means "gift," "duty," "obligation,"" but he notes that "*communitas* is affirmative while *immunitas* is negative" (2013, 58-59). While my focus throughout this section is on *immunitas*, it is necessary to understand *communitas* – particularly so we can know what *immunitas* works against. Esposito notes that "care, rather than interest, lies at the basis of community. Community is determined by care, and care by community. One may not exist without the other: 'care-in-common'" (2013, 25-26). Given the characterization of community as being obliged by gift or duty, or what Esposito calls a "law to care for the other," he then notes that "immunity implies the exemption or exception from such a condition," that the person who "is shielded from the obligation and the dangers that affect all others is immune" (59). I am particularly drawn to these concepts – especially the regulatory mechanisms of *immunitas*. Esposito links *immunitas* to apparatuses of governmentality (law and the police), but in the colonial context, the process of immunization translates to the larger body politic in which it operates to eliminate the obligations of community to those who are excluded. While at times abstract, Esposito's theorizations of *immunitas*, immunization, and inoculation are generative for delineating how governmentality operates through *the individual and the body politic* and grasping how relations between individuals and the body politic unfold.

At its most basic form of operation, *immunitas* works to protect members of a community from an outside risk – and an outside risk can also take the form of individuals who are not wanted in a community. Esposito contends that "everywhere we look, new walls, new blockades, and new dividing lines are erected against something that threatens, or at least seems to, our biological, social, and environmental identity. . . [and] the risk of contamination immediately liquidates contact, relationality, and being in common" (2013, 59). Ultimately, "*immunitas* is

what deactivates *communitas*" (Esposito 2013, 127). Esposito argues that "to allow the community to withstand the entropic risk that threatens it, and with which it ultimately coincides, it must be sterilized of its own relational contents. It must be immunized from the *munus* that exposes it to contagion using that which, coming from within it, goes beyond it" (2011, 13). Of course, it is imperative to remember that contagion and risk is formed and rationalized through particular logics and structures of governmentality. In this vein, Esposito notes that "once the immunitary paradigm is combined with . . . nationalism and then racism, the paradigm becomes what determines and orders the destruction of life (let's recall again that immunization was born so as to protect life from its communitarian drift into chaos)" (2013, 130). It is here that we see the differential governance of populations through the technology of immunization and the way in which immunization protects the privileged and causes harm to those who are not folded into the protection of the community.

The process of inoculation, and thus immunization, is employed in biopolitical health interventions beyond just the process of the immune system protecting the corporeal organism from viruses. In the governmentality of health, inoculation occurs through the process of disciplining people into good biocitizens. Biocitizens who do not adhere to immunitary protocols or who are rejected from participating in immunization are then removed from the bio-community. What I really want to emphasize here is the role and purpose of immunization as a metaphor (and thus the exemption from and shielding from risk) as a way in which individuals are separated from the community to negate any possible obligations owed to them. Public health interventions have often been linked to the economic health of the nation through technologies such as soda taxes, and rationalities that seek less economic expenditure on health and thus

promote self-regulation of health – all of which serve to negate care and obligation to those who have been deemed poor biocitizens.

The process of *immunitas* is well entangled with biopolitical rationalities, technologies, and programs (Lemke 2002; Rose 2004; Li 2007a). Esposito suggests that conceptualizations of "biopolitics must be merged with that of immunization" to see where it "lays bare the lethal knot that thrusts the protection of life towards its potential negation" (2013, 84). Such a negation of life and of care and obligation is a standard feature of differential governmentality – and those who are differentially governed will not be protected by what Esposito has theorized as immunization – the exemption from and shielding from risk. Biopolitics are oriented towards what Esposito refers to as the "pathological condition: what is healthy is only defined through contrast by the "decision" about what is diseased – the origin, development, and outcome of the illness" (2011, 122). Esposito posits that increased medicalization of biopolitical governmentality has resulted in "the hypertrophy of the security apparatuses that are increasingly widespread throughout contemporary societies" (2011, 15). Biopolitical employment of immunization requires an apparatus that not only defines what is health, what is worth protecting and what is not, but it also establishes a security apparatus to protect health and life at all costs. But of course, not every biocitizen qualifies for such protection.

At its core, immunization serves a purpose of security – it secures the individual from the risk of an outside threat, and the risks associated with community obligations. It should not be surprising that Esposito's theorizations of immunization do not radically differ from theorizations of the role of the individual within an apparatus of governmentality. Moreton-Robinson has argued (via Foucault's theorizations of biopower) that "race became a means of regulation and defending society from itself" (2015, 156). Similarly, Li has noted that "at the

level of the population, it is not possible to coerce every individual and regulate their actions in minute detail," so instead, government operates by "educating desires and configuring habits, aspirations and beliefs" (2007a, 1). Moreover, government "sets conditions" so citizens will do as designed, while thinking that they are merely acting in self-interest (Li 2007a, 1). Nikolas Rose has theorized the connections between individuals, community, control, and security and argues that "collective logics of community" are collapsed with "the individualized ethos of neo-liberal politics: choice, personal responsibility, control over one's own fate, self-promotion and self-government" (2004, 249). Governmental security is then activated through "individual commitments, energies and choices, through personal morality within a community setting," and perhaps most significantly for our discussion here – community "is itself a *means* of government . . . instrumentalized in the hope of enhancing the security of each and of all" (2004, 250). Individuals make up a body politic, a community, a means of government. Not all individuals are welcomed into this fold – and those who are excluded remain on the outside, the receiving end of disciplinary, differential governmentality.

Community establishes a form of security through government, but technologies of security in the form of law, policy, and police are also required for the aims of governmentality. An apparatus of security (the law or police) comes at the cost of violence, which Esposito poignantly describes as "this is what law is: violence against violence in order to control violence" (2011, 29). Esposito contends that "if violent means such as the police apparatus or even the death penalty are used to exclude violence external to the legitimate order, the legal system works by adopting the same thing it aims to protect against" (2011, 29). Ultimately, "what law seeks to eliminate is not the violence, but the 'external'" (2011, 30). These apparatuses of security that enforce immunization are part in parcel of white possession in

colonial contexts. Much like white possession, security and immunization rely on a collective buy in – they do not solely operate through a governmental legal apparatus. Moreover, with securitization, citizens are given license to reproduce particular forms of violence, securitization, and immunization if they align with the pre-existing goals already deemed legitimate through the law, police, and rationalities of white possession. In Winnipeg, this takes the shape of vigilantism, securitization of food resources, and multiple modes of policing. Theorizations of immunitas as governmentality proves useful in two ways: 1) it directs us to the apparatuses that employ immunization as a technology of security and white possession, and 2) it directs us to the larger body politic that employs techniques of immunization through their own self-governing citizenship.

Healthism literature has not sufficiently theorized race, and thus has neglected to account for how individuals cannot be self-regulating biocitizens under the conditions of white possessive securitization. Thus far the theorizations of *communitas* and "the community" have been relatively abstract, but they are useful for analyzing the everyday context of white possessive securitization in Winnipeg. Esposito contended that "now more than ever, the demand for security has become truly obsessive" (2013, 131). In a similar vein, Rose posits that "surveillance is 'designed in' to the flows of everyday existence" (2004, 234). In Winnipeg, this rings true with a police force that is funded by over one quarter of the city budget and increased security measures at many retail locations – including libraries and Liquor Marts that have installed identification checkpoints to access their stores (Cooper et al. 2019; Gowriluk 2019). Increased securitization of public spaces operates differentially – for some, increased security can make spaces much more unsafe with racism and criminalization, and for others, increased securitization is perceived as protection from risk. Indeed, the Millennium for All Report on

Securitization of the Millennium Public Library argued that claims about "the degree of unsafety have not been borne out by evidence" to justify increased security measures (Cooper et al. 2019, 6). Moreover, concepts of 'safety' may be "unconsciously racialized" (Cooper et al. 2019, 17). Here we see that "community is simply the interface of its own immune system" (2011, 51). There is no single monolith community when we speak of *communitas* and *immunitas* – it operates much like governmentality in that communities (like populations) are rendered differentially based on divisions including but not limited to race, socioeconomic status, or geographic locale. In the settler colonial context, theorizing how the body politic works to immunize itself from perceived risks of Indigenous peoples – namely that Indigenous people pose a threat to white possessions – is a necessary venture to determine how such contexts impact everyday realities including attaining food security.

As noted in the previous chapter, the healthism literature has failed to emphasize the extent to which healthism operates through differential governance. Here, I argue that surveillance and securitization act as twinned processes in the differential governance of Indigenous health. Differential governance of health – and racism writ large – has long been produced through public health "panics" that frame Indigenous populations as a risk to both themselves and others. Examples of such public health scares that were differentially managed to prevent risk to the larger settler population include: the Winnipeg Core Area Initiative meant to remedy "urban decay" in a demographic area of residents who were of predominately "native ancestry" and "lacked the necessary education and vocational skills to function productively in the city's economy" (Decter and Kowall 1990, 6-7); the earlier-generation removal of Métis families from Rooster Town in Winnipeg due to public health and welfare concerns (Peters, Stock, and Werner 2018); and the establishment of Indian hospitals for the management of

tuberculosis in First Nations, Métis, and Inuit populations (Lux 2016). Moreover, Owen Toews has noted the intersection of security, governance of health, and policing, arguing that "Winnipeg's dominant bloc deployed municipal state power – primarily through the police force but also via more mundane authorities such as the health department – to drive Indigenous peoples out of the city" (2018, 62). In contemporary public health interventions, even non-communicable risk (e.g. a disease that is not transmissible between individuals) amongst Indigenous populations is still managed with the aim to protect the larger population – as evidenced in interventions to manage diabetes in Indigenous communities that operate from the rationality of needing to manage the risk of the economic cost to the nation.[41] Moreton-Robinson reminds us that "the discourse of pathology is a powerful weapon that the patriarchal white sovereign deploys to gain support from its white citizens" (2015, 172). Moreover, biopower interventions that are meant to support life are "conditional on the perceived appropriateness of the individual, the measure of which is the good white citizen" (Moreton-Robinson 2015, 172). Differential governance of Indigenous health occurs against the standard of the good white biocitizen and governments and citizens take great measures against risk from those who do not conform.

Collective enforcement of biocitizenship standards not only results in increased surveillance of some bodies more than others, but it also results in the securitization of resources from undeserving individuals, as well as the policing of those who do not adhere to white biocitizenship norms. Esposito has suggested that we can find the mechanisms of the logic of immunity "where it operates – at the juncture between the spheres of the individual and the

[41] Winnipeg Food Atlas. "Winnipeg Food Atlas." *Manitoba Collaborative Data Portal*. Accessed May 2, 2020. http://www.mbcdp.ca/fns.html. See: diabetes dashboard. Diabetes policy is framed by identifying estimated economic burden to nation, which is then connected to population data sets to identify risk groups.

species" (2011, 136). This juncture is also where we can identify the process of citizen investment in governmentality. Governmentality scholars situate the individual subject as an integral component for the ongoing functioning of governance – the 'individual' is one of the major points of the application of governmentalized power (Miller and Rose 1990; Rose and Miller 1992; Hindess 2001; Lemke 2002; Dean 2015). Peter Miller and Nikolas Rose argue that "governing operates through subjects . . . government to that extent is a 'personal' matter, and many programmes have sought the key to their effectiveness in enrolling individuals as allies in the pursuit of political, economic and social objectives" (1990, 18). Miller and Rose contend that individuals themselves "can be mobilized in alliance with political objectives" and governmentality relies on a number of technologies to educate "citizens in techniques for governing themselves" (1990, 28). Indeed, government depends on and operates through "a web of technologies for fabricating and maintaining self-government" (Miller and Rose 1990, 28). Colin Gordan has posited that according to Foucault, governmental rationality is "simultaneously about individualizing and totalizing" through a balance of determining how individuals "or population of individuals" are made governable (1990, 36). Individuals may become agents of governmentality and may end up employing the same techniques of possession, surveillance, immunization, regulation and disciplining that their governments do.

Police/Policy State

Police are integral to the maintenance, security, and justification of white possession. In his genealogy of police, Foucault (2009) noted that "the term 'police' does not signify (at least not exclusively) the institution of police in the modern sense; 'police' is the ensemble of mechanisms serving to ensure order, the properly channeled growth of wealth, and the conditions of preservation of health 'in general'" (329). Police can thus signify policy and apparatuses of

security that maintain order amongst the population. For Foucault, police signify "a condition of existence of urban existence" (2009, 336). Police essentially emerged as "urban and market based, or to put things more brutally, it is an institution of the market, in the very broad sense" (335). Police have always operated as a technology of a security apparatus to protect property and the interests of the mercantile class. Foucault notes that by the seventeenth century 'police' begins to "refer to the set of means by which the state's forces can be increased while preserving the state in good order" (2009, 313). Moreover, "each state must have a good police so as to prevent the relation of forces being turned to its disadvantage" (315). Much like the governmentality of health, policing counts on a collective citizen investment in the police as a technology of security that exists to quell risks that threaten white possession.

In Canada, and the prairies more specifically, the police have served explicitly colonial purposes. Of course, in settler colonial contexts the demand for the securitization of white possessions is not a new phenomenon for Indigenous peoples who have been the target of policing and surveillance in both historical and contemporary contexts (Monaghan 2013; Nichols 2017; Dhillon 2017). The police (specifically the North-West Mounted Police) "played a key part in creating a white settler society" (Comack 2019, 175). The police, along with other technologies of a settler colonial apparatus of security, employed surveillance (especially racialized surveillance) to "eliminate indigenous opposition to settler colonial expansion in the North-West" (Monaghan 2013, 488). Jeffrey Monaghan argues that racialized surveillance was an integral tool of settler colonial governmentality that marked Indigenous peoples as deviant from, or threats to, "the expansion of settler governance" (2013, 488). In a similar vein, Elizabeth Comack contends that contemporarily in the prairies police have "been tasked with the management and containment of Indigenous people" – a process that is demonstrated through

practices such as red zoning, starlight tours, and racialized policing (2019, 175). Police protection and surveillance (whether this is through the police or other security mechanisms) operate according to racialized logics that are meant to secure white possessions above all else – and indeed, their existence is inherently anti-Indigenous.

The operation of white possessive securitization in Winnipeg most explicitly manifests itself in the multiple forms of policing and surveillance that Indigenous people in the city are subject to. In his article on the role of Manitoba's NDP and unions in advancing a police state in Winnipeg, Winnipeg based journalist James Wilt (2019) argued that in the midst of "brutal austerity" and "relentless cuts" to community services, "ever-growing police power" is "emblematic of how colonialism, capitalism, and incarceration decimate communities and advance white supremacy" (para 5). Wilt urges readers to "understand that "crime" is defined by the ruling class and weaponized to physically remove and detain vulnerable people for capitalist goals like increasing property values and triggering gentrification" (2019, para 33).

Policing in Winnipeg occurs through several avenues. The Winnipeg Police Service received $301.4 million in funding in 2019, which was an increase of 3.4% from the previous year – the police make up 26.8% of the city's operating budget.[42] The Winnipeg Police Service also relies on Auxiliary Cadets – a group of peace officers that are meant to "enhance the Service's visual presence, build positive relationships in the community and allow police members to focus on core police duties."[43] Conducting foot patrols is a key role of the cadets. In addition to these two key arms of the police, another force of policing in the inner-city comes through the Downtown BIZ patrol, private security at key inner-city locations (like at

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[42] Winnipeg Police Cause Harm (@WpgPoliceHarm). 2019. "The Winnipeg Police Cost a Lot." Twitter, October 25, 2019, 10:25 a.m. https://twitter.com/WpgPoliceHarm/status/1187752045534765060?s=20.
[43] Winnipeg. n.d. "Auxiliary Force Cadets." Winnipeg Police Service. Accessed May 15, 2020. https://winnipeg.ca/police/policerecruiting/cadet/default.aspx.

Millennium Library and most grocery stores). And when it comes to the policing of grocery stores, many grocery stores have turned to bringing off-duty police officers into stores for security via “special hires.” These modes of policing that exist outside of the police are emblematic of individual citizens becoming agents of colonial governmentality. Wilt reminds us that “buying into the narrative of ‘public safety’ as determined by private companies like True North or organizations like the Downtown BIZ is tacit acceptance that some people (affluent white homeowners) have a right to the city which justifies the trumping of those same rights for others (poor Indigenous people)” (2019, para 33). I will delve deeper into these mechanisms of securitization and policing in the following section, particularly as they relate to the constraining of access to food and health resources.

In Winnipeg media, the police are often framed as being integral to responding to a ‘crisis’ – whether it’s the ‘meth crisis’ or ‘theft crisis’ (which are often linked). However, this view has been sharply criticized (Blunt 2019). In the context of Winnipeg, I argue that police are the crisis, and police sustain the crisis. A state of ‘crisis’ serves to usher in securitization and immunization. In *Policing the Crisis*, Stuart Hall et al. (2013) write about the police response to the ‘crisis’ of mugging in British cities during the early 1970s. In their analysis of response to ‘crisis,’ they contended that “the police, reacting to these events, spurred on by a vigilant press, by public anxiety and professional duty, took rapid steps to isolate the ‘virus’ and bring the fever under control. The courts administered a strong inoculating dose of medicine” (Hall et al. 2013, 21). The language of the ‘virus’ here resonates with Esposito’s inoculation and immunization. Police and media shaping of ‘crises’ works to give a certain amount of license to the general public to lean into anxiety and fears, and to implement practices of immunization that exclude individuals associated with the crisis (and thus a risk) from any community obligation. In

Winnipeg, we see this in increased securitization of spaces. In the following section, I provide three vignettes of grocery stores, city budget resources, and securitization of space in Winnipeg to demonstrate how white possessive securitization operates through the individual as a form of governmentality and immunization of risk.

Vignettes

The white possessive securitization of food, resources, and spaces in Winnipeg renders any policy solution entrenched in healthism inadequate. The failure to account for how an apparatus of healthism cannot operate under the conditions of a settler colonial apparatus of security results in the reification of approaches to food insecurity that are divorced from reality. In this section I want to return to fully flesh out three scenes of white possessive securitization that speak to what Hall et al. would define as "conditions of existence," which accounts for the relations between social forces and the wider historical context in which a phenomenon occurs (2013, 2). In this work I aim to challenge an "unwillingness to focus on conditions of existence" as it relates to inner-city Indigenous food security and healthism.[44] I situate grocery stores, austerity budgets, and all forms of securitization and policing within an apparatus of security that operates at odds with an apparatus of healthism, and results in disciplinary governmentality of Indigenous health. Grocery stores, austerity budgets, and securitization all have implications for Indigenous food security, and highlight the impossibility of meeting the standards of healthism. In the following chapters on expertise and biocitizenship, I delineate the health standards that food insecure citizens are supposed to meet – all of which are increasingly impossible for Indigenous individuals to meet within the securitized context of Winnipeg.

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[44] I credit my friend and co-thinker Jacob Nikkel with his thought-provoking theorizations of settler "unwillingness" to focus on conditions of existence, particularly as it relates to police violence in Winnipeg.

Grocery Stores

In Winnipeg the physical features of grocery stores are modified in low-income and racialized neighbourhoods to better surveil and criminalize shoppers who are profiled. This takes many forms, including permanent parking for police, one-way turnstiles to enter and exit, locked doors, security guards, 'special duty' police serving as store security, or chained cashier isles.

A few Winnipeg grocery stores in particular warrant a deeper description of what it is like to move through these highly securitized spaces. Convenience stores, like the Colony Food Store or the inner-city Dollaramas, are villainized by many academics, nutritionists, and policy makers in the field of food security: despite carrying a wide array of affordable foods, they predominantly sell processed foods, and thus fail to meet dominant nutrition guidelines as per Canada's Food Guide. In Winnipeg, these stores are often surveilled by both security cameras and security guards. Alternatively, full-service grocers carry a wider variety of produce that is deemed much healthier by proponents of healthism – even though a wide selection of exotic or organic produce may not be what buyers want to spend their limited funds on. Unfortunately, these grocers are where white possessive securitization is on full display.

Safeway, located at Sergeant and Maryland, is a really well stocked location that has a large produce area (an essential for proponents of healthism who just want poor people to eat healthier food), and is extremely secure. A security guard is posted immediately inside the entrance to take note of any shoppers of interest who may need to be surveilled. In addition, when I initially visited this location,[45] signs were posted indicating that their side doors would be permanently closed (and were barricaded on the inside of the store with excess grocery basket and sign stands to prevent any exits through them), and the only exit once inside the store was

[45] I visited this location on May 1, 2019.

through the entrance/exit door by the posted security guard, once proceeding through a checkout. All checkouts that were not staffed by a cashier were barricaded.

No Frills, located at Furby and Notre Dame, features more of the same security features. A security guard was posted at the gated one-way entrance turnstile, and a sign posted on the door advised that the store had “video surveillance equipment designed for both our customer’s protection and to help keep prices low.” I wonder which customers they are referring to, and I wonder if they think an individual stealing food for survival is a threat to their other customer’s protection. The only exit at No Frills is through an open cashier lane. The entrance turnstile cannot be exited through, and all cashier lanes that are not in use are gated and chained. When I left this location without making a purchase, I had to ask the security guard to let me out through one of the gated lanes so I could exit the store. You cannot move through any of these spaces without being heavily surveilled, unless your whiteness affords you the privilege to avoid surveillance.

The geography of Downtown Family Foods, located on Donald Street, might make it one of the most immediately hostile grocery environments in Winnipeg’s inner-city. As soon as I walked in the entrance, I was faced with a collage of security footage screenshots of individuals who have been banned from the store. Almost all of the images are of Indigenous people. One image in particular on the massive collage has the caption: “Do not buy food!” As soon as customers enter, indigeneity is immediately on display as criminal. Once inside, there is no shortage of securitization features including a security guard, theft detection devices at all exits, and four or five surveillance cameras with signs that say “smile, you’re on camera” in the meat section. Even though this grocery store is stocked with a variety of affordable healthy foods, it

would not come as a surprise that Indigenous people would want to avoid shopping here to avoid racism, profiling, and criminalization.

The white possessive geographies of grocery stores in Winnipeg have responded to ‘crises’ in the city – increases in theft (of liquor and food) have consistently been linked to the ‘meth crisis’ (Vanraes 2019). Some grocers have turned to hiring security guards or police, “changing store configurations,” or putting an end to selling “small, easily concealable packages of meat” that can be stolen (Vanraes 2019, para 12). When it comes to the recent upward trend of grocery stores to bring ‘special duty’ police into their stores for added security, criminal justice scholar Bronwyn Dobchuck-Land has argued that “adding police to retail stores does little to address the root causes of why people are stealing from stores,” and that “it shows just how far we’re willing to go to not deal with the actual problems that the city is facing and how deeply punitive and vengeful our approach to problem solving is” (Monkman 2019a, para 41-42). In the month of December 2019 alone it was reported that nearly 500 police officers were hired by stores to deter theft and make arrests (Thompson 2019). In the same month an Indigenous couple were asked to leave a Michael’s store because they looked like thieves (Caruk 2019); two Indigenous women were racially profiled by police working security at a Superstore (Monkman 2019a); a former Superstore employee spoke out about policy to monitor visibly Indigenous people in their stores (Monkman 2019b); and an Indigenous man filed a human rights complaint against Superstore after being removed from the store by police two times after being ‘mistaken’ as someone who had stolen in the past (Monkman 2019b).

In the midst of extreme measures of securitization and policing of grocery stores, citizen vigilantism has encapsulated the limits and bounds of white possessive securitization. Munther Zeid, the owner of the Food Fare grocery chain in Winnipeg, has publicly touted that he and his

staff have taken a “proactive approach to tackling crime” (Thompson 2019b, para 2). Regarding his ‘proactive approach’ to halting food thefts in his store, Zeid has said: “It’s no secret. We approach them armed. We have baseball bats, and all we want is our product back” (Thompson 2019b, para 4). Zeid told the Winnipeg Sun that “there are several bats placed strategically through out [sic] his store, when they are notified of a theft in progress [they] will grab a bat and meet the thief at the front door” (Aldrich 2019, para 3). Zeid reported that if the customer refuses to “unload their pockets” and leave, “then the choice becomes break an arm or a leg” (Aldrich 2019, para 4).

Grocers who implement technologies of securitization are agents of governmentality through which the “collectivization of risk” is displaced in favour of individuals “to *take upon themselves* the responsibility for the security of their property and persons” (Rose 2004, 247). In contrast to security guards, video surveillance, and public criminalization – extreme security measures undertaken by Zeid shift from governmentality to violence that are indicative of lingering forms of sovereign power in which the threat of violence for the protection of the grocery store as territory is legitimated. Zeid implements mechanisms of security outside of the law, yet however violent, such measures are ultimately approved as form of immunitary governmentality because it is largely accepted by the *communitas* as reducing risk (risk to his economic possessions). The Winnipeg journalists who have given Zeid airtime have presented his incitation of violence with little to no criticism of why thefts may be increasing, or whether Zeid possibly assaulting another citizen is an appropriate response to minor thefts (Aldrich 2019; Thompson 2019b; Vanraes 2019). The absence of any denouncement of Zeid’s behaviour by the police alongside uncritical media reports together give license to this type of behaviour (Aldrich 2019). In an attempt to minimize the potential for injury, Winnipeg police have recommended

that individuals who witness thefts not video or photograph the incident or intervene in any capacity (CBC News 2019; McGuckin 2019). It is assumed that those protecting property are at risk of injury – yet Zeid and others are the ones to respond with violence. In 2009, a Winnipeg store owner assaulted Geraldine Beardy with a baseball bat after he confronted her for allegedly stealing a can of luncheon meat worth $1.49 (CBC News, 2009). Beardy died of her injuries less than a week later. Charges against the store owner were dropped after a key witness left the country (CBC News n.d.). In case it needs to be said: property theft does not give citizens license to assault someone else in the name of white possessive securitization.

In case it is not clear, food theft points to larger conditions of existence in Winnipeg: high rates of food insecurity, decimated city budgets that fail to prioritize community services, and endemic, everyday racism. All of these conditions of existence, felt most acutely by Indigenous residents, make meeting the standards and expectations of healthism impossible. When it comes to the 'crisis' of food theft in Winnipeg, a substantial cognitive disconnect on the part of citizens, media, and store owners like Zeid about the social context of food insecurity and why people may steal food, is minimalized. Moreover, in an inner-city that is already limited in full-service grocery locations, these limitations are further compounded if Indigenous people want to avoid explicitly racist and policed spaces. In the next vignette, I turn to austerity budgets as another condition of existence in Winnipeg that impacts Indigenous food insecurity and increases securitization.

City Budget Resources

Community groups like Winnipeg Police Cause Harm, Millennium for All, and Budget for All have organized against increasingly austere city budgets that consistently increase police funding while reducing funding to essential community services. Winnipeg Police Cause Harm,

for example, has drawn attention to the 2019 operating budget for the Winnipeg Police Service – a whopping $301.4 million, an increase of 3.4% from 2018, which accounts for 26.8% of the city's operating budget.[46] Winnipeg Police Cause Harm have argued that if the average police salary of $104,485.02 was capped at $80,000 a year the city could save $50,835,846.00 per year.[47] Winnipeg Police Cause Harm have developed these scenarios to demonstrate that $50 million of city funding could drastically alter the social landscape of the city – they compare police salaries to the budget of the West End 24 hour safe space for youth in the Spence neighbourhood that "has offered a space for over 550 youth a year to sleep and eat at night on the weekends with a mere $380,000 of public funding over three years."[48] The 2020-2023 budget that was approved in early March 2020 has once again increased the Winnipeg Police Service budget while continuing to cut essential social services and grants.[49]

It should not surprise anyone that the police force continues to garner public support and economic resources, even during times of widespread austerity impacting almost every other sector.[50] Hall et al. (2013) have thoroughly explicated how the "ideological closure" that occurs between police, media, and courts works in conjunction to create social anxiety and affect on how to respond to social crises (67). Hall et al. note that "the paradox is that the selectivity of police reaction to selected crimes almost certainly serves to *increase* their number . . . [thus]

[46] Winnipeg Police Cause Harm (@WpgPoliceHarm). 2019. "The Winnipeg Police Cost a Lot." Twitter, October 25, 2019, 10:25 a.m. https://twitter.com/WpgPoliceHarm/status/1187752045534765060?s=20.

[47] Winnipeg Police Cause Harm (@WpgPoliceHarm). 2019. "The Winnipeg Police Cost a Lot."

[48] Winnipeg Police Cause Harm (@WpgPoliceHarm). 2019. "The Winnipeg Police Cost a Lot."

[49] Kavanagh, Sean. "Winnipeg Budget Passes as Political Business Winds Down at City Hall." *CBC News*. March 20, 2020. https://www.cbc.ca/news/canada/manitoba/city-winnipeg-budget-2020-passes-1.5505101. Also see: Winnipeg. n.d. "Multi-year Budget 2020 – 2023." Budget. Accessed May 15, 2020. https://www.winnipeg.ca/interhom/Budget/2020Budget/default.stm#5.

[50] In online budget engagement sessions for the proposed 2021 budget, citizens who participated ranked golf services, parking, and police service as the three least important city services. The three most important services ranked were medical response, community liveability, and public transit. See: Winnipeg. 2020. "City of Winnipeg Preliminary Budget: Volume 2 for 2021 Budget." Winnipeg: City of Winnipeg, 52.

when the ‘crime wave’ is then invoked to justify a ‘control campaign’, it has become a ‘self-fulfilling prophecy’” (2013, 41). Moreover, “public concern is itself strongly shaped by the criminal statistics (which the police produce and interpret for the media) and the impression that there is ‘wave after wave’ of new kinds of crime” (Hall et al 2013, 41). The Winnipeg Police Service 2020 Operating and Capital Budget presentation included statistics on citizen perceptions of crime and policing. Citizens were asked to indicate what actions should be taken to improve the quality of life in Winnipeg and 51% of respondents cited crime/policing as an action area to improve quality of life.[51] The ideological closure of police and media has evidently been effective – a mere 6% cited housing, 4% cited poverty, and 2% cited health care as areas in need of improvement for the quality of life in Winnipeg. Police and those who support policing (ideologically and financially) operate in a loop to maintain white possessive securitization. The city budget then effectively prioritizes white possessive securitization and immunization over community services and programming that could actually serve the health of Indigenous people in the city.

Securitization of Space

In addition to the securitization of grocery stores by private security, store owners, and police officers, the public space of inner-city Winnipeg more broadly has undergone increasing amounts of securitization. Downtown Winnipeg BIZ has a volunteer force of Downtown Watch Ambassadors who “act as additional ‘eyes and ears’ for the Winnipeg Police Service” and can “quickly report any criminal activity” to the police.[52] Downtown Watch Ambassadors are meant

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[51] Winnipeg. 2019. “2020 Operating and Capital Budget: Winnipeg Police Service.” November 12, 2019. https://www.winnipeg.ca/interhom/Budget/2020Budget/pdfs/2020-Multi-year-Budget-Presentation_Winnipeg-Police-Service_20191112.pdf.

[52] Downtown Winnipeg BIZ. n.d. “Watch Ambassadors.” Downtown Winnipeg BIZ. Accessed May 15, 2020. https://downtownwinnipegbiz.com/programs-services/safety/watch-ambassadors/.

to promote "a safer and friendlier downtown" – and while this may be the case for white city goers who like to attend hockey games, it is hardly the case for Indigenous people who live and move through downtown every day.[53] Downtown BIZ pitches joining the watch as an excellent volunteer opportunity for anyone interested in criminology and criminal justice. Downtown BIZ adds an additional layer of securitization on an already heavily policed area.

The announcement of the new Downtown Safety Partnership was announced in November 2019 – the partnership will include Downtown Winnipeg BIZ, True North Sports and Entertainment, City of Winnipeg, and Winnipeg Police Service. The partnership aims "to see partners, like private security and Downtown Winnipeg BIZ Watch Ambassadors, work collaboratively and share information in real time" (Scarpelli 2019, para 5). This partnership further entrenches the legitimacy of Downtown BIZ patrol as a citizen police force. The securitization of space in inner-city Winnipeg speaks to the white possessive priorities of the city, police, and citizens who seek to negate obligations of being in common and would rather immunize themselves from perceived risks.

Increased security and police presence does little to increase actual safety in the inner-city. In the *Millennium for All Report on Securitization of the Millennium Public Library* the authors argue that "increased securitization leads to increased criminalization – not higher incidents of crime, but higher incidents of people, most often poor and BIPOC communities, being marked as deviant and thus brought into contact with the criminal punishment system" (Cooper et al. 2019, 30). Flooding public spaces with security guards and police is counterintuitive for creating safety and "rather than making communities safer, they introduce

[53] Downtown Winnipeg BIZ. n.d. "Volunteer Watch Ambassador." Downtown Winnipeg BIZ. Accessed May 15, 2020. Downtown Winnipeg BIZ. n.d. "Watch Ambassadors." Downtown Winnipeg BIZ. Accessed May 15, 2020. http://www.downtownwinnipegbiz.com/wp-content/uploads/2013/05/Volunteer-Watch-Ambassador-Job-Description.pdf.

opportunities for bias and harm" (30). Moreover, Cooper et al. (2019) argue that increased presence of policing and security "are theatrics – mechanisms of social control – that are meant to shape people's conduct" and these mechanisms of securitization "ensure that people who have been profiled by security and police before make their own decisions not to come around in the first place – and we know from research that those most likely to have had these bad experiences and been treated repeatedly as suspects are Black, Indigenous, poor, and gender non-conforming people" (31). The implications of increased security and policing in public spaces (like downtown streets and millennium library) and private spaces (grocery stores) can effectively serve to put Indigenous people in those spaces at greater risk for criminalization and violence, or to attempt to remove them from those spaces entirely.

Community Care Without Policing Health

I have sought to keep the focus of this chapter on the deficits of whiteness and the individualized operation of settler colonial governmentality. I do not think it is necessary to belabour statistics of food insecurity, crime rates, or to focus on the socioeconomic factors that are often identified to explain the conditions of existence for urban Indigenous people. While such statistics are usually employed in interventions of governmentality, as we will see in later chapters, they operate to render populations as deficient, a security risk, or in need of intervention. Instead, I find it necessary to instead focus on the conditions of existence that stem from settler colonialism, white possessive securitization, and policing. It may not seem immediately apparent as to how food security policies that employ healthism, and thus promote self-regulation of diet according to hegemonic biomedical nutrition standards, are connected to securitized and policed spaces. However, I argue that it is necessary to account for these conditions of existence. If food insecurity is being reduced to a matter of healthism when

Indigenous people cannot access food without being policed and criminalized – the wrong questions are being asked, and the wrong solutions are being offered.

Community commitment to obligations of care exists in many spaces in Winnipeg and is fostered by those who refuse to immunize against risk at the cost of people. Being obligated to community care is a process that requires reflection on what constitutes community security. In his analysis of white possession (a process which is inherently occupied with security), Lipsitz conveyed that "while one can *possess* one's investments, one can also *be possessed* by them. I contend that the artificial construction of whiteness almost always comes to possess white people themselves unless they develop antiracist identities, unless they disinvest and divest themselves of their investments in white supremacy" (2006, viii). The community members in Winnipeg who are invested in community care have invariably divested themselves from any notions that increased securitization and policing provides any substantial benefit or safety for Indigenous people, although some community organizations divest from securitization and policing more than others. Organizations and businesses like Meet Me at The Bell Tower, Winnipeg Police Cause Harm, Millennium for All, Bear Clan, Eadha Bread, and the Bell Tower Community Café – amongst many others and all of the individuals who join in this work.[54]

Eadha Bread exemplifies ethics of community commitment to obligations of care. Eadha is a sourdough bakery located in Winnipeg's West End and is committed to doing "business through a queer, anti-racist, decolonial lens."[55] Eadha often show mutual support for other organizers in Winnipeg by closing shop to participate in crucial protests and events. When it comes to support community food security, they have established a successful no questions

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[54] Concerns have been raised over alliances between Winnipeg Police Service and Bear Clan (Cannon 2020). However, even with tensions and contradictions amongst community organizing, it is prudent to recognize what obligations of community care still exist, such as Bear Clan's food security programming (Bergen 2019).
[55] Eadha Bread. n.d. "About Us." About Eadha. Accessed May 15, 2019. https://www.eadhabread.com/about.

asked pre-paid food voucher program for community members in need to access. Eadha has noted that "building systems outside of capitalism means we work together, creatively, and this program is a participatory way of redistributing wealth immediately."[56]

Community care that actually supports Indigenous food security in Winnipeg exists in spite of white possessive securitization. More importantly, when citizens refuse immunization in favour of obligation or sense of responsibility, their approaches to food security reject securitization and the self-regulation of healthism. Food shifts from being regulated by hegemonic biomedicalized nutrition and to a source of community care not because it meets health guidelines, but because it sustains people in the face of a multitude of structures and apparatuses that impede Indigenous food security in the city. Expanding existing health research in the area of social relations contributing to well-being (Richmond and Ross 2008), to account for how food security can be conceptualized beyond healthism, and beyond securitization, will be a necessary endeavour.

Conclusion

In this chapter I brought together the resonating theories of white possession and *immunitas* to delineate how *white possessive securitization* operates through *the individual and the body politic*. I argued that individual citizens become agents of governmentality who employ techniques of immunization and securitization through their own self-governing citizenship. I situate this process as integral to understanding the empirical context of healthism in Winnipeg. In this chapter I have attempted to chart some of the conditions of existence Indigenous people in inner-city Winnipeg have to contend with in their everyday lives to access food. Even the most

[56] Eadha Bread (@eadhabread). 2020. "This Weekend We Processed $260.16 of Interac E-transfers." Instagram photo, January 24, 2020. https://www.instagram.com/p/B7toDawA7Ti/?utm_source=ig_web_copy_link.

everyday tasks such as grocery shopping reveal how expectations of healthism are impossible for people to fulfil. The everyday process of grocery shopping for Indigenous people in Winnipeg is heavily policed and criminalized. What is additionally troubling is that promoters of healthism take for granted the social context in which Indigenous people are expected to govern themselves into better biocitizens within conditions that work to disallow it at every turn. This process is one of differential governance – in which Indigenous people are meant to regulate their health without having the equitable resources and conditions to do so. In the next chapter I focus on *the expert and expertise* to identify an apparatus of healthism and the rationalities, programs, and technologies that constitute it at a federal level. In the following chapter, I return to Winnipeg to turn my attention once again to how the apparatus of healthism operates to discipline Indigenous people into being better biocitizens, in a city that does not offer the resources for them to meet such expectations.

Chapter Five – An Apparatus of Expertise

Can there be good Indigenous social policy under late liberal settler occupation?
– Tess Lea[57]

Population points the finger at masses rather than distributions and accumulations, at people rather than economy.
– Michelle Murphy[58]

Expertise is the focus of this chapter – namely, how experts design policy and interventions, and how populations are formed to be intervened upon. This chapter builds upon the previous chapters, connecting governmentality, healthism, and white possessive securitization to an apparatus of expertise that sustains policy, and ultimately the differential governance of Indigenous health. In chapter 2 I demonstrated that governmentality is a project of biopower that operates through an ensemble of apparatuses of governmentality – apparatuses that are constituted by institutions, programs, technologies and informed by the rationalities of political economy. I argued that healthism operates through many of the same mechanisms as governmentality, but specifically targets individual health. Healthism is indeed a governmentality of health – it operates through the individualization and self-regulation of health, which when carried out differentially operates as a form of social control. In this chapter, through analysis of the political economic context of liberalism as the governing rationality of healthism, it is clear that social control is not necessarily a dominating form of power, but in the liberal context, takes shape in a perceived lack of intervention. In chapters 2 and 3 I identified three elements of the operationalization of both governmentality and healthism – *the individual and the body politic, the expert and expertise, and the biocitizen*. In this chapter, I more specifically address how governmentality and healthism operate through expertise.

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[57] Tess Lea. 2020. *Wild Policy: Indigeneity and the Unruly Logics of Intervention*. Stanford: Stanford University Press, 13.
[58] Michelle Murphy. 2017. *The Economization of Life*. Durham: Duke University Press, 137.

In this chapter I analyze how policy operates through experts and expertise to promote biocitizenship and thus establish standards for how populations are intervened upon by provincial, municipal, and not-for-profit intermediaries. I focus specifically on federal health policy and how, why, and what expertise policy makers rely on and create to administer populations. I begin this chapter by reviewing scholarship in the field of health policy, and then turn to how Indigenous health policy scholars have theorized the limitations and possibilities of health policy. In contradistinction to the field of general Canadian health policy, Indigenous health policy scholars recognize and indeed *require* that there be different possibilities that result from effective health policy to specifically account for how Indigenous health is determined in Canada. In the final sections of this chapter, I analyze expertise in federal policy, and how Indigenous bodies and populations are administered through policy. I argue that experts quantify Indigenous populations as a risk to the security of the settler colonial state. However, through the operationalization of regulatory power and differential governance, expert driven intervention in Indigenous health falls short of being 'good policy.'

Policy Making

In order to understand how approaches to food insecurity perpetuate differential governmentality and healthism, it is critical to comprehend the broader landscape of policy making in Canada, particularly health policy. In Canada, public health predominantly focuses on population health, and thus the determinants of the populations' health which is measured and indicated by a number of complex social, economic, environmental, and individual influences (Fierlbeck 2000, 104). Much of Canada's health policy has focused on two key areas of intervention – health promotion as a model that promotes well-being and supports preventative health care (Fierlbeck 2000, 73; Raphael 2008) and the social determinants of health model (that

often works alongside health promotion) that recognizes the impact of social, economic, environmental, biological, cultural, and personal factors as determining health outcomes (Fierlbeck 2000; Raphael 2015). Such models of public health invariably influence how food insecurity is rendered as an indicator of poor health that must be remedied through interventions that require individual action.

The process of policy making – what outcomes and objectives are valued, and how policy is operationalized – is largely dependent on the social, political, and economic contexts it operates within. Deborah Stone contends that "the project of making public policy rational rests on three pillars: a model of reasoning, a model of society, and a model of policy making" (2012, 11). Stone argues that "the *model of reasoning* is rational decision making . . . the *model of society* underlying the contemporary rationality project is the market . . . [and] the *model of policy making* in the rationality project is a production model, where policy is, or should be, created in an orderly sequence of stages, almost as if on an assembly line" (2012, 11-12). Within the social, political, and economic context of a settler colonial state like Canada, these three pillars are reflected in governmentality, liberalism, and the capitalistic business of intervention.

The making of Canadian health policy cannot be separated from its operation as a mechanism of liberal governance (Fierlbeck 2000; Raphael 2008; Raphael 2015; Williams and Fullagar 2019). Katherine Fierlbeck argues that underlying "public health reform in all modern liberal states is the ideology of liberalism itself" (2000, 105). Health policy created under the conditions of liberalism is contradictory – it is aligned with liberal ideology that values the market, individualization, and non-interference, yet yielding to markets, off-loading responsibility onto individuals, and limiting interference results in particular forms of governmentality that work to intervene and administer populations in spite of prevailing liberal

ideologies. Michel Foucault's theorizations of governmentality – the conduct of conduct – is an inherently liberal form of governance (2009). Indeed, liberalism has not functioned as "background music to a real state" as it could be believed with the values that are touted by liberalism, but instead has operated as a "continuing vector of political invention," and intervention (Gordon 1991, 18). Fierlbeck argues that "because liberalism stressed individual autonomy as a keystone of political organization, there is always a tension between those who view health as primarily an individual responsibility and those who see it as a consequence of social organization" (2000, 105). Yet of course, liberalism is not just about individual autonomy, it is about perceived autonomy through an elaborately designed vector, or apparatuses, of governmentality. Fierlbeck poses the example of nutrition, asking if it is concerned with "getting people to take responsibility for eating more healthy food, or is it also firmly linked to patterns of work, the cost and availability of fresh food, the strength of the agrifood industry, urban design, socio-economic disparity, and so on" (2000, 105). Beyond concerns of individual responsibility for health, the practice of health policy in Canada is further constrained by federalism and institutional responsibility in public health efforts.[59]

Health promotion has been an integral model in Canadian health policy, despite being constrained by the limits of the economic priorities of liberal governmentality. Health promotion models identify "roles that societal structures and public policy play in shaping the health of populations," while also supporting the position that individuals and communities can "increase their control over the determinants of health" (Raphael 2008, 483). Dennis Raphael argues that the aims of health promotion should "create healthy public policy that is responsive to the needs

[59] Federalism refers to the division of power between federal and provincial governments, which is of importance here because this model "clearly gives the jurisdiction over public health to the provinces" (Fierlbeck 2000, 108). Jurisdiction and health care will come into focus more later in the chapter when we further complicate it by considering overlapping jurisdictions of Indigenous health.

of the citizenry" (2008, 483). Raphael contends that health promotion in Canada works with an "ambitious agenda," yet has remained a "marginal discourse" in policy largely due to the realities of creating policy in a "liberal political economy" (2008, 484). In the context of a liberal political economy, even "strong public policy – supported by community action – in the service of health promotion is difficult to implement" (Raphael 2008, 484). Whether it is "skittish" attitudes regarding intervention, jurisdictional disputes, coordination of services, or debates over the role of health(y) policy, implementing public health policy faces no shortage of obstacles (Fierlbeck 2000, 130).

Health policy and research has understood social determinants of health (SDOH) as being integral to efforts to reduce health inequalities and to promote health and development (Raphael 2008; Fierlbeck 2000; Raphael 2015; Williams and Fullagar 2019; WHO 2008). The extent of relevant factors of SDOH becomes troubling in relation to the limitations and constraints of what health policies and outcomes are feasible under liberalism. Fierlbeck conveys that "the *extensiveness of the scope of issues* that public health must address" is a political concern, especially given that with the recognition of social determinants of health by policy officials, "there is little that does not fall under the rubric of 'health care'" (2000, 107). Implementing effective health policies addressing SDOH is further complicated by the fact that policy that does not result in instant political gratification, gain, and capital is often neglected (Fierlbeck 2000, 125). Given the limits of addressing SDOH under liberalism, Raphael argues that Canadian policy actually generates health inequities through a skewed distribution of resources that shape the conditions that determine health, through the influence of the market on the state (2015, S17). Moreover, Raphael argues that little is done to address SDOH because "the logic inherent in the country being a liberal welfare state has rather little to say about addressing the structural sources

of health inequalities . . . because the market – rather than the state – is its dominant institution," which ultimately makes policy "susceptible to the influence of the corporate and business sector and of growing economic globalization, which elicits public policy-making that skews the distribution of SDOH" (2015, S17).

A focus on SDOH is integral to understanding the breadth of influences on health and inequalities and inequities that occur as a result, yet as long as health policy operates under liberal conditions of existence it will remain unlikely that policy will actually ameliorate inequities resulting from SDOH.[60] The advancement of a SDOH framework has attempted to shift the focus of health from the individual to the larger social environment. However, without the institutional capacities, commitments, and governing rationalities to intervene in the social and structural determinants of health, Canada is left "hanging on by its fingernails" and becoming "weaker and weaker" in its capabilities to address SDOH (Raphael 2008, 491). The seeming infeasibility of altering social and structural determinants of health should not deter analysis of such determinants, except to proceed with pragmatic caution for its ability to significantly alter structural realities.

A central predicament in implementing health policy under liberalism's fixation with non-interference and market values is that policy 'solutions' and interventions inevitably take the form of expecting individuals to become consumers and agents of their own health. Raphael argues that "perusal of any public health document or disease agency publication gives lip service to the broader determinants of health but quickly succumbs to exhortations about making healthy choices in the service of health" (2008, 488). Despite the intentions of policies that seek

[60] Health Canada. "Social Determinants of Health and Health Inequalities." *Government of Canada.* Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html.

to adhere to models of health promotion and social determinants of health, given the realities of operating within liberal political and economic contexts, such policies are essentially just healthism by another name. The liberal political economy is antithetical to health policy if it actually requires remediating social determinants of health.

Health policy researchers in Canada and the United Kingdom have analyzed policy that has been implemented in their respective countries and have well documented trends of shifting responsibility for health onto citizens (Fierlbeck 2000; Raphael 2008; Williams and Fullagar 2019). Such research highlights the incongruities with employing such interventions as a *solution* to SDOH. Oli Williams and Simone Fullagar argue that in the United Kingdom, "the lack of progress made in reducing health inequalities has been explained in part by a policy trend known as 'lifestyle drift'" (2019, 22). Williams and Fullagar describe lifestyle drift as the process by which governments attempt to address SDOH in health policy, but end up pivoting to individualized lifestyle interventions, even if institutional action would offer better outcomes (2019, 22). What Williams and Fullagar describe as individualized lifestyle interventions is indeed healthism. As we saw in chapter 2, healthism is employed to address health and social ills, but rather than receive any robust response from governments, responsibility is off-loaded onto individuals as personal failings.

Following 'lifestyle drift,' Williams and Fullagar conceptualize the further individualization of health as a process they call "citizen shift" (2019, 29). With 'citizen shift' individuals are made into consumers, rather than recipients of healthcare who are meant to make active choices – so rather than a citizen with rights, they are citizen consumers with a responsibility to pay for health services, and to regulate their own health activities (2019, 30). The authors critique "advanced liberal governance by paying specific attention to how power

operates through normalised 'truths' about citizen rights and responsibilities and why these political rationalities impede policy aims to more significantly influence social change to reduce health inequalities" (Williams and Fullagar 2019, 32). Williams and Fullagar contend that "once policy has drifted into the terrain of lifestyle, the currents of advanced liberal governance are liable . . . [to] shift responsibility to individual citizens" (2019, 33). Similarly, Canadian health policy has taken efforts to "make health care recipients more responsible for their own health" (Fierlbeck 2000, 68). Again, the shifting of responsibility of health onto individual citizens is healthism. The impact this has on Indigenous populations is clear – research and policies that intertwine Indigenous food insecurity with diet-related disease outcomes often "citizen shift" the burden onto Indigenous people to take responsibility for their own health – instead of actually reducing health inequalities, research and policies deter unhealthy choices, and educate individuals to better choices.[61]

If we recognize that health policies – at best – get passed over politically unless they have immediate gains and capital, and have limited capabilities to address broader determinants of health – where does that leave us? What is the role of experts and expertise in the self-perpetuating loop of health policy in Canada? Deborah Stone offers valuable insights on the limitations of policy with her theorizations of complex causal stories. Stone identifies three complex causal stories – complex systems, historical, and institutional – all of which are "fights about the possibility of control and the assignment of responsibility" (2012, 207). Stone contends that the story of complex systems "holds that the social systems necessary to solve modern problems are inherently complex . . . it is impossible to anticipate all possible events and side

[61] For examples of Indigenous health research and policies that perpetuate healthism through techniques like "citizen shift" see: the intersections of Indigeneity and "food swamps" in Balcaen and Storie 2018; Canada's Food Guide; and the Public Health Agency of Canada's "Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights."

effects, so failure or accident is inevitable. Failures also involve so many components and people that it is impossible to attribute blame" (2012, 215). Similarly, "the institutional causal story can place blame in many places – on large organizations and their rules, as well as on people – but like the complex systems story, it can serve as an excuse for inaction" (Stone 2012, 217). The final complex causal story is historical, which places blame on early policy that established "institutions and procedures that perpetuate themselves and make it hard for subsequent policy makers to embark on different solutions or even make adjustments to the original policy" (Stone 2012, 217). All three models of complex causal stories "create a sense of unavoidability and suggest a kind of innocence, because no identifiable actor can exert control over the whole system or web of interactions" (Stone 2012, 218).

Using governmentality as an analytic throughout this research proves useful for identifying the institutions and actors employing complex causal stories. An example of a federal healthism policy (that predominately targets Indigenous populations) employing complex causal stories is Nutrition North. A policy that is meant to lower the cost of food in the North (where communities are predominantly First Nations and Inuit), where food insecurity rates are higher than anywhere else in Canada, directs most of its efforts towards subsidizing only nutritious foods, offering nutrition education, and harvesters support grants to increase access to traditional foods.[62] Nutrition North ultimately tells a causal story about the need to make healthy foods available to Northerners at a subsidized rate without addressing the complexity of institutional or historical factors (e.g. colonialism, capitalism, hegemonic biomedical nutrition). Stone notes that

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[62] See: Nutrition North Canada. "Eligible Food and Non-Food Items." *Government of Canada.* Accessed November 1, 2020. https://www.nutritionnorthcanada.gc.ca/eng/1415548276694/1415548329309. Nutrition North Canada. "Harvesters Support Grant." *Government of Canada*. Accessed November 1, 2020. https://www.nutritionnorthcanada.gc.ca/eng/1586274027728/1586274048849. Nutrition North Canada. "Nutrition Education Initiatives." *Government of Canada.* Accessed November 1, 2020. https://www.nutritionnorthcanada.gc.ca/eng/1593459095716/1593459154774.

"there is always choice about which causal factors in the lineage to address, and different choices locate the responsibility and burden of reform differently" (2012, 225). Liberal health policy is an iteration of biopolitical governmentality that works to intervene in the health of the population through the individualization of self-governing subjects – a model that subsequently off-loads responsibility onto the citizen, thus writing a complex causal story about the failures of unhealthy citizens, rather than the failures of an unhealthy state.

Health policy fails by design – it is designed by experts to sustain expertise and to constantly reinvent interventions. Policy meant to promote health and address SDOH is limited to the realm of individual responsibility by the constraints of a liberal political economy. When policies fail, the complex causal story told is one of subjects failing to be an appropriate biocitizens, which then activates a loop of further expertise to devise 'better' interventions. Policy, and interventions, rely on failure to self-sustain expertise to administer interventions (Miller and Rose 1990; Li 2007b). Tess Lea argues that "policy is not trying to eradicate foundational inequalities . . . ameliorating or softening the harsher collateral effects of inequality, rather than overturning the socio-economic system that relies on serial exploitations to thrive, is the actual (albeit disavowed) task of social policy within most democratic nation-states" (2020, 19). Moreover, she argues further that "failed interventions lead to an insistence on more interventions of the same kind" (2020, 24). I began this chapter with a question posed by Lea – can there be good Indigenous social policy under late liberal settler occupation (2020, 13)? In this chapter I think we will come to see that there can be good *liberal social policy* – its success can be marked precisely by its self-sustaining failures – but whether there can be good health(y) policy for Indigenous peoples under late liberal settler occupation is another question yet to be answered.

Indigenous Health Policy

In the field of Indigenous health policy, scholars have further theorized the limitations and possibilities of health policy. In my brief charting of Canadian health policy thus far, most scholars have indicated the limitations to effective policy within the context of a market driven political economy. However, when it comes to the governing of Indigenous health there is a multitude of complexities that need to be further accounted for including – jurisdiction, funding, social determinants of health, colonialism, self-determination, and competing models of health. In this section I expand on the key factors that need to be taken into consideration when accounting for how health policy operates differentially for Indigenous people, review the major contributions from the field of Indigenous health policy, and interrogate the role of expertise at the intersections of Indigeneity and SDOH.

Missing from most of the general literature on health policy in Canada and trends to address SDOH and implement health promotion is the extent to which these interventions are not, and cannot, be blanket approaches to health policy in Canada due to existing forms of differential governmentality – one example being jurisdictional limitations of health care for Indigenous people. Indigenous health policy scholars have consistently sought to draw attention to the "institutionalization of inequity" of Indigenous health care in Canada (Adelson 2005, S57; Lavoie 2013). Naomi Adelson links this inequity to the First Nations and Inuit Health Branch (FNIHB) of Health Canada, which delivers "public health and health promotion services on-reserve and in Inuit communities" and provides "drug, dental and ancillary health services to First Nations and Inuit people regardless of residence" (2005, S58).[63] Adelson identifies

[63] Eligibility for the Non-Insured Health Benefits program of the FNIHB is limited to: a First Nations person registered under the Indian Act as a 'status Indian' and; an Inuk recognized by an Inuit land claim organization; and a child less than 18 months old whose parent is a status Indian or recognized Inuk. See: Indigenous Services Canada.

inequities in the FNIHB as stemming from its inception resulting from the 1989 government approval of Health Transfer Policy. The policy resulted in the transfer of many services to First Nations, and it "retains and reproduces the pre-existing dependent relationship" that essentially limits control and self-determination over the services implemented in community (2005, S58). However, one of the larger inequities of concern for this research, and for many of the scholars writing in the field of Indigenous health policy, is the exclusion of First Nations, Inuit, and Métis living in urban centres from receiving many of the services and benefits from FNIHB (Adelson 2005, 58; Lavoie 2013; Richmond and Cook 2016). The inequities and limitations of governing Indigenous health in relation to limited jurisdiction and responsibility for Indigenous health care provisions by the federal government have spurred three key critiques in the field of Indigenous health policy – the identification of 'patchwork policy,' the need for Indigenous health policy to recognize the impacts of colonization on health, and the need for specific determinants of health for Indigenous people in Indigenous health policy.

The limitations of jurisdiction and the resulting differential governance of health has led to the theorization of 'patchwork policy' (Lavoie 2013; Dwyer et al. 2014; Powell and Gabel 2018). Josée Lavoie contends that the responsibility for the inter-related components of the Canadian health care system is divided between federal, territorial, provincial, municipal governments, First Nation authorities, and the private sector – resulting in a fragmented health care system (2013, 1). The jurisdictional issues that complicate the governing of Indigenous health has resulted in a health care system that offers little federal responsibility for services and programming and leaves many people – especially urban Indigenous people – left to navigate a "patchwork of policies and programmes" (Lavoie 2013, 1). Judith Dwyer et al. have argued that

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"Who is Eligible for the Non-Insured Health Benefits Program." *Government of Canada*. Accessed October 17, 2020. https://www.sac-isc.gc.ca/eng/1574187596083/1576511384063.

community-based organizations in Canada (and in Australia and New Zealand) that seek to provide primary health care services "have little choice but to 'patch together' many precisely targeted funding programmes" (2014, 1093).

Like Lavoie, Alicia Powell and Chelsea Gabel argue that Indigenous health policy is a patchwork of policy and programs "with significant overlaps and gaps" and that "the participation of all three levels of government makes health care delivery highly complicated and uncoordinated" (2018, 243). Moreover, Powell and Gabel contend that "the urban Indigenous population is perhaps most significantly affected by the lack of clarity in health-care-service provision, as it is often located within a policy vacuum" (2018, 243). Depending on the region, it could be more useful to consider lack of coordination – particularly when there are apparent overlaps in policy and programming (Andersen and Strachan 2011). Jurisdiction and patchwork policy will become increasingly relevant later in the chapter in connection to analysis of expertise as it operates through health and nutrition policy.

Patchwork policy is precisely a result of the governmentality of health in the context of liberalism. Liberalism touts non-interference, market values, and citizen self-regulation above all else.[64] Within this context, community organizations are left to patch together policy, programming, and services to meet the needs of Indigenous people not covered by FNIHB. As necessary as it is to understand how many health services and programs for Indigenous people operate in this patchwork manner (including overlapping and redundant policy), Lavoie has sought to document "policy silences" as well (2013, 2). Policy silences, gaps, and shortcomings

[64] Even welfare state liberalism can be considered to operate via these principles. While welfare state liberalism may seem more interventionist on the surface, it still operates according to logics that individuals must generate "capacities required for autonomous action" within a "benign and supportive social environment" established by a welfare state (Hindess 2001, 101). Additionally, as I demonstrate throughout this research, non-interference does not equate with non-affective. Non-interference has disciplinary outcomes (Hindess 2001, 101; Dean 2015, 400).

are necessary areas of interrogation – and indeed much of the field of Indigenous health policy studies has emerged out of key critiques of existing policy, while simultaneously providing incisive alternatives for what healthy and functional policy for Indigenous health could look like.

Indigenous health policy researchers have worked with the aim of having health policy recognize and address the impacts of colonization on Indigenous health. In doing so, Indigenous health policy researchers have not only considered how colonization has impacted and continues to impact and determine Indigenous health in areas of income inequality, unemployment, education, housing, health care access, and water and food access, they have also sought to delineate necessary alternatives to existing policy (Adelson 2005; Reading and Wien 2009; Lavoie 2013; Reading and Halseth 2013; Gabel, DeMaio, and Powell 2017; Powell and Gabel 2018). Moreover, many of the determinants of health resulting from colonization can be linked to the "protracted effects of land dispossession" (Czyzewski 2011). Adelson contends that even given the gaps in researching and implementing health initiatives for Indigenous people, "the most significant problem is the lack of control of a comprehensive health-care program" (2005, S59). Lavoie's extensive survey of existing health policies, programs, and services resulted in the recommendation that "Canada needs an overarching national mechanism, a National First Nations, Inuit and Métis Health Policy, to realize improvements in Aboriginal health through federal, provincial, and territorial healthcare systems" (2013, 6). Lavoie ultimately argues that "critical and systemic engagement is the only mechanism that will yield a credible product, and it is the only way forward" (2013, 6).

It has been well established that Canadian health policy needs to undergo significant changes to better meet the needs of Indigenous peoples. There has been a number of interventions into what such changes would look like, and why they are necessary (Lavoie 2013;

Richmond and Cook 2016; Gabel, DeMaio, Powell 2017; Powell and Gabel 2018; de Leeuw, Lindsay, and Greenwood 2018). One of the most consistent critiques being made by Indigenous health policy researchers is the need for increased self-determination in the design and implementation of Indigenous health policy. Chelsea Gabel, Peter DeMaio, and Alicia Powell argue that "Indigenous health policies are far more likely to yield substantive health improvements if they are developed as part of a continuing and genuine partnership between Indigenous communities and government with the understanding that Indigenous people and communities design and implement their community health programs and policies as they see fit" (2017, 49-50). While Gabel, DeMaio, and Powell are specifically speaking in the context of increased self-determination for health service delivery, the argument remains compelling for all health policy contexts.

Alongside the call for increased self-determination in Indigenous health policy, researchers have been arguing for different conceptualizations of health that account for Indigenous experiences with colonialism, as well as Indigenous epistemologies and ontologies of health. Chantelle Richmond and Catherine Cook argue that "healthy public policy recognizes that the health of a population requires investment and coordination on a *whole range* of economic, social, environmental and political forces" (2016, 1-2). Similarly, Sarah de Leeuw, Nicole Marie Lindsay, and Margo Greenwood argue for an expansion of standard SDOH used in health policy, noting that they are "not satisfied with a biomedical or even a strictly 'social' determinants framework" and instead, they urge for "theorizations that extend more broadly to include Indigenous ways of knowing and being" (2018, xli). Moreover, scholars have identified land as integral to social and political well-being for Indigenous communities (Czyzewski 2011). Questions and critiques about what constitutes health, what constitutes healthy policy, and why

Indigenous health policy needs to expand on normative health policy definitions of health culminates in conversations regarding Indigenous determinants of health.

Indigenous health policy researchers have extended existing frameworks of SDOH to specifically account for Indigenous experiences of health in Canada. Adelson notes that while health disparities indicate disproportionate burden of disease on particular populations, "health *inequities* point to the underlying causes of the disparities, many if not most of which sit largely outside the typically constituted domain of 'health'" (2005, S45). Gabel, DeMaio, and Powell argue that more attention must be directed to interrogating the role of colonial structures and power relations as they contribute to health inequities (2017, 51). Similarly, de Leeuw, Lindsay, and Greenwood contend that "colonialism has yet to be fully and consistently accounted for as a significant determinant of health . . . despite the fact that Indigenous peoples – who globally experience the greatest disparities in health – identify colonialism as perhaps the *most* important determinant of their (ill) health" (2018, xxii). Given the intertwining of colonialism and Indigenous peoples health, Indigenous health policy scholars have leveled critiques that argue for the recognition of colonialism as a SDOH for Indigenous people.

The push to account for colonialism as a determinant of health for Indigenous peoples is a push to account for and trace the underlying causes of health inequities. de Leeuw, Lindsay, and Greenwood argue that "colonialism is indeed the broadest and most fundamental determinant of Indigenous health and well-being in countries where settler-colonial power continues to dominate" (2018, xxii). Indeed, many determinants of Indigenous peoples' health, including "geographic determinants, economic determinants, historical determinants, narrative and genealogical determinants, and structural determinants," all "interface with and are impacted by colonialism" (de Leeuw, Lindsay, and Greenwood 2018, xxiii). Powell and Gabel argue that

using a SDOH framework that accounts for colonialism "indicates the burden of colonialism, and its responsibility for health inequities experienced by Indigenous people," which then "enables decision makers and service providers to make decisions on the best ways to address and approach health inequities in policy and practice" (2018, 242). However, Powell and Gabel argue that Indigenous health policy must do more than address SDOH – Indigenous people must also participate in policy making, planning, and delivery of services while attending to Indigenous understandings of health and well-being (2018, 253). In a similar vein, de Leeuw, Lindsay, and Greenwood wonder if the popularity in employing a SDOH framework has "become so enduring and all-encompassing that it threatens to eclipse or subsume attention to other determinants of health" (2018, xxvi). Foregrounding colonialism as a determinant of Indigenous health requires balancing other determinants of Indigenous health – including Indigenous epistemologies and ontologies of health and well-being.

In recognizing colonialism as a determinant of Indigenous health, an Indigenous SDOH framework is able to do the important work of pathologizing colonialism, rather than pathologizing Indigenous people. Many SDOH frameworks situate *being Indigenous* as a determinant of health.[65] Rather than pathologize Indigenous people and render indigeneity as deficient and a factor that contributes to ill health, Indigenous SDOH frameworks can better define determinants of health as stemming from both colonialism, and Indigenous concepts of well-being. Powell and Gabel note that the Truth and Reconciliation Commission calls on "health policymakers to recognize and include Indigenous concepts and approaches to health in

[65] See: Health Canada. "Social Determinants of Health and Health Inequalities." Canadian Mental Health Association, Ontario. "Social Determinants of Health." *Canadian Mental Health Association, Ontario*. Accessed October 17, 2020. https://ontario.cmha.ca/provincial-policy/social-determinants/. Canadian Public Health Association. "What Are the Social Determinants of Health?" *Canadian Public Health Association*. Accessed October 17, 2020. https://www.cpha.ca/what-are-social-determinants-health.

addressing Indigenous health" (2018, 252). When using SDOH frameworks, it is not enough to just name colonialism as a determinant, or name other structural determinants as needing to be rectified – we must continuously name the more pervasive forms of colonial logics that continue, particularly through policy and governmentality of health. Even when Indigenous concepts and approaches to health are folded into policy to address Indigenous health it will be necessary to continuously interrogate the existing colonial logics and structures that determine the extent to which Indigenous approaches to health are able to be implemented. It is not enough to simply add Indigenous and mix.

Analysis of how SDOH frameworks are constituted and conceptualized is necessary for understanding how healthism is intertwined with and responds to particular determinants of health. Health Canada indicates education and literacy, social supports and coping skills, and healthy behaviours as main determinants of health.[66] These determinants bolster healthism by situating ill health at the level of the individual behaviours and requiring individuals to self-regulate their health to change their health outcomes.[67] Shifting to Indigenous SDOH frameworks provides the possibility of turning away from healthism by focusing instead on positive determinants of health that can be supported, such as Indigenous concepts and approaches to health (de Leeuw, Lindsay, and Greenwood 2018; Powell and Gabel 2018). Health policies have the power to directly impact and alleviate determinants of health – however, when they only target individual behaviours, rather than targeting or intervening in broader

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[66] Health Canada. "Social Determinants of Health and Health Inequalities." *Government of Canada.* Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html.

[67] Even determinants of health that are structural and environmental such as physical environments, access to health services, income and social status, and employment and working conditions require individual initiation spurred by policy measures that encourage individuals to make better health decisions. See: Health Canada. "Social Determinants of Health and Health Inequalities." *Government of Canada.* Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html.

determinants of health (e.g. housing, economic capacity, health care access), their outcomes will be insufficient.

To demonstrate how this iteration of healthism impacts Indigenous populations we need to look no further than how Indigenous food security is approached by researchers who are clearly situated in different SDOH camps. Martine Balcaen and Joni Storie's research on geographic food access use a social deprivation index (Aboriginal-identified populations are one of seven variables) to identify food deserts and food swamps (2018, 15). Balcaen and Storie situate food insecurity as an issue of poor behaviour that needs to be remediated. In contrast, Erika Mundel and Gwen E. Chapman's research on the Urban Aboriginal Community Kitchen Garden Project in Vancouver, Canada accounts for health inequities, social determinants of health, and the structural and historical factors that determine Indigenous peoples' health (2010, 172). However, Mundel and Chapman argue that the garden project focuses on participants' experiences with colonization, while engaging Indigenous culture, practices, and perspectives on health to consider what decolonized health promotion could look like (2010, 172). An integral difference between these two types of health interventions is that the latter moves away from behavioural deficits as determinants of health, instead focusing on structural and historical determinants, while also accounting for how and what Indigenous peoples determine as healthy.

I began this chapter with Lea's provocation about whether there can be good Indigenous social policy under late liberal settler occupation – and I think we can extend this to consider whether there can be good policy, or more specifically, whether there can be healthy policy. And if so, what is healthy policy? Indigenous health policy researchers, and those working in the area of Indigenous planning, have argued for policies that are Indigenous led, designed, and measured (Matunga 2013; Richmond and Cook 2016; Warbrick, Came, and Dickson 2018). However, even

policies carried out by Indigenous organizations are often stuck within infrastructures of liberal governmentality and beholden to particular parameters for funding and institutional materialization. Richmond and Cook (2016) argue that “there are few instances where the political will in Canada has mandated the health and well-being of the Aboriginal community” (7) and that despite a number of policy recommendations, “the current federal government’s failure to implement action plans based on these recommendations demonstrates their lacking political will to make health equity a reality for all” (8). Richmond and Cook insist that “without healthy public policy in place” the government has no responsibility to rectify health inequities and no accountability for existing inequities (2016, 10). However, it is important to note that *political will* in Canada is antithetical to healthy public policy for Indigenous people. The *will* of liberal governments is invested in very particular forms of intervention, seated in expertise, and this is not so much indicative of a *lack* of political will, but rather, a will that works towards an end that favours the state rather than the health of its populations.

An Apparatus of Expertise

Discerning what we actually have to work with, and what we are stuck with, in the Canadian health policy landscape is a necessary endeavour. If we want to consider whether “good” policy is attainable, it would be prudent to consider Lea’s assertion that Indigenous social policy under settler occupation is “fundamentally about amelioration, not ‘cure’” (2020, 157). If good policy is not attainable and the political will of liberal governments does not result in the production of healthy policy for Indigenous peoples – how do we proceed? Lea contends that “if we remove the lazy option of calling for ‘better policy’ or of naively assigning responsibility for solving everything on the shoulders of Indigenous wisdom, creativity, and resistance, what might be done, even so? For me, the resort of decrying the state, then conjuring some place ‘other’ that

is magically free of state tentacles, is a failure of intellectual nerve. We have to stay with the state" (2020, 157). It is a pragmatic approach to think about how to stay with the state. In this research, particularly through analysis of the apparatus of expertise, I posit that we must identify and comprehend how these state tentacles — or rather, technologies and programs — operate. Policy will always be implicated and co-constituted with the state. Understanding the extent of the limitations and possibilities of policy creation, as it is constrained by the apparatuses and structures of settler colonial governmentality, is a necessary project to undertake.

One of the constraints we must work with if we 'stay with the state' is how the state formulates populations. The Canadian state formulates populations through statistical technologies such as the census and surveys. Bruce Curtis argues that 'population' is "a theoretical, not an empirical, entity. Population is not an observable object, but a way of organizing social observations" (2001, 24). Maggie Walter and Chris Andersen argue that "population statistics in particular are an evidentiary base that reflects *and* constructs particular visions considered important in and to the modern state. They map the very contours of the social world itself. They shape and thus create the accepted reality of things most of us think of the social world itself" (2013, 7). Walter and Andersen further argue that population statistics are integral to how nations see themselves because "they map national social and trends empirically: education levels; age and gender distributions; patterns of birth, morbidity, and mortality; labor and market figures; income dynamics; and many other phenomena. Via this mapping process they provide to the nation-state and its various populations a portrait of themselves" (2013, 7). Walter and Andersen contend that through this process, the phenomena that are included are as important as those that are excluded for rendering a portrait of the nation (2013, 7).

The statistical portraits of the nations and the population(s) that are organized as a result are often assumed as natural and left unquestioned. Andersen argues that "statistics must be understood for their *constitutive* powers in conjuring up (in the form of tables, charts, and graphs) summaries of more complex everyday realities about, in this case, Aboriginal communities and populations that come to be taken for granted ('the population is growing' or 'Métis are healthier today than they were 20 years ago')" (2016, 79). Moreover, "since statistics are, literally, a language 'of the state,' they carry their own independent weight not only in terms of political efforts to attain legitimacy, but also in the very constitution of the realities upon which that political legitimacy rests" (2016, 79). The organization of observations through population statistics tells us what is and is not important to the state when it comes to governmental interventions, but it also indicates *who* is important to the state through the populations that are made legible through statistics.

It is imperative to interrogate how populations are implemented in the apparatus of healthism within the federal government. It is particularly crucial to identify what populations are formed, and for what purposes of intervention. Statistics Canada serves as an arbiter of populations through the census and surveys that operate to indicate populations and the interventions required to govern them. Examples of this include the census, which establishes a population of First Nations, Métis, and Inuit – an organized social observation – that informs how (and for whom) Indigenous health is governed.[68] The governance of Indigenous health in relation to how the government has rendered First Nations, Métis, and Inuit as a population is especially evident in how Indigenous people are governed as a population in differential ways

[68] Statistics Canada. "2016 Census Aboriginal Community Portrait – Canada." *Statistics Canada.* Accessed October 17, 2020. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/infogrph/infgrph.cfm?LANG=E&DGUID=2016A000011124&PR=01.

through both Health Canada and Indigenous Services (Ladner 2009; Andersen 2016; Smylie et al. 2018). I further address this differential governance later in the chapter, but here it suffices to say that even within the Canadian 'Indigenous population,' the population is further fractured into sub-populations who are eligible for health care through Indigenous Services.[69] The Canadian Community Health Survey collects data on topics such as chronic health conditions, use of health care services, and health behaviours such as physical activity and consumption of fruits and vegetables.[70] The Canadian Community Health Survey data coheres further populations based on age, geography, race, and 'health issues.'[71] The Canadian Income Survey is yet another technology employed to cohere populations based on unmet health care needs, housing, and food security.[72] Even with a national population that encompasses all Canadian citizens, many policies directly target the statistical sub-populations that have been constituted through the technologies of Statistics Canada.

Statistics, and the populations that are formed through them, are a key technology of governmentality. Populations are made governable through expertise – including the statistics that define the bounds of populations, and the interventions that are then made upon those populations at the helm of experts. Populations are integral to the operation of an apparatus of healthism – they indicate a defined point of intervention and set apart subjects to be worked upon. Curtis argues that "the government of population thus operates along two axes: one of individualization, the other of totalization" (2001, 41). Curtis contends further that "individuals become the objects of projects that seek to change their conduct by effecting their bodily forces,"

[69] Indigenous Services Canada. "Who is Eligible for the Non-Insured Health Benefits Program."
[70] Statistics Canada. "Canadian Community Health Survey – Annual Component (CCHS)." *Statistics Canada*. Accessed October 17, 2020. https://www.statcan.gc.ca/eng/survey/household/3226.
[71] Statistics Canada. "Canadian Community Health Survey – Annual Component (CCHS)."
[72] Statistics Canada. "Canadian Income Survey (CIS)." Accessed October 17, 2020. https://www.statcan.gc.ca/eng/survey/household/5200.

while on the axis of totalization “individuals may be grouped together into categories within which their health, understandings, morals, and desires become the objects of particular governmental projects” (41). The Winnipeg Food Atlas interactive food atlas map exemplifies how statistical populations are used as a technology of healthism. The interactive food atlas map allows users to overlay a number of statistical bounds to render particular deficit, unhealthy populations through the data sets of male life expectancy, Aboriginal origins, recent immigrants, median household income, diabetes rates and cases, food deserts, food stores, food banks, and neighbourhood boundaries.[73] In the following sections I chart an apparatus of healthism through its rationalities, programs, and technologies and attend to how expertise operates as a governing rationality of healthism.

Rationalities, Programs, and Technologies of an Apparatus of Healthism

Analyzing modes of federal governmentality is necessary for delineating how and where an apparatus of healthism operates. The federal government – through its departments, policies, and the experts who sustain its many apparatuses – is a seat of expertise. How Indigenous populations have been quantified through such expertise informs how Indigenous health is governed by provinces, municipalities, not-for-profit intermediaries, and self-governing subjects. In this section I analyze an apparatus of healthism within the federal government via rationalities, programs, and technologies, while simultaneously focusing on how an apparatus of healthism relies on and operates through expertise. I have charted an apparatus of healthism within the federal government and have paid particular attention to health, nutrition, and food

[73] Winnipeg Food Atlas. “Winnipeg Food Atlas.” *Manitoba Collaborative Data Portal*. Accessed May 2, 2020. http://www.mbcdp.ca/fns.html. See: diabetes dashboard.

related policies.[74] In addition, I have delineated how each aspect of this apparatus operates through rationalities, programs, and technologies of governmentality (and thus healthism).

To analyze how this apparatus of healthism operates, it is necessary to identify the rationalities that govern how it conceptualizes power and how it exercises power. Thomas Lemke contends that "*government* refers to more or less systematized, regulated and reflected modes of power (a 'technology') that go beyond the spontaneous exercise of power over others, following a specific form of reason (a 'rationality') which defines the telos of action or the adequate means to achieve it" (2002, 53). Lemke goes on to argue that "a political rationality is not pure, neutral knowledge that simply 'represents' the governed reality. It is not an exterior instance, but an element of government itself which helps to create a discursive field in which exercising power is 'rational'" (2002, 55). Randy K. Lippert contends that rationalities are comprised of "the moral reasons for particular ways that diverse authorities exercise power; notions of the appropriate forms, objects, and limits of politics; and the right distribution of governing duties," and given this, rationalities are "not simply theories, philosophies, or ideologies; they are broad, historically developed discourses of rule" (2005, 4). In the context of this research, governmentality (and thus, healthism as a form of governmentality) operates through a liberal rationality. Earlier in the chapter I identified how health policy operates in a liberal social, political, and economic context. In this section, I identify how liberal rationalities – individualization, non-interference, valuing markets – shape the exercise of power, the distribution of governing duties (onto individuals), and the limits of intervention within health policy.

[74] See appendix 1.

For the purposes of identifying the rationalities that govern Indigenous health, the federal Health Portfolio and the Indigenous Health portfolio of Indigenous Services Canada will be the focus of our attention. The federal Minister of Health is responsible for "the Health Portfolio which comprises Health Canada, the Public Health Agency of Canada, the Canadian Institutes of Health Research, the Patented Medicine Prices Review Board, and the Canadian Food Inspection Agency."[75] The Health Portfolio is driven and sustained by experts and "consists of approximately 12,000 full-time equivalent employees and an annual budget of over $3.8 billion."[76] The two portfolios that inform an apparatus of healthism are Health Canada and the Public Health Agency of Canada. Health Canada is the federal department "responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances."[77] The very mandate of Health Canada indicates a liberal governing rationality that offloads responsibility for health onto individual citizens. Rationalities of liberal governmentality shift responsibility for risks onto the individual and emphasize individual choice and freedom (Miller and Rose 1990, 24; Lemke 2002, 59; Rose 2004, 64; Dean 2015, 400).

The rationalities of the Public Health Agency of Canada may initially appear to differ from Health Canada, but they are one in the same. The Public Health Agency of Canada was created to "help protect the health and safety of all Canadians," and focuses on "preventing chronic diseases, like cancer and heart disease, preventing injuries and responding to public health emergencies and infectious disease outbreaks."[78] The Public Health Agency of Canada "was established in 2005 as a means of making the public health system more effective"

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[75] Health Canada. "Health Portfolio." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/health-canada/corporate/health-portfolio.html.
[76] Health Canada. "Health Portfolio."
[77] Health Canada. "Health Portfolio."
[78] Health Canada. "Health Portfolio."

following the 2003 SARS outbreak that "illustrated quite vividly the flaws in Canada's public health system" (Fierlbeck 2000, 111). The Public Health Agency of Canada is much more interventionist than Health Canada, but it is still governed by liberal rationalities. In addition to disease prevention and responding to outbreaks, the Public Health Agency of Canada is also focused on health promotion, health education, and it "values scientific excellence and provides national leadership in response to public health threats."[79] One of the key programs of the Public Health Agency of Canada is the Pan-Canadian Healthy Living Strategy, which resulted in the Creating a Healthier Canada framework and the Curbing Childhood Obesity program. Each of these programs, behind a facade of health promotion, operate to situate the failures of self-governing responsibilized individuals as public health *threats*.

In the following sections, I interrogate the programs and technologies that are connected to the Public Health Agency of Canada as part of the healthism apparatus and I identify how they operate regulatory and disciplinary power to treat the failures of individualized responsibility for health via Health Canada. In using governmentality as an analytic to "pinpoint the strategic character of government" (2002, 56) Lemke argues that:

> To differentiate between rationalities and technologies of government does not mark the clash of program and reality, the confrontation of the world of discourse with the field of practices. The relations between rationalities and technologies, programs and institutions are much more complex than a simple application or transfer. The difference between the envisioned aims of a program and its actual effects does not refer to the purity of the program and the impurity of reality, but to different realties and heterogenous strategies. History is not the achievement of a plan but what lies "in between" these levels. Thus, Foucault sees rationalities as part of a reality that is characterized by the permanent "failure" of programs (2002, 56).

It is integral to understand the role of governing rationalities throughout the apparatus of healthism. Rationalities are not solely guiding telos but *do work* as well. Rationalities determine

[79] Public Health Agency of Canada. "Public Health Agency of Canada." *Government of Canada.* Accessed October 17, 2020. https://www.canada.ca/en/public-health.html.

what programs are envisioned to govern populations, what technologies are utilized to carry out interventions, and they operate through continued failure. The failures of Health Canada that get picked up by the Public Health Agency of Canada for further intervention as public health threats are not failures of liberal rationalities – it is a facet of liberal rationality – the failures between rationalities, programs, and technologies are part of these operations, and a condition of their existence. Governmentality is a self-sustaining machine.

Programs of governmentality reflect their rationalities, which in the context of this research means that the programs within the healthism apparatus identified here adhere to liberal rationalities of non-interference, market values, and citizen self-regulation. Programs in this context are "imagined projects, designs, or schemes for organizing and administering social conduct" (Lippert 2005, 4). According to Peter Miller and Nikolas Rose, "governmentality has a characteristically 'programmatic' form," and it is "inextricably bound to the invention and evaluation of technologies that seek to give it effect" (1990, 1). Miller and Rose contend that governmentality is programmatic not just via "the proliferation of more or less explicit programmes for reforming reality" but in that it is "characterized by an eternal optimism that a domain or a society could be administered better or more effectively, that reality is, in some way or other, programmable" (4). In the apparatus of healthism, Health Canada, the Public Health Agency of Canada, the Office of Nutrition Policy and Promotion, and Indigenous Health are all programs of government that operate to administer life through their respective technologies and interventions. Miller and Rose argue that programs constitute "a space within which the objectives of government are elaborated, and where plans to implement them are dreamed up . . . the programmer's world is one of constant experiment, invention, failure, critique, and

adjustment" (1990, 14). Programs reflect the rationalities of government, and are spaces where experts trial their interventions.

Technologies of governmentality are implemented to attempt to materialize the aims of programs. Technologies are the translative devices between the apparatus and population – they interpret the population for the apparatus, but they also refract back and further constitute relations of power between the apparatus and population(s). Rose argues that "technologies of government are those technologies imbued with aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired events" (2004, 52). To connect this back to the apparatus of healthism, the Public Health Agency of Canada deploys such technologies to attempt to produce desired effects, and to attempt to avert (or revert) other undesired population health events. Lippert similarly argues that "technologies of government are the material and intellectual means, devices, and mechanisms that make different forms of rule possible" (2005, 4). In the following section I demonstrate how the technologies within the healthism apparatus foster liberal governmentality and regulatory and disciplinary power through "self-regulation—namely, 'technologies of the self'" (Lemke 2002, 59). In the next section I interrogate a number of federal policies that constitute an apparatus of healthism to identify how the apparatus operates, where its tentacles reach, and who is targeted to provide a more complex and robust analysis of how Indigenous health is governed.

Expertise and the Apparatus

The purpose of this section is to analyze each policy and program featured in the charted healthism apparatus. I pay specific attention to how experts shape processes of risk management, by off-loading risk and responsibility onto individual citizens to self-regulate their health, through interventions at the level of the population and the individual. Perhaps most importantly,

I return to Tania Li's concept of "rendering technical" to demarcate how this federally situated apparatus of healthism operates through expertise. Li contends that "rendering technical" involves "the bounding and characterization of an 'intelligible field' appropriate for invention," which in this context is apparent in the creation of statistical populations through technologies such as Statistics Canada's census and surveys that then inform a variety of policies based on populations of race, "healthiness," socioeconomic status, and perceived risk (2007b, 7). Li argues that an "intelligible field" subsequently "confirms expertise and constitutes the boundary between those who are positioned as trustees, with the capacity to diagnose deficiencies in others, and those who are subject to expert direction" (2007b, 7). In addition to making diagnoses and interventions, the process of rendering technical produces a discursive field to govern social conduct that then informs other apparatuses of healthism at provincial, municipal, and community levels.

In order to interrogate how the federal apparatus of healthism operates, it is necessary to begin with a broad hierarchal rendering of the central programs that produce other programs and technologies. In this section I look to the broad hierarchal levels of the apparatus – Health Canada, the Office of Nutrition Policy and Promotion (a sub-program of Health Canada), the Public Health Agency of Canada, and Indigenous Health (a portfolio of Indigenous Services Canada) – and consider how each of these formations within the apparatus refract each other, and how they determine other programs and technologies. The apparatus charted here is limited to federal governmentality – it is not necessarily an all-encompassing rendering of healthism – and indeed, in the final chapter I trace the networked connections between the federal programs and technologies analyzed here, with the materializations of food policy and programming at the municipal level in Winnipeg.

It is important to remember that Indigenous populations are governed through expertise in areas other than health, and through other apparatuses of governmentality. Aboriginal title and rights have been governed through a Canadian legal apparatus, which operates through a multitude of experts – judges, lawyers, expert witnesses, and plaintiff testimonies. Apparatuses of governmentality are not necessarily divorced, and varying apparatuses can refract the governing rationalities of others. The "pizza test" or "pizza Indian" doctrine exemplifies how legal and healthism apparatuses have refracted to co-constitute Indigenous governmentality. The "pizza test" or "pizza Indian" doctrine was a strategy used during the Delgamuukw v British Columbia Supreme Court of Canada case by Crown lawyers to argue that the Gitxsan and Wet'suwet'en peoples had assimilated, as demonstrated by their transition from subsistence solely on a traditional diet to more 'modern' foods like pizza, and therefore were no longer Aboriginal and eligible for the title and rights associated with that.[80] The pizza test establishes an argument that situates pizza as a food that is related to whiteness and modernity, but it also indicates a refraction between Canada's apparatuses of health and law, in which a penchant for pizza simultaneously marks subjects as not Indigenous enough, and not healthy enough.

Health Canada has two key programmatic policies that serve to imagine and rationalize the administration of population health. These two frameworks – social determinants of health and health inequalities[81] and implementing the population health approach[82] – cohere an

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[80] Ebert, Mark. 2015. "Overcoming the Dispositionism of Aboriginal Rights in Canada: Culture in the Mind Versus Life in the World." *UBC Law Review* 48 (1): 178. Ray, Arthur J. 2003. "Aboriginal Title and Treaty Rights Research: A Comparative Look at Australia, Canada, New Zealand and the United States." *New Zealand Journal of History* 37 (1): 10.
[81] Health Canada. "Social Determinants of Health and Health Inequalities."
[82] Health Canada. "Implementing the Population Health Approach." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/population-health/implementing-population-health-approach.html.

assemblage of programs and technologies that make health and nutrition interventions that are in line with the rationalities established by these guiding principles and policies. The social determinants of health and health inequalities framework outlines factors that influence health and distinguishes determinants of health from social determinants of health.[83] The framework identifies that "some Canadians are healthier and have more opportunities to lead a healthy life," and such differences in health are referred to as health inequalities.[84] Health inequalities are determined to be "due to your genes and the choices you make," while social determinants of health can also influence health inequalities – Health Canada provides the off-putting example that "Canadians with higher incomes are often healthier than those with lower incomes." Health Canada marks the distinction between health inequity – which refers to inequalities that are "unfair or unjust and modifiable" and health equity – which refers to the absence of unfair systems and policies that cause health inequalities.[85] Health Canada does not aim to achieve *health equity* though; they only operate to *reduce health inequalities* by giving "everyone the same opportunities to be healthy."[86] Such an approach to governmentality of health results in differential governance – providing the same resources for everyone could be described as equality, but to have health equity would require resources for populations based on specific

[83] Health Canada identifies the main determinants of health including: 1) income and social status, 2) employment and working conditions, 3) education and literacy, 4) childhood experiences, 5) physical environments, 6) social supports and coping skills, 7) healthy behaviours, 8) access to health services, 9) biology and genetic endowment, 10) gender, 11) culture, and 12) race / racism. Health Canada sets apart social determinants of health as a specific group of social and economic factors within the broader determinants of health. Health Canada also notes that "*experiences* of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, LGBTQ and Black Canadians." The structural determinants of health that determine health inequities for Indigenous people (such as colonization) are not identified here as a determinant, but instead is reduced to an individualized *experience of*. See: Health Canada. "Social Determinants of Health and Health Inequalities."

[84] Health Canada. "Social Determinants of Health and Health Inequalities."

[85] Health Canada. "Social Determinants of Health and Health Inequalities."

[86] Health Canada. "Social Determinants of Health and Health Inequalities."

needs. Health Canada relies on programs and technologies of expertise to reduce health inequalities (or rather, produce expert knowledge about possible interventions) through data sets to inform decision-making, engaging expertise outside of the health sector, and sharing knowledge across Canada.[87]

The Health Canada framework "Implementing the Population Health Approach" outlines *health promotion* as a way to take action on the "social, physical, economic and political factors that affect health."[88] The implementation strategies for population health rely on health promotion, risk management, and prevention. Health promotion is meant to take action on population health, risk management guides decision-making processes, and prevention occurs at three levels to intervene in the health of individuals. Health Canada identifies primary prevention as being "aimed at reducing factors leading to health problems," secondary prevention involving "early detection of and intervention in the potential development or occurrence of a health problem" and tertiary prevention as "treatment of a health problem to lessen its effects."[89] Analysis of the programs and technologies within the federal apparatus of healthism indicate that when it comes to Indigenous health (particularly as it relates to nutrition and food security), most health prevention is occupied with secondary modes of prevention. There are little to no efforts that actually aim to reduce factors leading to health problems (e.g. determinants of health, colonialism, inequitable access to health resources), and few efforts of tertiary prevention (e.g. reducing food insecurity). Most efforts lie in the realm of secondary prevention, which speaks to the role of expertise in the governing of health through the detection, or "problematization," and subsequent intervention through the "rendering technical" of a statistical unhealthy population, in

[87] Health Canada. "Social Determinants of Health and Health Inequalities."
[88] Health Canada. "Implementing the Population Health Approach."
[89] Health Canada. "Implementing the Population Health Approach."

what Health Canada would refer to as a "entry point" to health intervention.[90] The two Health Canada frameworks analyzed here demonstrate how the federal government approaches health through the twinned processes of health promotion and addressing health inequities. Health promotion and health inequities are cohering logics that go on to be employed throughout many other programs and technologies in the healthism apparatus.

The Office of Nutrition Policy and Promotion is a program nested within the program of Health Canada and essentially constitutes its own small-scale nutritional apparatus within the larger apparatus of healthism. Health Canada has operated to provide "national leadership in nutrition since the 1930s" and works with all levels of government and other intermediaries to develop and implement "evidence-based policy that defines healthy eating and promotes environments that support Canadians in making healthy food choices."[91] Health Canada has established itself as an "authoritative source of nutrition information" through its range of programs and technologies that are housed within the Office of Nutrition Policy and Promotion.[92] The assemblage of programs and technologies within the Office of Nutrition Policy and Promotion produces biomedical hegemonic nutrition guidelines and interventions that inform policies, programs, and services well beyond the federal sector.

The Office of Nutrition Policy and Promotion has four key functions: 1) policy leadership and collaboration, 2) dietary guidance, 3) promotion and knowledge translation, and 4)

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[90] Health Canada identifies entry points as valid places to begin in considering health and interventions to improve health. Entry points include demographic groups (e.g. Indigenous people, low income people), diseases (e.g. diabetes), settings (e.g. municipalities), behaviours and lifestyle (e.g. nutrition and exercise), and determinants of health (e.g. income and social status, education, social support). See: Health Canada. "Implementing the Population Health Approach."

[91] Health Canada. "Nutrition and Healthy Eating." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/health-canada/services/food-nutrition/healthy-eating.html.

[92] Health Canada. "Nutrition and Healthy Eating."

surveillance, research, data analysis, and knowledge development.[93] The leadership and collaboration indicates the reach of this office's expertise – they work with multiple sectors, jurisdictions, non-governmental, and international organizations to promote healthy eating.[94] In the areas of dietary guidance and promotion and knowledge translation, the office intends to promote dietary guidelines that are "relevant for Canadians" through "coherent and consistent public health nutrition messages."[95] However, analysis of programs such as Canada's Food Guide indicate that these efforts are lacking when it comes to *all Canadians*. Attempts have been made to tailor the advice in Canada's Food Guide for sub-populations, like the Eating Well with Canada's Food Guide for First Nations, Inuit, and Métis, but such efforts have so far been limited to the swapping of culturally appropriate foods in place of food items approved by existing hegemonic nutrition guidelines. The food guide is an exemplification of healthism – its sole purpose (at the level of the individual consumer) is to educate individuals on how to self-regulate their diet.

The Office of Nutrition Policy and Promotion is a nucleus of expertise – all four key functions of the office produce and disseminate expertise – but the function of surveillance, research, data analysis, and knowledge development is essential for problematization and rendering technical for the purpose of intervention through the development of health surveys, data analysis and interpretation, monitoring of health nutrition indicators, and the development and implementation of nutrition data collection tools.[96] This office is invariably the most

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[93] Health Canada. "Office of Nutrition Policy and Promotion." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/health-canada/corporate/about-health-canada/branches-agencies/health-products-food-branch/office-nutrition-policy-promotion.html.
[94] Health Canada. "Office of Nutrition Policy and Promotion."
[95] Health Canada. "Office of Nutrition Policy and Promotion."
[96] Health Canada. "Office of Nutrition Policy and Promotion."

significant and far-reaching sector of the healthism apparatus and the interventions they do not make will tell us as much as those that they do.

Health Canada identifies a healthy and nutritious diet as an essential factor to maintaining "a healthy, productive population."[97] Ensuring Canada maintains a healthy, productive population that contributes to the security of the state requires "surveillance of food and nutrient intakes, food safety, nutritional status and nutrition-related health outcomes," as well as surveillance of "individual factors like knowledge, attitudes and practices."[98] Food and nutrition surveillance involves "collection, integration, analysis, interpretation and dissemination of food and nutrition data."[99] The Office of Nutrition and Policy and Promotion undertakes nutrition surveillance including: collecting data on what Canadians are eating, measuring contaminant levels in some foods, developing methodological and data collection tools and standards, providing guidance on interpreting surveillance data, and analyzing and interpreting data to inform programs and policies.[100] An example that I analyze later in this section is the report *Food and Nutrition Surveillance in Canada: An Environmental Scan*. It is important to remember that nutrition surveillance is laden with regulatory and disciplinary power and is wielded by experts to make value judgements about what and how people eat, and to make interventions into statistical populations that have been rendered unhealthy and thus, a threat to the security of the *population*.[101]

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[97] Health Canada. "Food and Nutrition Surveillance." *Government of Canada.* Accessed October 17, 2020. https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance.html.
[98] Health Canada. "Food and Nutrition Surveillance."
[99] Health Canada. "Food and Nutrition Surveillance."
[100] Health Canada. "Food and Nutrition Surveillance."
[101] Winnipeg Food Atlas. "Winnipeg Food Atlas." *Manitoba Collaborative Data Portal*. Accessed May 2, 2020. http://www.mbcdp.ca/fns.html. See: diabetes dashboard. Diabetes policy is a prime example of how nutrition surveillance relies on statistical populations that have been rendered unhealthy. Diabetes is seen as a threat to the security of the state's economic health, and statistical populations (e.g. Aboriginal, low income, diabetes rates) are essential for surveillance and intervention.

Health Canada has implemented the use of the "Conceptual Model of a Food and Nutrition System" framework to support a systematic approach to surveillance and other nutrition policies.[102] The conceptual model "points to potential areas for data collection, analysis, surveillance related research, dissemination and implementation and supports the need for a systemic approach to surveillance activities, which can be applied to other domains such as research and policy."[103] The conceptual model uses a food to health pathway approach – which essentially utilizes a top down approach to consider how food results in health outcomes.[104] The conceptual model outlines central elements of the food to health pathway that hierarchizes influences and elements of the food system as moving through the respective stages of food supply, distribution, consumption, utilization, and health outcome.[105] The conceptual model exhibits several blatant deficiencies. The hierarchization of the varying elements fails to account for co-constitution and refraction of outside pressures and influences on food consumption and health outcomes. The model does account for some factors that would be identified in a social determinants of health framework; however, it is lacking in substantial accounting for larger structural determinants of health, consideration of how health status can refract food consumption (food consumption is not just a top down indicator of health status), and it reifies "entry points" or statistical populations for health intervention. The conceptual model's rendering of predominantly individual influences on food and nutrition (e.g. food preferences, income, age, sex, physical status, housing, and existing health status to name a few) reifies

[102] Health Canada. "Conceptual Model of Canadian Food and Nutrition System." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/conceptual-model-canadian-food-nutrition-system.html.
[103] Health Canada. "Conceptual Model of Canadian Food and Nutrition System."
[104] Health Canada. "Conceptual Model of Canadian Food and Nutrition System."
[105] See appendix 2. For a PDF chart of the conceptual model see: Health Canada. "Conceptual Model of Canadian Food and Nutrition System."

individual deficits rather than focussing on larger structural and environmental determinants. These individual influences at the "entry points" for intervention that are made into statistical populations based on whatever particular challenges pigeonhole them into being unhealthy. To reflect back to Murphy's provocation at the beginning of this chapter, through the creation of such statistical populations, it "points the finger at masses rather than distributions and accumulations, at people rather than economy," and here, at people rather than structural, economic, and political determinants of health (2017, 137).

The Health Canada *Food and Nutrition Surveillance in Canada: An Environmental Scan* report provides insight into the establishment of surveillance sub-populations, especially for Indigenous populations. The report notes that "surveillance is not investigation, planning, intervention, research, priority setting, policy development, issue management or risk management. But surveillance provides information essential to all of these activities" (McAmmond and Associates 2000, 3). Surveillance does not simply provide a source of untapped information for policy activities, it does indeed determine what social phenomena are investigated, how subsequent interventions are made, and renders portraits of populations of risk. The environmental scan notes that Indigenous populations require "better surveillance of dietary intakes, nutritional status, nutrition-related knowledge, attitudes and behaviours, and health outcomes" because as a population, Indigenous peoples "experience a high incidence of nutrition-related health problems" (McAmmond and Associates 2000, 10). Such surveillance is indispensable when it comes to healthism and impacts the self-regulatory, educational, and ultimately disciplinary interventions on Indigenous populations. The scan reproduces common renderings of Indigenous health that fail to identify the refractions between poor health outcomes, food insecurity, and other determinants of health.

The *Food and Nutrition Surveillance in Canada* report argues that improved surveillance of Indigenous populations must include recognition of unique needs and interests, particularly in regard to "ownership and control of data" which will "require different approaches than those normally used for population surveillance" (McAmmond and Associates 2000, 14). The report identifies issues and considerations for surveillance of Indigenous populations, largely focusing on Indigenous ownership of data and biological samples, surveillance responding to community directives and capacities, and that surveys be able to "take into account the ability to compare the Aboriginal population to the larger population, as well as the ability to draw conclusions about Aboriginal sub-populations and do comparisons among different Aboriginal groups and areas" (McAmmond and Associates 2000, 27). Indigenous driven and owned health data is absolutely fundamental. However, it would be prudent to proceed with caution when gathering population data to compare to the larger population, or to surveil particular deficit areas of Indigenous health, lest such surveillance merely serve to reinforce individual deficits, rather than actually gather data about or intervene in determinants of health.

The Office of Nutrition Policy and Promotion wields expertise through the operation of technologies of surveillance to intervene in health; however, they have also produced dietary guidance that informs and infiltrates many other food and nutrition programs and services beyond the federal sector. Health Canada's healthy eating strategy informs many of the programming and technologies that are produced through the Office of Nutrition Policy and Promotion and is particularly refracted through Canada's Food Guide – and the food guide is an arbiter of "nutrition" and "health" for many more policies. The healthy eating strategy aims "to improve the food environment in Canada to make it easier for Canadians to make the healthier

choice."[106] The healthy eating strategy works with the aim of improving healthy eating information, improving nutrition quality of foods, protecting vulnerable populations, and supporting increased access to and availability of nutrition foods.[107]

A key effort of improving healthy eating information is Canada's Food Guide, which went through its most recent revisions in January 2019. I have more extensively engaged with the food guide in chapter 3, as one of the many technologies that comprises what I refer to as a biomedicalized hegemonic nutrition conglomerate. It will suffice here to reiterate how diffuse Canada's Food Guide is amongst the reaches of the healthism apparatus. For example, the hegemonic nutrition and dietary guidelines established through the food guide inform other programs and technologies that regulate and discipline Indigenous peoples' food and nutrition practices. The Nutrition North Canada program is identified as a program to support "increased access and availability to nutritious foods" for residents of isolated northern communities (communities that are predominantly Indigenous and facing high rates of food insecurity).[108] Nutrition North Canada is an example of a policy that has prioritized nutritional expertise at the expense of substantially rectifying food insecurity. Similarly, Indigenous Services Canada and the Public Health Agency of Canada also provide funding to eligible communities for nutrition education programming that aims to "increase health eating knowledge" and to "develop skills in selecting and preparing nutritious foods."[109] Again, the dietary regulations established in Canada's food guide inform programs and technologies that are not necessarily recognized as being meant to make interventions into nutrition, but through the governing rationalities of

[106] Health Canada. "Health Canada's Healthy Eating Strategy." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/services/health/campaigns/vision-healthy-canada/healthy-eating.html.
[107] Health Canada. "Health Canada's Healthy Eating Strategy."
[108] Health Canada. "Health Canada's Healthy Eating Strategy."
[109] Health Canada. "Health Canada's Healthy Eating Strategy."

healthism and its interconnectedness with biomedicalized hegemonic nutrition, such programs and technologies invariably operate to regulate and discipline individuals.

Two final manifestations of the interventional reach of the Office of Nutrition Policy and Promotion that I want to briefly examine are the reports *Measuring the Food Environment in Canada* and *Working with Grocers to Support Healthy Eating*. The *Measuring the Food Environment in Canada* report partnered with several academics, researchers, and nutrition scientists to determine how they are "conceptualizing and assessing food environments and using food environment data" (Health Canada 2013a, 3). The report is largely concerned with how to gather, utilize, and connect data on nutrition-related chronic diseases, healthy eating patterns, and access to nutritious foods. The *Working with Grocers to Support Healthy Eating* report similarly links concerns about nutrition-related chronic diseases to the mandates of "eating well, being physically active, and maintaining a healthy body" to reduce risks of disease (Health Canada 2013b, 9). The report is primarily concerned with outlining what can be done "to support healthy eating in the food retail setting, including suggestions for program development, implementation, and evaluation" (Health Canada 2013b, 9). Grocery stores are the point of application for nutrition interventions due to the understanding that "the availability, accessibility, and promotion of nutritious food in food retail environments may help to reduce the risk of obesity as many food purchasing decisions take place in-store" (Health Canada 2013b, 9). I analyze aspects of these reports in other chapters in the context of food deserts and white possessive securitization of grocery stores, but reference them here as an exemplar of technologies that employ expertise to establish the bounds of intervention in the aim of regulating the health conduct of citizens.

The Public Health Agency of Canada's Pan-Canadian Healthy Living Strategy has endorsed and produced two initiatives (technologies) that address disease and health promotion – *Creating a Healthier Canada: Making Prevention a Priority*, a declaration on prevention and promotion, and the *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*.[110] These two governing technologies resulted from the Pan-Canadian Healthy Living Strategy's framework to focus on the prevention of disease, promotion of health, and to align and co-ordinate "efforts to address common risk factors such as physical inactivity and unhealthy eating."[111] The Pan-Canadian Healthy Living Strategy meant to "target the entire population" but put a "particular emphasis on children and youth, those in isolated, remote and rural areas, and Aboriginal communities – to improve overall health outcomes and to reduce disparities in health among Canadians."[112] The Pan-Canadian Healthy Living Strategy situated poor health as a serious security threat for the nation – noting that "the estimated total cost in Canada of illness, disability and death attributable to chronic diseases amounts to over $80 billion annually" and that "physical inactivity costs the Canadian health care system at least $2.1 billion annually in direct health care costs, and the estimate annual economic burden is $5.3 billion."[113] The strategy identified policy and programing initiatives, research and surveillance, and public information as necessary for implementing outcomes of the strategy.[114] The two technologies that resulted reveal how particular forms of expertise are employed to make interventions into particular statistical

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[110] Public Health Agency of Canada. "Overview of the Pan-Canadian Healthy Living Strategy." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/healthy-living/overview-canadian-healthy-living-strategy.html.
[111] Public Health Agency of Canada. "Overview of the Pan-Canadian Healthy Living Strategy."
[112] Public Health Agency of Canada. "Overview of the Pan-Canadian Healthy Living Strategy."
[113] Secretariat for the Intersectoral Healthy Living Network in Partnership with the F/P/T Healthy Living Task Group and the F/P/T Advisory Committee on Population Health and Health Security (ACPHHS). 2005. *The Integrated Pan-Canadian Healthy Living Strategy*. (Ottawa: Minister of Health), 1.
[114] Secretariat for the Intersectoral Healthy Living Network, *Integrated Pan-Canadian Healthy Living Strategy,* 6.

populations, and how Indigenous peoples are determined to be a risk to the economic security of the nation but not deserving of health equity.

The *Creating a Healthier Canada: Making Prevention a Priority* declaration on prevention and promotion indicates that the "promotion of health and the prevention of disease, disability and injury are a priority and *necessary to the sustainability of the health system*."[115] The declaration, through a liberal rationality, connects the health of the nation to economic health and the reduction of health care costs.[116] Indeed, the guiding principles of the declaration forefront the need to focus on promotion of health and prevention of chronic diseases to not only improve quality of life and reduce disparities in health, but to also reduce the impact poor health has on "individuals, families, communities, the health-care system and on society."[117] The declaration seems to posit that having individuals self-regulate health to prevent negative health outcomes reduces disparities in health – and while this may be true in the sense that if more of the population adheres to a particular standard of health, then a higher percentage of the population will be recorded as healthy – but it does little to address determinants of health that produce health disparities that cannot be altered through self-prevention measures alone. Moreover, aside from recognizing that "some people, such as some First Nations, Inuit and Métis people – who occupy a unique place in Canada by virtue of history and health status – and those with lower levels of income and education, do not enjoy the same good health as the rest of the Canadian population," the declaration does little to significantly attend to why such inequities

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[115] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/healthy-living/creating-a-healthier-canada-making-prevention-a-priority.html. Emphasis added.
[116] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority."
[117] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority."

exist and how health could be achieved beyond simply asking individuals to self-regulate themselves to the standard of Canadian health.[118]

The focus on prevention in the declaration seemingly serves the purpose of off-loading risk and responsibility onto individuals. Prevention is framed as a priority to "create healthier populations, and to sustain our publicly funded health system."[119] Promotion efforts become intertwined with goals of prevention, predominately through self-regulatory measures and education. The declaration identifies several approaches that can be used to promote health, including changing risk factors and conditions that lie outside of the health sector, providing public health services, ensuring access to clinical prevention services, and creating and using research and evidence to determine "what creates good health."[120] However, the declaration also identifies that prevention can occur through "helping people learn and practise healthy ways of living."[121] The rationalities at play through prevention and promotion efforts occur time and time again in responses to Indigenous health globally. Lea recalls Australia's former prime minister Tony Abbott supporting "a campaign to shut down more than half the remote Aboriginal communities of Western Australia" because "taxpayers should not be expected to finance Indigenous people's 'lifestyle choices'" (2020, 12). In a similar vein, Judith Collins, the New Zealand National party leader was criticized this year, 2020, for "calling obesity a 'personal choice,'" and arguing that it is "not that hard" to "get frozen vegetables out of the freezer . . . and do something with them."[122] New Zealand is identified as "the third fattest country in the world,"

[118] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority."
[119] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority."
[120] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority."
[121] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority."
[122] Australian Associated Press. "New Zealand National Party Leader Judith Collins Calls Obesity a 'Personal Choice.'" *The Guardian*. October 12, 2020. https://www.theguardian.com/world/2020/oct/14/new-zealand-national-party-leader-judith-collins-calls-obesity-a-personal-choice.

with 31% of the population being identified as obese, and with 48% of the Māori population being identified as obese – rates that Collins thinks can be addressed solely with "personal responsibility."[123]

Several of the approaches outlined in the declaration would be legitimate and productive approaches to changing health outcomes for many populations; however, there is little commitment to some of these approaches within the declaration. For instance, the declaration notes that many "determinants of health lie outside the reach of the health sector," so many actions required to improve health lie outside of the scope of the health sector as well.[124] More tellingly, the declaration indicates that how a health issue is approached is based on "knowledge of the approach's effectives, *cost-effectiveness*, and on the characteristics of the community or group involved."[125] It should come as no surprise that determinants of Indigenous health often lie outside the direct purview and realm of the health sector and would not be simple and cost-effective approaches. Expert intervention through education results in regulatory and disciplinary approaches to promote prevention, and thus work to shape better biocitizens out of Indigenous people because "promoting health and preventing diseases is *everyone's business*," regardless of whether they have the capacities, resources, or desire to do so.[126]

The Public Health Agency of Canada operationalizes technologies that situate poor health as a risk to the security of the greater population and economy, and the report *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights* is an exemplar of this. The framework posits that Canada is in the "midst of a

[123] Australian Associated Press. "New Zealand National Party Leader Judith Collins Calls Obesity a 'Personal Choice.'" *The Guardian*. October 12, 2020.
[124] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority."
[125] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority." Emphasis added.
[126] Public Health Agency of Canada. "Creating a Healthier Canada: Making Prevention a Priority."

childhood obesity epidemic" with overweight and obesity rates for youth aged 12 to 17 being at 29 percent, while "young people of Aboriginal origin (off-reserve) had a significantly high combined overweight/obesity rate of 41 per cent."[127] The report links a range of health issues such as high cholesterol, high blood pressure, Type 2 diabetes, sleep apnea, and joint problems to increased childhood obesity.[128] The framework contends that childhood obesity then leads to "an increase in health care costs, and a high risk of lost productivity in the Canadian economy as a result of an anticipated greater level of absenteeism and weight-related illnesses."[129] The framework relies on statistical populations to differentiate rates of obesity between non-Indigenous and Indigenous children and reproduces the legitimacy of Body Mass Index (BMI) as a measure of health. BMI has been well criticized as being abstract, arbitrary, and normalizing – and fails to account for differences in bodies across "genders and across different cultural, socio-economic and geographical groups" (Halse 2009, 47; Guthman 2012, 1115; Gard 2016, 33). In the following chapter, I further demonstrate how the obesity framework has determined programming and services relating to food insecurity in Winnipeg through surveillance, education, and built environment changes.

Food Policy for Canada set a "vision for the future of food in Canada" which is that: "all people in Canada are able to access a sufficient amount of safe, nutritious, and culturally diverse food. Canada's food system is resilient and innovative, sustains our environment and supports our economy."[130] Food Policy for Canada received "over $134 million in initial investments to

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[127] Public Health Agency of Canada. "Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/healthy-living/curbing-childhood-obesity-federal-provincial-territorial-framework.html.
[128] Public Health Agency of Canada. "Curbing Childhood Obesity."
[129] Public Health Agency of Canada. "Curbing Childhood Obesity."
[130] Agriculture and Agri-Food Canada. 2019. *Food Policy for Canada: Everyone at the Table*. (Ottawa: Minister of Agriculture and Agri-Food), 5.

support the food policy" from the federal government beginning in 2019 and has indicated that this "first-ever" policy will "help Canada build a healthier and more sustainable food system – one that builds on a robust agenda to support growth for farmers, producers, and food businesses in Canada."[131] The housing of this policy within Agriculture and Agri-Food Canada explains its leanings towards prioritizing economy and food production, rather than everyday experiences of food. Food Policy for Canada has set a number of priority outcomes such as improving community capacity and resilience, increasing governance and partnerships across the food system, improving health status and reducing the burden of diet-related diseases, developing strong Indigenous food systems, improving sustainable food practices, and ensuring an economically viable food system.[132]

Food Policy for Canada action areas that have been identified for 2019-2024 include helping communities access healthy food, making Canadian food the top choice at home and abroad, supporting food security in northern and Indigenous communities, and reducing food waste.[133] While the action items of helping communities access healthy food and supporting food security in northern and Indigenous communities is promising, it is unclear whether they will produce any significant amelioration of food insecurity. "Reconciliation" is one of six principles guiding the policy, as a way to account for how "historic Government policies" have disrupted Indigenous food systems, and to account for the need of including a distinctions-based approach, Indigenous food self-determination, a holistic approach, looking seven generations ahead, and two-eyed seeing in all policy decision making going forward.[134] Given the continuity of government policies that disrupt Indigenous food systems and impact health, nutrition, and food

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[131] Agriculture and Agri-Food Canada. 2019. *Food Policy for Canada: Everyone at the Table*, 3.
[132] Agriculture and Agri-Food Canada. 2019. *Food Policy for Canada: Everyone at the Table*, 6-7.
[133] Agriculture and Agri-Food Canada. 2019. *Food Policy for Canada: Everyone at the Table*, 9.
[134] Agriculture and Agri-Food Canada. 2019. *Food Policy for Canada: Everyone at the Table*, 10-11.

security, it remains to be seen whether a solely distinctions based approach to a separate Indigenous food system will provide Indigenous communities with the resources they need when high rates of food insecurity are actually more related to the challenges of navigating settler colonial food systems.

Food Policy for Canada completed extensive consultation leading up to the creation of the policy. Consultations were held with Indigenous organizations and organizations who had stakes in food security and food production. In addition, an online survey was administered that had over 45,000 citizen responses. The government identified four national Indigenous organizations to consult during this process: Congress of Aboriginal Peoples (CAP), Inuit Tapiriit Kanatami (ITK), the Assembly of First Nations (AFN), and the Native Women's Association of Canada (NWAC). ITK, AFN, and NWAC all chose to complete "self-led engagement on the policy, with support from the government."[135] Both NWAC and ITK have released their own reports on a Canadian food policy (ITK 2017; NWAC 2018). A review of the two reports highlights that many of the key recommendations being made by both NWAC and ITK have been glossed over. For instance, ITK outlined the challenges and barriers Inuit face as including institutionalized discrimination, quantity and access, quality, cost, and knowledge and skills (2018, 16-18). These concerns are not sufficiently reflected in Food Policy for Canada. The glossing over of Indigenous recommendations in Food Policy for Canada is just as troubling as the lack of recognition their self-led engagement received in the final policy, which serves to highlight the restrictions of working within liberal governmentality frameworks that are overly determined by settler government. It remains to be seen whether Food Policy for Canada will

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[135] Agriculture and Agri-Food Canada. "Consulting with Canadians for The Food Policy for Canada." *Government of Canada*. Accessed February 15, 2021. https://www.agr.gc.ca/eng/about-our-department/public-opinion-and-consultations/consulting-with-canadians-for-the-food-policy-for-canada/?id=1597864030202.

contribute significant material outputs to promote Indigenous food security during its first term between 2019 and 2024.

Indigenous Health, a portfolio of Indigenous Services Canada, is the final node of the healthism apparatus that will be analyzed in this chapter. Indigenous Health provides information on "health care services and non-insured health benefits (NIHB), careers, how to fight drug and substance use, environmental health, food safety and how to have a healthy pregnancy."[136] Indigenous Health provides scant resources relating to food and nutrition, and those that are offered required some digging. Under "diseases that may affect First Nations and Inuit communities," information can be found about the Aboriginal Diabetes Initiative; otherwise there are few resources available regarding healthy eating and food safety for Indigenous peoples.[137] The only programs and services Indigenous Health feature are Canada's Food Guide and Nutrition North Canada – both of which have been addressed in previous chapters.[138] The actual department responsible for Indigenous health is meager. Even though Indigenous peoples are accounted for under broader health policies, I have demonstrated throughout this chapter that those policies do not do a sufficient job of governing population(s).

Administering Indigenous Populations and Bodies

When it comes to Indigenous health and nutrition, the federal apparatus of healthism operates to administer Indigenous populations and bodies through regulatory and disciplinary power. Regulatory power is operationalized at the level of the population, whereas disciplinary power intervenes in the individual body. Nikolas Rose argues that Michel Foucault's theorization

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[136] Indigenous Services Canada. "Indigenous Health." *Government of Canada.* Accessed October 17, 2020. https://www.sac-isc.gc.ca/eng/1569861171996/1569861324236.
[137] Indigenous Services Canada. "Diabetes." *Government of Canada.* Accessed May 2, 2020. https://www.sac-isc.gc.ca/eng/1569960595332/1569960634063.
[138] Indigenous Services Canada. "Healthy Eating and Food Safety for Indigenous Peoples." *Government of Canada*. Accessed October 17, 2020. https://www.sac-isc.gc.ca/eng/1581522106156/1581522147811.

of power posited that it was too "simplistic" to see societies of normalization as solely disciplinary, and that instead "life was taken in charge by the interplay between the technologies of discipline focused on the individual body and the technologies of bio-politics, which acted on those bodies *en masse,* intervening in the making of life, the manner of living, in how to live" (2004, 23). Regulatory power is operationalized to administer *the population*. In the apparatus of healthism, regulatory power operates through programs such as Health Canada's social determinants of health and health inequalities framework and implementing the population health approach framework – these programs are broadly concerned with how to administer the health of the population, and while they reify rationalities that go on to make individualization possible, they are not concerned with bodies themselves. Thomas Lemke posits that "disciplinary or sovereign power are reinterpreted not as opposite forms of power but as different technologies of government" (2002, 53). Tracing the technologies of healthism leads to technologies of discipline. Technologies such as *Curbing Childhood Obesity* and Canada's Food Guide are technologies of healthism and technologies of discipline that operate to make interventions in individual bodies, not bodies *en masse*. However, it is a necessary task to interrogate how regulatory power can result in disciplinary outcomes through the process of differential governance.

The federal apparatus of healthism demonstrates how Indigenous populations are differentially governed through policies that are meant to intervene in the population as a whole. When programs and technologies of healthism are implemented with no accounting for specificities of *populations*, it results in differential and insufficient governance that is felt differently amongst populations, particularly Indigenous populations. For example, most nutrition and health policies identify diet-related diseases as stemming from poor diets and may

recognize that poor diets occur in lower socio-economic populations or food insecure households. However, many nutrition programs and technologies that operate to create a 'healthier Canada' focus on educating individuals (albeit *en masse*) into eating healthier, rather than reconciling with the fact that many populations being governed by such policies require a substantial change to their food insecurity landscape. An average, white, middle-class Canadian will feel the effects of *Creating a Healthier Canada* differently than someone who is Indigenous and in a lower socio-economic bracket, has unmet health care or housing needs, or is food insecure.

Interrogating how Indigenous populations and bodies are administered through an apparatus of healthism illuminates how the majority of federal governmentality of Indigenous health occurs through differential governance. The implications of differential governmentality, particularly the felt effects and material realities that result, need to be at the center of analysis for Indigenous health policies. Lea poignantly notes that "policy particles from decisions made by other people, for other people, bioaccumulate in the present" (2020, 4). The felt effects, or bioaccumulations, of differential governance is a compounding process that further entrenches how policies and interventions propagate corporeal consequences. Differential governmentality hinges on *population.* Murphy posits that "it is hard to be against the term *population*, because the concept is so built into the epistemological structures of policy and rule. Yet it is possible, and I think necessary, to be against population. I want better concepts for aggregate life" (2017, 137). Engaging with Murphy's provocation for better concepts for aggregate life should be at the forefront of emerging policy analysis. Questions that should orient future inquiry include: Can we abandon *population*? Can better concepts for aggregate life be employed within biopolitical structures under late liberal settler colonial rule? And will accounting for *difference* (as a logic to

produce a particular iteration of indigeneity) of Indigenous populations within health policy serve to counter the felt effects of differential governance?[139]

Conclusion

In this chapter I situated the governmentality of Indigenous health within the context of Canadian health care and policy. I analyzed what I have identified as an apparatus of healthism – and I focused specifically on the rationalities, programs, and technologies that constitute it at a federal level. I have argued that the federal government is the seat of expertise that informs all other iterations of healthism at the provincial, municipal, and community level. In the following chapter I extend the analysis established in this chapter to consider the reach of the federal apparatus and how it determines policy, programming, and services in Winnipeg through provincial, municipal, and not-for-profit intermediaries. In the following chapter I turn my attention to how the apparatus of healthism operates in Winnipeg to discipline Indigenous people into being better biocitizens.

[139] Here I draw on Jessica Kolopenuk's theorizing of "iteration(s) of indigeneity" to consider how "colonialism involves the re/iteration and regulation of bodies deemed *Aboriginal, Native American,* or *Indian,* etc." (2020a, 2).

Chapter Six – The Biocitizen

Their own bodies were to be part of the infrastructure of persuasion. Motivation was to pass between bodies, become contagious and collective.
– Michelle Murphy[140]

Within the race war, Indigenous sovereign counter-rights claims pose a threat to the possessiveness of patriarchal white sovereignty, requiring it to deploy a discourse of Indigenous pathology as a weapon to circulate a strategic truth: if Indigenous people behaved properly as good citizens, then their poverty would disappear.
– Aileen Moreton-Robinson[141]

The two provocations I begin this chapter with do not directly name *biocitizenship* as the target of their analysis, yet they elucidate how and why biocitizenship is deployed through the operationalization of governmentality.[142] I specifically focus on how Indigenous health is differentially governed in Winnipeg through governmental and non-governmental programs. I argue that when it comes to addressing food insecurity through the governmentality of Indigenous health, programs and technologies aim to make Indigenous people better biocitizens (predominately through the medium of nutrition), rather than more food secure. The technologies employed through the apparatus of healthism at the provincial and municipal level attempt to establish populations that self-regulate themselves and each other – or in a similar vein to Murphy's comment – their bodies are vectors for an infrastructure of persuasive biocitizenship. The examples I draw on later in this chapter of how interventions into food insecurity are made for Indigenous populations via an apparatus of healthism in Winnipeg circulate a "strategic truth" that is parallel to Moreton-Robinson's assessment – if Indigenous people behaved properly as good biocitizens, their poor health and food insecurity would disappear.

[140] Michelle Murphy. 2017. *The Economization of Life*. Durham: Duke University Press, 73.
[141] Aileen Moreton-Robinson. 2015. *The White Possessive: Property, Power, and Indigenous Sovereignty*. Minneapolis: University of Minnesota Press, 172.
[142] Biocitizenship links notions of rights and citizenship with the self-regulation of the body and health.

In this chapter I analyze how the governing rationalities present in the federal healthism apparatus featured in the previous chapter are distilled down into provincial, municipal, and non-governmental intermediaries that implement food insecurity programming and technologies in Winnipeg. I begin by broadly charting the contours of the provincial and municipal apparatus of healthism, paying particular attention to how the programs and technologies connect to and refract the federal apparatus outlined in chapter 5. With the three empirical points of application of biocitizenship I draw on in the second section of this chapter, I complete the final analysis of the three elements of the operationalization of both governmentality and healthism that I identified in chapters 2 and 3 – *the individual and the body politic, the expert and the expertise, and the biocitizen*. In chapter 4, I analyzed how individual citizens become agents of governmentality – which in the context of Winnipeg's white possessive securitization of foodscapes, results in differential governance where Indigenous people are meant to regulate their health without having the equitable resources and conditions to do so. In chapter 5, I analyzed how a federal apparatus of expertise differentially governs the health of Indigenous populations through the prevailing rationalities, programs, and technologies of liberal governmentality, and thus, healthism to promote biocitizenship and reduce risk to the settler colonial state. Here, in chapter 6, I identify the points of application of the apparatus of healthism to demonstrate how efforts to address food insecurity are conflated with notions of biocitizenship that ultimately result in regulatory, disciplinary, and differential governance of Indigenous populations who fail to be appropriate biocitizens.

Provincial and Municipal Apparatus of Healthism

The jurisdictional power of provinces to govern health means that when it comes to an apparatus of healthism, we can identify more programs and technologies that have direct outputs

and immediacy for populations. Moreover, given the nature of Indigenous health care jurisdiction in Canada for non-status Indians, Métis, and urban Indigenous people, much of the health care and health services at their disposal are filtered through provincial and municipal mechanisms. In this section I will provide an overview of what I have charted as Manitoba's apparatus of healthism – paying particular attention to Winnipeg. I will not belabour each node of the apparatus like I did in the previous chapter. Instead, I demonstrate how the programs and technologies that constitute the apparatus of healthism charted here connect back to and are informed by the federal apparatus – here we will see that these are not separate apparatuses, but rather a cohesive apparatus of healthism that operates to differentially govern the health of Indigenous populations.

Several key departments and policies charted so far delineate how Indigenous health is governed in Manitoba, and Winnipeg more specifically.[143] Much like at the federal level, limited Indigenous specific policies, especially for health, exist, yet policies meant for the *entire* population still do work to govern Indigenous people, albeit often differentially. At the provincial level, I have indicated three points of interest for the purpose of this research – the Department of Indigenous and Northern Relations, the Department of Health, Seniors and Active Living, and the Regional Health Authorities, of which I focus specifically on the Winnipeg Regional Health Authority (WRHA) – to identify the programs and technologies operating within the Winnipeg region. The municipality does not offer much in terms of health governance – with the exception of the Winnipeg Food Council. I have also charted several 'intermediaries' – programs and technologies that refract the governing rationalities that have been identified in the federal apparatus of healthism. Some of these intermediaries are more closely connected to

[143] See Appendix 3.

and determined by governmental policies. I will briefly address these intermediaries in this section but will return to them in greater detail in the three points of application of biocitizenship.

The components of the provincial apparatus indicate that healthism rules the limits of what the province is willing to intervene in and provide resources for – and when it comes to Indigenous health and food insecurity, it is not much. Manitoba's Department of Indigenous and Northern Relations is limited in scope when it comes to services related to health and food, despite being focused on "supporting healthy, safe and sustainable Indigenous communities," while also "working to enhance food security for Indigenous people."[144] Northern Healthy Foods Initiative is one of the major initiatives sponsored by Indigenous and Northern Relations. It is a service delivery model program that is meant to "increase food security efforts at the community level" and "strengthen community-led development" through corporate, government, and First Nations government partnerships.[145] The Northern Healthy Foods Initiative is aligned with the Affordable Food in Remote Manitoba (AFFIRM) program, which is essentially a Manitoba version of Nutrition North Canada – it is meant to reduce the price of select nutritious foods in eligible remote communities.[146] Indigenous and Northern Relations and its food security initiatives are beyond the scope of this immediate research, except to note that much like the federal apparatus of healthism there are limited resources reserved for Indigenous health, and interventions are largely limited to areas of self-regulation, such as interventions meant to rectify food insecurity requiring individuals to self-regulate according to hegemonic biomedical

[144] Indigenous and Northern Relations. "Indigenous and Northern Relations." *Government of Manitoba*. Accessed November 19, 2020. https://www.gov.mb.ca/inr/index.html.
[145] Indigenous and Northern Relations. "Northern Healthy Foods Initiative." *Government of Manitoba*. Accessed November 9, 2020. https://www.gov.mb.ca/inr/major-initiatives/nhfi/index.html.
[146] Indigenous and Northern Relations. "Northern Healthy Foods Initiative." *Government of Manitoba*.

nutrition guidelines to receive what limited assistance the government is willing to offer in the form of subsidized food costs.

The bulk of provincial healthism sits within the Department of Health, Seniors and Active Living in the form of programs and technologies that make broad interventions into the population as a whole, as individuals to self-regulate as biocitizens. Health Equity and Prevention Unit is nested under the Public Health arm of the Health, Seniors and Active Living department and is where we will find many programs and technologies that are governed by healthism and designed by liberal rationalities.[147] The Health Equity and Prevention Unit is reminiscent of the federal frameworks on social determinants of health and health inequalities and implementing the population health approach – both of which require individual regulation of health, without the substantial resources required, thus often resulting in differential governance of health.[148] The Health Equity and Prevention Unit is meant to "support all Manitobans to make healthier choices, reduce health inequities, and improve the health status of the population."[149] Despite such aims, program streams on healthy eating and health equity within the unit demonstrate that the unit is much more concerned with having individuals self-regulate their health to improve the health status of the population – with little in the way of support or serious reduction of inequities.

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[147] Health, Seniors and Active Living. "Public Health." *Government of Manitoba.* Accessed November 9, 2020. https://www.gov.mb.ca/health/publichealth/index.html.

[148] Health Canada. "Social Determinants of Health and Health Inequalities." *Government of Canada.* Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html. Health Canada. "Implementing the Population Health Approach." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/population-health/implementing-population-health-approach.html.

[149] Health, Seniors and Active Living. "Health Equity and Prevention." *Government of Manitoba*. Accessed November 9, 2020. https://www.gov.mb.ca/health/hep/index.html.

The Chief Provincial Public Health Officer Position Statement on Health Equity further illuminates the lack of substantial commitment to reduction of health inequities. The statement is actually quite robust in identifying what health equity means, how health inequities impact health, how social determinants of health influence health outcomes, and how some populations experience health inequities differently – for example, that "First Nations, Metis and Inuit peoples face persistent health gaps resulting from historic and contemporary traumatic experiences related to racism and colonization."[150] Yet in outlining government responsibility, the statement identifies that there is a responsibility to "apply an equity perspective," to integrate healthy equity "considerations" into policy, to "disaggregate" population data "by social characteristics" to make comparisons "between more disadvantaged and more privileged populations groups," and to implement the Calls to Action of the Truth and Reconciliation Commission.[151] Despite concluding that the health equity approaches hold the most potential to improve population health, such approaches require "upstream preventive measures" to mitigate "the structural drivers of inequity."[152] In other words, even though the statement recognizes the complexities of health inequities, and the most effective measures to take do require the mitigation of structural drivers of inequity, it fails to indicate governmental responsibility beyond equity 'perspectives' and 'considerations.'

The 2015 Health Status of Manitobans Report *Healthy Environments, Healthy People* provides further insights into the ruling liberal rationalities that inform health and nutrition policy in the province. As I argued in chapter five, health policy created under liberalism is full of contradictions. Liberal ideology is preoccupied with market values, individualization, and

[150] Chief Provincial Public Health Officer. 2018. *Chief Provincial Public Health Officer Position Statement on Health Equity*. Winnipeg: Department of Health, Seniors and Active Living, 1.
[151] Chief Provincial Public Health Officer. 2018. *Position Statement on Health Equity*, 2.
[152] Chief Provincial Public Health Officer. 2018. *Position Statement on Health Equity*, 2.

non-interference, yet the actual act of yielding to markets, off-loading responsibility onto individuals, and limiting interference is a form of interference that is expressed through liberal governmentality that works to intervene and administer populations under the guise of non-interference. Health policy researchers have well documented forms of intervention and administration that rely on shifting responsibility onto the individual citizen (Fierlbeck 2000; Raphael 2008; Williams and Fullagar 2019). This usually occurs alongside economic aims and a ruse of non-interference – citizens must take responsibility for their health to lower government expenditures, and governments expect citizens to do the right thing, so government does not need to tread on liberties by implementing population wide health measures or restrictions.

The *Healthy Environments, Healthy People* report blatantly demonstrates the liberal rationalities that inform how the province governs health. A feature in the report declares "the bottom line," asserting in a bold typeface that: "Public health saves lives. Public health saves money."[153] In this feature on 'the bottom line,' the report notes that beyond any health benefits, the benefits of addressing determinants of health include having children perform better in school and enabling more productive citizens because "higher productivity, in turn, reinforces economic growth."[154] Perhaps most concerningly, the report notes that "a healthy population requires less government expenditures on income support, social services, health care and security."[155] What a contradiction – surely a healthy population requires *investment* in health care and social services. According to liberal rationalities, citizens are expected to become healthy subjects on their own. The 'bottom line' feature breaks down the return on investment that can be identified for every dollar of health care spending, and some of the examples used

[153] Chief Provincial Public Health Officer. 2015. *Healthy Environments, Healthy People: 2015 Health Status of Manitobans Report*. (Winnipeg: Department of Health, Healthy Living and Seniors), 12.
[154] Chief Provincial Public Health Officer, 2015, *Healthy Environments, Healthy People,* 12.
[155] Chief Provincial Public Health Officer, 2015, *Healthy Environments, Healthy People,* 12.

indicate the extent of differential governmentality in public health interventions. Of note are the examples that note that every $1 spent “adding fluoride to drinking water saves $38 in dental care” and every $1 spent on “mental health and addictions saves $7 in health costs and $530 in lost productivity and social costs.”[156] I mention these points because when it comes to Indigenous health, it is well known that many communities are more concerned with access to drinking water than fluoride, that many communities have poor dental health outcomes (which is often linked to a poor diet, and not water quality), and that many communities have been advocating for mental health services (Adelson 2005). These figures blatantly demonstrate that $1 will not benefit all populations in the same way, and the differential governance that results is stark.

The Healthy Together Now program in the Department of Health, Seniors and Active Living, in the Health Equity and Prevention Unit, is a key node in the provincial apparatus of healthism. Healthy Together Now is meant to create “supportive environments” and change “lifestyle habits” as an effective way to “prevent chronic disease and improve the quality of life for Manitobans.”[157] Healthy Together Now supports community led programming to “tackle chronic disease risk factors” by funding projects that promote non-smoking, active lifestyles, healthy eating, and mental well-being.[158] Even though Healthy Together Now is a provincial program, because it is regionally coordinated it is possible to delineate what projects receive funding in Winnipeg, and which populations they target. I will return to Healthy Together Now later in the chapter in the analysis of educating biocitizens. Here it suffices to note that the material outputs of Healthy Together Now are in line with the rationalities of liberal

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[156] Chief Provincial Public Health Officer, 2015, *Healthy Environments, Healthy People,* 12.
[157] Health, Seniors and Active Living. “Healthy Together Now.” *Government of Manitoba.* Accessed November 9, 2020. https://www.gov.mb.ca/health/hep/htn.html.
[158] Health, Seniors and Active Living. “Healthy Together Now.”

governmentality that provide limited funding with the expectations of big self-regulation returns from citizens to become healthier biocitizens.

The final cluster of programs and technologies that I want to address is the Healthy Eating unit in the Department of Health, Seniors and Active Living. The unit provides resources and services for healthy eating at different ages and stages of life, eating well in your community, and nutrition programs and dietician services.[159] The eating well in your community unit links to a meager unit on food security.[160] This unit predominantly features programs that have already been identified in this chapter and previous chapters – the Affordable Food in Remote Manitoba program, Nutrition North Canada, Northern Healthy Foods Initiative, Winnipeg Harvest, and Food Matters Manitoba.[161] This unit is an amalgamation of resources offered in other sectors of the government, and even non-governmental services such as Winnipeg Harvest and Food Matters Manitoba. These are all accounted for in the charted healthism apparatus and I will return to some of the more relevant ones later in the chapter. It is integral to note that all of these programs adhere to the governing rationalities present in federal nutrition policies – only foods that are deemed 'healthy' per federal standards are eligible to be reduced in price or are at the centre of education initiatives.

The Winnipeg Regional Health Authority contributes several programs and technologies to the provincial apparatus of healthism. As indicated on the chart – Indigenous health in particular is governed through Nutrition and Food Services, the *Health for All* equity action plan, a commitment to the Truth and Reconciliation Commission calls to action, and the Indigenous

[159] Health, Seniors and Active Living. "Healthy Eating." *Government of Manitoba*. Accessed November 9, 2020. https://www.gov.mb.ca/health/healthyeating/index.html.
[160] Health, Seniors and Active Living. "Eating Well in Your Community." *Government of Manitoba*. Accessed November 9, 2020. https://www.gov.mb.ca/health/healthyeating/community/index.html.
[161] Health, Seniors and Active Living. "Food Security." *Government of Manitoba*. Accessed November 9, 2020. https://www.gov.mb.ca/health/healthyeating/community/security.html.

Health unit. It is necessary to note that the Indigenous Health unit of the Winnipeg Regional Health Authority is concerned with offering cultural supports and patient services for individuals going through Winnipeg's health care system. Indeed, with the exception of the Indigenous Health unit that does offer advocacy supports for Indigenous people navigating Winnipeg's health care system, there are few concrete supports offered through the provincial apparatus that are not rationalized by liberal governmentality and operationalized through healthism.

The Nutrition and Food Services unit of the Winnipeg Regional Health Authority offers a wide range of services that adhere to hegemonic biomedical nutrition and tactics of healthism.[162] Like many other nutrition programs and technologies analyzed throughout this research, these services do not specifically tailor programming for Indigenous populations. The unit offers services for food literacy, a Community Nutrition Educator Program, Craving Change (a licensed program to assist in changing eating behaviours), and the Dial-A-Dietitian program.[163] The Community Nutrition Educator Program is a free service "to support community program non-profit organizations with general healthy eating information."[164] The volunteer educators provide "reliable, unbiased and current information on healthy eating and food to the community" and work with a variety of people and community areas in Winnipeg to facilitate workshops on Canada's Food Guide, menu planning, food safety, and budgeting.[165] Dial-A-Dietitian is another free resource that individuals can use. Individuals simply call a line to be connected with a registered dietitian to receive advice on food and nutrition to "assist Manitobans and their

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[162] Winnipeg Regional Health Authority. "Nutrition and Food Services." *Winnipeg Regional Health Authority*. Accessed November 9, 2020. https://wrha.mb.ca/nutrition/.
[163] Winnipeg Regional Health Authority. "Nutrition and Food Services."
[164] Winnipeg Regional Health Authority. "Community Nutrition Educator." *Winnipeg Regional Health Authority*. Accessed November 9, 2020. https://wrha.mb.ca/nutrition/cne/.
[165] Winnipeg Regional Health Authority. "Community Nutrition Educator."

families to eat well, live well and stay healthy."[166] It is all too familiar now that nutrition takes precedence over food security – or rather, nutrition guidelines are conflated with food security due to the aggregation of diet related diseases with incidence of food insecurity. This is not surprising given that expecting citizens to self-regulate their health is seemingly more 'bottom line' than investing in population specific care or addressing structural determinants of health.

In the apparatus of healthism that I have charted within the confines of Winnipeg, I have noted three key programs – the Winnipeg Food Council, Food Matters Manitoba, and Winnipeg Harvest.[167] This is nowhere near an exhaustive list given the nature of urban Indigenous service providers having to operate within the constraints of funding that is often limited in time or scope, producing short lived runs of services and programming. However, these three included on the apparatus chart are perhaps particularly relevant due to how they refract federal governing rationalities, and ultimately how they influence and even determine what programs and technologies are employed to address Indigenous food insecurity in Winnipeg. Moreover, these programs most directly respond to food insecurity, and Indigenous food insecurity more specifically. However, we will see that food insecurity still gets conflated with nutrition and health, which yields programs and technologies invested in healthism that attempt to regulate and discipline individuals out of food insecurity.

The Winnipeg Food Council was established in 2017 and occupies a unique role in relation to the apparatus of healthism in Winnipeg – it does not offer services or funding for food security programming, but it does occupy a position of advocacy and advising within the

[166] Misericordia Health Centre. "Dial-a-Dietitian." *Misericordia Health Centre*. Accessed November 9, 2020. https://misericordia.mb.ca/programs/phcc/dial-a-dietitian/.
[167] Winnipeg Harvest is a not-for-profit food distribution centre. While the provincial government indicates Winnipeg Harvest as a resource for food security, they do not financially support their operation.

municipal government.[168] The Winnipeg Food Council follows the model of existing food councils (which are usually situated within municipalities) that aim to "improve the local food system by advising policy makers, which includes research, oversight, advising and advocating for specific policies," while also working to "gather information about the local food environment, build relationships with and between stakeholders, create an opportunity to study and discuss the food system as a whole, and develop strategies to better address community food security."[169] The Winnipeg Food Council has three main functions: 1) to advise the mayor and council on food related issues, 2) to support community, public health, and food security initiatives, increase food literacy, and access to food through "multi-sector and strategic approaches, fostering coordination and networking, and supporting ongoing consultation," and 3) to develop, implement, and maintain a "City of Winnipeg Agricultural and Food Strategy to address municipal food security and food system issues."[170] The Winnipeg Food Council does not offer monetary or service support – they are constrained to supporting communities through research and policy recommendations. With a vision to ensure that "Winnipeggers have what they need to eat well, all of the time," the council is at the mercy of other governmental offices and intermediaries to implement the material supports needed.

[168] The council is comprised of 12 members (11 voting members and one non-voting membership), including the Mayor of Winnipeg or designate, one City Councillor, one representative nominated by the Province of Manitoba (non-voting), one member from the health sector front-lines nominated by the Winnipeg Regional Health Authority, two members involved with food production, one member from food businesses, one member from a research sector, one member from community groups or networks connected to food issues, up to three citizen members at large with skills or experience to add value. See: Winnipeg Food Council. "About the Food Council." *City of Winnipeg*. Accessed February 13, 2020. https://winnipeg.ca/clerks/boards/WpgFoodCouncil/about.stm.
[169] Winnipeg Food Council. "Frequently Asked Questions." *City of Winnipeg*. Accessed November 9, 2020. https://winnipeg.ca/clerks/boards/WpgFoodCouncil/FAQ.stm#4.
[170] Winnipeg Food Council. "Winnipeg Food Council." *City of Winnipeg.* Accessed November 9, 2020. https://winnipeg.ca/clerks/boards/WpgFoodCouncil/default.stm.

The Winnipeg Food Council relies on a partnership with Food Matters Manitoba to complete the research and assessments required for the council to make policy recommendations. Beginning in 2019 the council has directed its operating funds of $25,000.00 to contract a Winnipeg Food Council Coordinator.[171] The council contracted Food Matters Manitoba to fulfil the Winnipeg Food Council Coordinator position and "deliver on initial outcomes of the city's very first food strategy."[172] The council partnered with Food Matters Manitoba to draw on their "expertise and deep roots in the community" to undertake to initial projects – a framework for monitoring city policies related to food, and a toolkit for conducting city ward food assessments.[173] The council has seats reserved for community and citizen partners, and likewise, Food Matters Manitoba has longstanding relationships with community partners. However, later in this chapter we will see that how food security is conceptualized and responded to by these intermediaries refracts hegemonic biomedical nutrition and responses to food insecurity. Such responses require individuals to become better biocitizens by adhering to particular expectations of health to access necessary resources to attain food security.

Food Matters Manitoba is a not-for-profit organization that offers food security programs and services all over Manitoba – with many of these being situated in Winnipeg. Food Matters Manitoba has "a solid reputation for developing high quality programs and curricula, nurturing networks and partnerships, and influencing public policy," all while operating initiatives that "support community partners, policy makers and public institutions in achieving their food

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[171] Executive Policy Committee. 2019. "Agenda – Executive Policy Committee – July 9." Winnipeg: City of Winnipeg, 1.
[172] Food Matters Manitoba. 2019. "Winnipeg Food Council and Food Matters Manitoba Announce Winnipeg Food Strategy." *Food Matters Manitoba*. Accessed September 24, 2019. https://foodmattersmanitoba.ca/winnipeg-food-council-and-food-matters-manitoba-announce-winnipeg-food-strategy/.
[173] Food Matters Manitoba. 2019. "Winnipeg Food Council and Food Matters Manitoba Announce Winnipeg Food Strategy."

security objectives."[174] Food Matters Manitoba is not a struggling community organization that gets by year to year on piecemeal funding. Instead, it is a prime example of a business of intervention that self-sustains its network of expertise in the form of a ten person staff. Food Matters Manitoba brings in funding from individual donors, foundations like Tides Canada, the Province of Manitoba via the Winnipeg Regional Health Authority and Indigenous and Northern Relations, as well as the Government of Canada via the Public Health Agency of Canada, Employment and Social Development Canada Career Focus, and the Western Economic Diversification Fund.[175]

It is necessary to understand the role of not-for-profit intermediaries beyond mere services providers and as fundamental operators of expertise through their research contributions to the apparatus. Identifying the reaches of the apparatus of healthism is integral to identify how governmentality operationalizes interventions. Moreover, as Tania Li has argued, governmentality is "not the product of a singular intention or will" (2007a, 2). Governmentality of Indigenous health is not merely seated within the federal government, or even the provincial government. If we are to think of governmentality as a methodological imperative and empirical question, then it is imperative to chart "to what extent various governmental initiatives are concentrated in, or coordinated by, the official state apparatus" (Li 2007a, 2). Governmentality as an analytic offers the opportunity to identify who governs, how power is distributed amongst networks, and how populations are constituted to be administered (Li 2007a, 2-3). Food Matters Manitoba is not outside an apparatus of governmentality – it is funded by provincial and federal health sectors, it has programming that refracts the governing rationalities of those sectors, and it

[174] Food Matters Manitoba. "Our Mission."
[175] Food Matters Manitoba. 2019. *Our Food – Our Health – Our Culture: Report 2018/19*. Winnipeg: Food Matters Manitoba.

wields expertise to constitute and administer food insecure populations within Winnipeg. In the following section, I turn to three points of application of how Indigenous health is governed in Winnipeg through a coordinated apparatus.

(Differentially) Governing Biocitizens: Three Points of Application

In this section I provide three accounts of how Indigenous health (and food security) is differentially governed in Winnipeg through interventions meant to make individuals into better biocitizens. While the main focus of these accounts is on biocitizenship, I also account for how expertise operates to set guidelines and expectations for biocitizenship to offload responsibility and risk onto citizens to self-regulate their health. Programs and technologies of healthism that aim to create better biocitizens require experts to maintain interventions in the form of research, education, and shaping environments. Moreover, with the accounts featured below I delineate the reaches of an apparatus of governmentality that stretches far beyond state actors but remains connected and coordinated with networks of state biopower.

Biocitizenship requires that individuals self-regulate their health as a form of 'active citizenship' in which individuals become responsibilized as mechanisms of governmental security. In chapter 2 I show how biocitizenship emerged as a particular form of liberal governmentality that was concerned with individuals exercising citizenship with respect to appropriate bodily conduct (Lemke 2002; Rose 2004; Rose 2007). However, in this chapter I focus specifically on how biocitizenship operates through healthism interventions in Winnipeg to interrogate how it produces disciplinary and differential governance of Indigenous health. Critical health scholars have established that biocitizenship is an inherently disciplinary process when citizens fail to live up to the expectations of active citizenship (Guthman 2011; Greenhalgh and Carney 2014; Rail and Jette 2015). Failure to be a good biocitizen results in healthism

interventions that have disciplinary effects when population needs are not considered, and it also "provides a protective veneer for neglect or exclusion" when government actors refuse to provide health care or resources for already failing citizens (Guthman 2011, 62). In the following accounts I demonstrate how efforts to establish food security amongst food insecure populations in Winnipeg is tied to notions of biocitizenship – a process that results in disciplinary and differential governmentality for food insecure Indigenous people.

Imagining Food Security

In Winnipeg, food insecurity is featured in everyday discourse as stemming from food deserts, food mirages, and food swamps (Distasio 2016; Frew 2020). How food insecurity is imagined, geographically mapped, and rendered by disaggregating population data sets based on social and health deficiencies overly determines how responses to food insecurity are rationalized as well. Food deserts yield responses that are focused on geographic deficits, food mirages yield responses that are focused on identifying geographic zones of abundance that are home to deficient individuals, and food swamps yield responses that are focused on identifying deficient geographic zones and individuals. Approaches to urban Indigenous food security that begin from the assumption that the solution to food insecurity is eating healthier tend to focus on the environment in which food insecurity exists (Bhawra et al. 2015; del Canto, Engler-Stringer, and Muhajarine 2015; Lotoski, Engler-Stringer, and Muhajarine 2015; Engler-Stringer et al. 2016). Normally, attention to environment would be a positive feature, but if that attention is directed towards how to intervene in food insecure environments, rather than the structures that cause them, analysis is lacking. Research that foregrounds the environment in which food insecurity exists to understand larger structural, political, and systemic forces that shape those environments is a necessary direction in Indigenous food studies (Neufeld 2020).

Urban food insecure environments are categorized by their socioeconomic and racial status (which is often combined in troubling ways), their food "deserts," and their "nutrition environments" (Bhawra et al. 2015; del Canto, Engler-Stringer, and Muhajarine 2015; Lotoski, Engler-Stringer, and Muhajarine 2015). It is absolutely necessary to advocate for change when it comes to larger structural, political, and systemic forces that sustain food insecure environments, and it is even more necessary to have ongoing organizing within communities that works to mitigate the harms of ongoing structural causes of food insecurity. Instead, there seems to be a reoccurring preoccupation with proposing interventions in the form of improvements to food insecure environments. Improvements are not necessarily inherently problematic, but when they occur at the cost of existing community capacities, or to merely improve predominantly Indigenous and people of colour neighbourhoods to bring them up to the standards of middle-class whiteness, then it should be seriously interrogated who improvements are for. Healthism is notoriously intertwined with capitalism, particularly as an antidote to poor health through better consumption, which comes in the form of rezoning, redevelopment, and economic strategies to enhance buying power of health foods – which we will see highlighted in each of the accounts of 'points of application' in this section (Guthman 2011).

In previous chapters I have extensively discussed the need to decouple healthism and food security. However, here it will suffice to reiterate that there is something seriously misplaced about the encouragement to self-regulate dietary practices as a response to food insecurity, which has its beginnings in rights and justice-based responses to lack of sufficient access to food. It is especially troubling that healthism, which originates as a predominantly middle-class phenomenon, has been increasingly deployed in research and policy that is focused on low socioeconomic populations. A current gap in the literature that needs to be further

analyzed is how healthism and nutrition are raced — especially when it comes to whiteness (Kimura et al. 2014, 42). The perpetuation and operationalization of whiteness in healthism is reiterated throughout research and policy – and serves to further cement inequities and differential governmentality. How food insecurity is imagined within research is very much part of the healthism apparatus.

Narrowing analysis to research in Winnipeg brings several things into focus — namely, how food insecurity is geographically imagined. The population at the centre of inquiry when it comes to food insecurity in Winnipeg is almost always determined by socioeconomic status, which tends to result in a focus on Winnipeg's inner-city neighbourhoods, which are predominantly populated by Indigenous residents, newcomers, or people of colour. Despite research situated within Winnipeg's inner-city being largely cognizant of the complex social context that sustains food insecurity, health and nutrition consistently overshadow issues of access, justice, and equity when it comes to food. In Chapter 3 I briefly reviewed research in Winnipeg that addresses food deserts, mirages, and swamps and how it reifies healthism. In this section I revisit these examples to specifically address how they render and intervene in populations, how they privilege biomedical hegemonic nutrition as a response to food insecurity, and to consider what the implications are for how Indigenous people are expected to become better biocitizens on their way to obtaining food security.

Food deserts are often employed as a tool to geographically locate zones that provide citizens with limited or no access to grocery stores, yet there are increasing trends to equate food deserts with particular populations (e.g., low socioeconomic status or racialized populations) and poor nutrition outcomes. Slater et al.'s (2017) study of food deserts in Winnipeg illuminates several troubling features of how food insecurity is geographically imagined through the lens of

a ‘food desert,’ including but not limited to what ‘counts’ as a food access point, how people access food from a variety of sources, and how data sets are aggregated to reify individual deficiencies and risks to be ameliorated. Slater et al. use three data sources to create two scenarios of food deserts that are based on proximity to grocery stores – 1) national chain grocery stores, 2) full-service grocery stores, and 3) 2011 Canadian census data on average household income and total population counts via the 2014 Manitoba population health registry (2017, 351-352). The authors define national chain grocery stores as “large, full-service grocery stores that had stores in Manitoba as well as other provinces” (2017, 251). Whereas full-service grocery stores are defined as “large, local grocery stores (not national chains) carrying a good selection of self-serve fresh fruits and vegetables (i.e. more than potatoes, onions and bananas, and not prepackaged), fresh meat and dairy products at reasonable prices (i.e. close to national chain prices), as assessed by local public health dietitians participating in the study, who had excellent knowledge of local stores, food costs and store characteristics” (2017, 351). Slater et al. rendered two food desert scenarios: 1) located greater than 500 metres from a national chain grocery, and 2) located greater than 500 metres from a national chain grocery or a full-service grocery (2017, 351). Slater et al. indicate that expanding their scope to include full-service grocers, and not just national chain grocers, decreases “the estimate of the population affected by food deserts in the Winnipeg Health Region by 38%, from 104 335 to 64 574 individuals” (2017, 354). The data used to geographically locate food insecurity in this study is a narrow and insufficient accounting for what is an acceptable access point for food, and what is acceptable food to access.

Limiting food access points to national chain grocers and full-service grocers that mimic the features of national chain grocers not only fails to account for other points of food access, it

serves to overdetermine policy responses to food deserts by limiting them to improving access to nutritious food via approved retailers. Slater et al. noted that to compile a database of all food retailers within the Winnipeg Health Region "dietitians were provided with lists of candidate stores, and judged whether they were appropriately classified" (2017, 351). Slater et al. recognize that "in many downtown areas, smaller local grocery stores may play an extremely important role in providing easy access to a wide range of affordable food products," yet they do not include these sources in the scope of their study (2017, 354). Slater et al. couple lack of proximity to national chain grocers and full-service grocers with low socioeconomic status as creating a "double burden for a significant number of Winnipeggers living in food deserts" (2017, 353). Slater et al. argue that such a burden results in individuals relying on "alternate food sources such as convenience stores, food banks and low-cost fast food options such as 'dollar' pizza and other bargain fast food outlets; or rely on taxis (which are expensive) or personal networks (which can be inconvenient and unreliable), if available, for rides to and from larger grocery stores" (2017, 353). The narrow focus on large chain grocers that meet the approval of dieticians eliminates all of these options that Slater et al. have sweepingly rendered as unhealthy, and as simultaneously an insignificant source to contribute to food security. Small grocery stores (like the three locations of Pal's Supermarket) have a wide variety of 'nutritious' foods, convenience stores cater to community needs and stock many essentials, food banks offer necessary assistance to get many families through the month, bargain fast food outlets similarly help people make ends meet *and* provide quick, easy, and delicious meals, and personal networks should be viewed as an asset, particularly when communities organize to create grocery shuttles.

Accounting for greater sources of food access could undoubtedly lower the estimated numbers of people living in food deserts. However, it could also result in renderings of food insecurity that are not solely focused on neighbourhood and individual deficiencies, and instead look to larger structural determinants that produce community food insecurity. By not factoring in further population data in their study, the research produced by Slater et al. is lacking – the failure to think about structural determinants in shaping food environments while also expecting individuals to be better biocitizens through their nutrition and economic choices, without actually providing corollary health and socio-economic resources will result in differential governance of food insecure populations. Slater et al. leave us with an inaccurate rendering of food environments that prioritize biomedical hegemonic nutrition, while negating individual agency, networks, and preferences.

The focus on an absence of large food retailers that offer a set variety of 'nutritious' foods to determine food deserts is troubling when it requires situating communities and individuals as deficient in relation. Slater et al. contend that "residents of food deserts may effectively be dependent on small retailers, such as convenience stores, with limited selection and typically higher prices, for the bulk of their food purchasing" (2017, 350).[176] Slater et al. do not identify this as a mere issue of access – they argue that "the lack of full-service, fair-priced grocery stores in a community may therefore promote inequities by leaving residents at increased risk of comprised diet quality, negatively impacting long-term health" (2017, 350). The crux of concern here is that Slater et al. recommend that "future studies should examine the impacts of food deserts on dietary behaviour and health outcomes, as well as residents' experiences of

[176] Slater et al. do not contextualize or trouble the fact that while residents of some neighbourhoods may pay higher prices to shop close to home, that it could significantly outweigh the costs of transportation to a nearby large food retailer. Slater et al. costed public transportation to grocery stores as up to $14.20 per round trip. For more information on their costing of transportation see: Slater et al. 2017, 354.

living in food deserts" (2017, 355). Research on residents' experiences of their *food environments* is absolutely necessary. The suggestion to examine the impacts of food deserts on dietary behaviour and health outcomes is misplaced and does work to refract risk and deficiency onto individuals who live in geographies that have been identified as food deserts and identifies *behaviour* as the target of intervention.

Geographic imaginings of food security through the framing of a *food mirage* ameliorates some of the troubling aspects of food desert research, namely what food access points are included in data sets, but it is still beholden to hegemonic biomedical nutrition. Kyle Wiebe and Jino Distasio identify food deserts as being concerned with "physical and economic barriers to accessing healthy food," which they argue fails to account for areas where "individuals live close to healthy food sources but face serious economic hardship that prevents them from accessing those healthier food choices" (2016, 1). Wiebe and Distasio identify the latter as "food mirages," which can "equally contribute to negative health outcomes but present unique challenges to meeting local food needs" (2016, 1). Wiebe and Distasio use similar methods to Slater et al. to identify food deserts and mirages in Winnipeg, including identifying a data set of supermarkets, calculating distance to supermarkets,[177] but where they differ is through the inclusion of identifying "areas of deprivation by constructing a social deprivation index," to ultimately distinguish "problematic food environments by linking an area's distance to a supermarket with its social deprivation score" (2016, 1). The methods and data sets used by Wiebe and Distasio raise similar concerns to those that emerged from Slater et al.'s research, most notably what food access points are accounted for. Wiebe and Distasio only account for national chains (e.g. The Real Canadian Superstore, Safeway, Walmart, Costco, etc.) and regional chains (e.g. Food Fare,

[177] Wiebe and Distasio calculate three distance points (less than 500 meters, 500 to 1000 meters, or greater than 1000 meters) to indicate high physical access, moderate physical access, and low physical access.

Family Foods, and Red River Co-op) and they recognize that a limit of their research is "the exclusion of independently owned large grocery stores, large grocery stores specializing in imported-goods or "ethnic foods," small grocery stores, and convenience stores" (2016, 4). Despite noting this limitation, Wiebe and Distasio justify it by arguing that "supermarkets offer consumers a greater diversity of healthy products . . . and generally offer products at more competitive prices" (2016, 4). It is true that large chain supermarkets offer a great diversity of healthy products, but reducing acceptable access points solely to chain retailers provides inaccurate renderings of food environments and presupposes several things – that individuals are not accessing 'healthy' foods elsewhere, that accessing marked up foods closer to home would not outweigh the time and travel costs for some individuals to make their way to larger supermarkets, and that individuals need to access a 'great diversity' of healthy products to meet nutrition guidelines, and thus expectations of what food security should look like as well.

The addition of a social deprivation index to geographically render food deserts and mirages works to extend gaps present in Slater et al.'s research that failed to account for population data beyond socioeconomic status. Unfortunately, rather than assist the researchers to demarcate larger determinants of health, it is employed in really troubling ways that mark individuals and communities as deficient. Wiebe and Distasio implement the social deprivation index to account for variables that "represent socio-economic characteristics that may present barriers to an individual's ability to travel to supermarkets and purchase healthy foods" (2016, 4). Wiebe and Distasio note that the variables were drawn from the 2006 Census and include: "(i) percentage of low income families; (ii) unemployment rate; (iii) population aged 25-64 with no high school certificate, diploma, or degree; (iv) percentage of recent immigrants (immigrants labour arriving between 2001 and 2006); (v) percentage of lone-parent families; (vi) percentage

of the labour force that does not drive; and (vii) percentage of the population that identifies as Aboriginal" (2016, 4). Moreover, Wiebe and Distasio contend that "it is important to note that one-quarter of the population in high deprivation areas are of Aboriginal ancestry and 7% are recent immigrants," which they highlight to note "the importance of culturally sensitive approaches to addressing food environments" (2016, 10). Culturally relevant programming is indeed important, but *culturally sensitive approaches* (whatever that means) seems insufficient for addressing the structural determinants of food environments. More than anything, the social deprivation index indicates a statistical deprivation. The social deprivation index disaggregates data sets to aggregate a portrait of deprived and deficient individuals and communities in Winnipeg's inner-city. Rather than render portraits of deficient individuals and populations living in food deserts and mirages, researchers could do well to turn a social deprivation lens onto the structures and modes of governance that result in low incomes, under employment, underfunded education, lack of supports for newcomers, lack of supports for families, and the differential governmentality of Indigenous populations.

It is ironic that in research about food mirages – where individuals live close to food sources but are prevented from always accessing those sources – that the authors fail to account for anything *more* than those mirages. Wiebe and Distasio note that "nearly 85,000 people live in inner city neighbourhoods classified as severly [sic] unsupportive food environments – either food mirages or deserts" (2016, 14). By only including national and local chain retailers in their data set, they effectively position small grocers, 'ethnic food' grocers, dollar stores, convenience stores, food banks, community food organizations, personal networks, and local food vendors like Eadha Bread who offer no questions asked pre-paid food vouchers to increase "access to

fancy tasty goodies to anyone who walks in" as part of a 'unsupportive food environment.'[178] Of course, narrowing food environments to solely factor in large retailers because of their economic affordability and variety of health foods indicates that individuals should only be spending their money in a particular way (e.g. getting the best deal), and that if they are food insecure, they should only be making efforts to increase their access to approved nutritious foods so as to not further burden society with poor health outcomes from their perceived diet related risk factors.

The requirement that individuals living in food deserts or mirages overcome their poor diets to purchase nutritious foods from approved grocers is biocitizenship in action. Food security, and increased access to food resources, will only be approved at the cost of disciplinary power and self-regulation of behaviour to meet hegemonic biomedical nutrition guidelines. Wiebe and Distasio connect eating behaviours, poor health, and food environments, noting that "unhealthy diets are known causative risk factors for multiple chronic health problems including heart disease, diabetes, and obesity," which they relate to "different food consumption habits between socio-economic groups, with low-income individuals tending to consume lower nutritional value foods . . . and having lower-quality diets" (2016, 1-2). Instead of undertaking an analysis of how increased income or resources could transform purchasing capacities for food insecure communities, Wiebe and Distasio situate the burden of poor health on individuals. Wiebe and Distasio contend that "since accessing healthy food for people in food deserts can be difficult, timely, and expensive, individuals may then turn to closer, less healthy options at nearby corner stores" (2016, 12). Wiebe and Distasio further note that "individuals in food mirages may actually be able to walk to healthy food sources but face socio-economic challenges

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[178] See: Eadha Bread (@eadhabread). 2020. "Since Re-Opening 4 Weeks Ago, Y'all Have Donated Almost $300 for Our Pre-Paid Food Board." Instagram photo, August 7, 2020. https://www.instagram.com/p/CDl9cfqAlgk/?utm_source=ig_web_copy_link.

to obtaining a healthy diet," which tells us that to better support food environments, it will be necessary to have "programs that target socio-economic issues, such as poverty, as well as the cost of food" (2016, 16). Increasing individual purchasing power seems like a promising approach to respond to mirages – increased resources could very well allow food insecure individuals to access food from previously unaffordable access points. Despite this, Wiebe and Distasio conclude that addressing issues of food accessibility in deserts and mirages "requires either bringing healthy and affordable food into an area, or bringing individuals to healthy and affordable food," by which they mean nutrition education (2016, 16). According to Wiebe and Distasio, these interventions "must be done in conjunction with efforts to ensure the availability of culturally sensitive foods and the promotion of nutritional and food skills education in order to fulfill a holistic understanding of food security" (2016, 16). The inclusion of culturally sensitive foods indicates that they recognize that the food deserts and food mirages they have rendered are home to high populations of Indigenous people and newcomers – and serves to present a *culturally sensitive* veneer on disciplinary and regulatory education programs to educate food insecure individuals into better biocitizens by healthy eating their way out of food insecurity.

The final geographic imagining of food insecurity in Winnipeg is the *food swamp*. The swamp extends many of the problematic aspects of the food mirage, reifies expectations of hegemonic biomedical nutrition, and perpetuates solutions to food insecurity that are rooted in healthism. A food swamp is a "spatial metaphor to describe neighborhoods where fast food and junk food inundate healthy alternatives" (Cooksey-Stowers, Schwartz, Brownell 2017, 2). Martine Balcaen and Joni Storie's research on identifying food swamps in Winnipeg defines food swamps as "the marginalized neighbourhoods whose food environment are dominated by restaurants," as well as convenience stores (2018, 15). Balcaen and Storie employ similar

methods to previous studies we have reviewed by undertaking a "geographic assessment of food swamps using (1) a Socioeconomic Deprivation Index (SDI) based on seven Census variables, (2) distance to restaurants, and (3) clustering of restaurants, to identify at-risk locations and populations" (2018, 15).[179] Balcaen and Storie found that dissemination blocks "with high deprivation levels, close restaurant access, and significant clustering of restaurants were identified as food swamps . . . [and] the most socioeconomically deprived populations in Winnipeg has easier access to highly clustered restaurants" (2018, 14). Similar to the mirage, swamps do not suffer from a *lack* of available food access points – they are just not the right kind that can be approved through hegemonic biomedical nutrition standards.

In addition to the lack of appropriate food access points, the food swamp is employed to identify points of intervention – both geographically and behaviourally. Balcaen and Storie posit that "to evaluate community-level nutrition environments, this model measures geographic food access in combination with the socio-demographic factors associated with eating patterns" (2018, 15). While Balcaen and Storie identify the need to address food insecurity in Winnipeg, their model conflates food insecurity with 'nutrition environments' and 'eating patterns,' making food security conditional by conduct. That is, access to food security is conditional on the individual's ability to self-regulate and change their eating behaviours. Balcaen and Storie emphasize a focus on self-regulation of health and nutrition, noting that "if an area is a food swamp, the policy should be on deterrents to unhealthy food choices" (2018, 15). Ultimately, Balcaen and Storie argue that "policies need to address zoning restrictions on restaurants, establish tax incentives to grocery stores, provide grants and loans to service high-risk populations, offer alternative strategies to curb poor dietary consumption patterns or further refine initiatives to support retail

[179] The seven census variables used to create the social deprivation index were taken from a 2016 study by Wiebe, Distasio, and Shirtliffe (Balcaen and Storie 2018, 17). The index is the same as featured in Wiebe and Distasio 2016.

food projects in underserved areas" (2018, 21). The geographic rendering of Winnipeg neighbourhoods (particularly those with low socioeconomic status and Indigenous and newcomer populations) as food swamps by Balcaen and Storie opens several problematic avenues for addressing food insecurity through inventions aimed at self-regulating individuals (which has disciplinary outcomes in instances of differential governmentality), and through rezoning interventions that deem inner-city neighborhoods as nutritionally deficient in order to have a hand in the pie of rezoning and redeveloping brown neighbourhoods into white and green spaces that espouse health and wellness through the removal of the foods and businesses communities have relied on to feed themselves when they have been profiled, surveilled, and barred from other 'healthy' sources of food throughout the city. In account three I further interrogate the proposal to rezone neighbourhoods in the name of health.

A final mode of imagining food security that I want to address is not a geographic imagining, but what constitutes a 'healthy diet.' Health Canada has set a national 'nutritious food basket' that is consistent with Canada's Food Guide dietary recommendations and is a "survey tool used by various levels of government and other stakeholders to monitor the cost and affordability of healthy eating."[180] The food basket includes just over 60 items, which provincial and regional stakeholders can collect food prices on for food costing reporting.[181] The food basket reflects the hegemonic biomedical nutrition guidelines set by Health Canada and Canada's Food Guide – and any attempts to make their nutrition guidelines culturally relevant or

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[180] Health Canada. "National Nutritious Food Basket." *Government of Canada*. Accessed November 20, 2020. https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/national-nutritious-food-basket.html.

[181] Health Canada. "National Nutritious Food Basket." The food basket items are updated when Canada's Food Guide undergoes changes. Health Canada most recently updated the 2008 version to be consistent with changes to Canada's Food Guide in 2019.

sensitive are missing from the food basket.[182] It is important to remember that Canada's Food Guide prioritizes "scientific knowledge about food while excluding complex economic, political, and sociocultural issues tied to how we eat" (Amend 2018, 718). The nutritious food basket features prominently in food insecurity research because the food costing reports that are produced based on the nutritious food basket inform researchers of estimated average food costs. Relying on nutritious food basket food costing reports can give us an idea of baseline food costs, and can indicate pricing disparities across regions (e.g. these reports clearly indicate higher prices in Northern and remote regions), but they cannot sufficiently account for food preferences, regional availability, or other sufficiently 'healthy' dietary choices.

In Manitoba, the most recent publicly accessible food costing report, *The Cost of Eating According to the 'Nutritious Food Basket'* was compiled by the Community Health Through Food Security group in 2011. An updated analysis was undertaken in 2017 by "a coalition of government and community agencies," but "the data and report have not been released by Manitoba Healthy Living and Seniors" as of yet.[183] However, the report completed in 2011 provides necessary insights into how food costing operates with aims of healthism. In addition to reflecting the national nutritious food basket and Canada's Food Guide nutritional guidelines, the report author team was "comprised of nutrition professionals who work closely with or who advocate for adequacy of diet in order to support optimum health" (Rand et al. 2011, 7). The report used the standardized list of food items to develop a survey tool "to measure the cost of basic healthy eating that represents current nutrition recommendations and average food purchasing patterns" (Rand et al. 2011, 15). The data collected is then used to determine average

[182] See Appendix 4 for the nutritious food basket itemized food list.
[183] Food and Nutrition Security. "Food Basket/Food Costing." *Manitoba Collaborative Data Portal*. Accessed May 2, 2020. http://www.mbcdp.ca/fns.html.

monthly or weekly grocery costs for various household formations across different regions in Manitoba – but whether these food items reflect average food purchasing patterns is debatable.[184]

Like the data sets used to determine food deserts, mirages, and swamps, the data garnered from food costing renders a less than sufficient rendering of how individuals actually eat and why. Rand et al. recognize some of the limitations of the nutritious food basket, contending that "some of the foods listed are not commonly consumed (i.e. rutabaga). One aspect of food security is food that is 'personally acceptable.' With this in mind, the actual cost of foods that are commonly eaten is higher than what is reported" (2011, 40). Moreover, Rand et al. noted that one of their data collectors stated that "it was 'mentally exhausting' to find the lowest unit price for each of the foods listed," which is telling information about "the energy, skills, and determination needed to eat healthy on a low-income" (2011, 39). Rand et al. established a table outlining the percentage of stores where food items were unavailable, and 22 items were unavailable anywhere from 20% to 46.4% at the stores surveyed.[185] Of the items that were frequently unavailable, many of them require significant cooking skills and time to prepare, such as inside round roast, dry lentils, and cabbage. Another frequently unavailable item, such as cantaloupe, is a prime example of how out of touch the nutritious food basket is for individuals who are food insecure, low income, or living in a food desert. Cantaloupe requires prep (unlike an apple, banana, or orange) and due to its size is unlikely to be an item at the top of a grocery list for someone who has to walk to and from the grocery store and is limited to purchasing what they can carry in a couple bags or in a backpack.

[184] In Winnipeg average food costs varied, but not by drastic amounts – for instance, average monthly food costs for a family of four was $821.63 in the Downtown region, whereas it was $778.90 in St. James Assiniboia region (Rand et al. 2011, 27).
[185] See Appendix 4.

Food costing would be much more effective if consultation occurred with stakeholder groups about commonly eaten foods, rather than basing it off of an arbitrary list of foods determined by Health Canada nutritionists.[186] Furthermore, the nutritious food basket does not reflect actual diets that would include 'non-nutritious' items in moderation, which is deemed acceptable by Canada's Food Guide. And finally, Rand et al. note that when it comes to food security, additional factors that need to be considered are access to full-service grocery stores (like those we see featured in food desert, mirage, and swamp research), budgeting skills, literacy and numeracy, access to storage and cooking equipment, cooking skills, and self-efficacy (2011, 5). The insufficiency of the nutritious food basket becomes clear when we account for time, labour, and skills required to transform items from the basket into meals. Expecting that citizens adhere to a set of foods that require significant time and energy to prepare (and find for the lowest possible price), further indicates the disciplinary measures food insecure citizens face when they fail to abide by nutritional guidelines or educate or skill their way out of food insecurity.

All of the imaginings of food security in this section reify accessing 'nutritious' food over other possible responses to food insecurity such as universal income, better transportation infrastructure, or funding community food hubs, amongst many other options. Ultimately, approaches to food insecurity that privilege nutrition are self-regulatory, meant to reduce risk, and require citizens to change their own intakes. The few examples of Winnipeg food security research interrogated here are indicative of the place research occupies in an apparatus of healthism. In the following accounts I will demonstrate how research that has geographically

[186] Similarly, consultation with communities regarding costs associated with procuring country food (and the varying types of country food harvested in various locales) in rural and remote settings is a necessary undertaking if 'supporting access' to traditional foods is going to figure into policy responses to Indigenous food insecurity. See: Randazzo & Robidoux 2019.

imagined food insecurity in Winnipeg as a desert, mirage, or swamp impacts policy interventions and material outputs that address food insecurity in the inner-city through healthism technologies that require Indigenous people to be better biocitizens. As we saw with the nutritious food basket, programs and technologies that were identified in the federal healthism apparatus such as Health Canada and Canada's Food Guide inform provincial policies that go on to have substantial influence on how food insecurity is conceptualized and intervened upon in inner-city Winnipeg. Given that apparatuses are ensembles of governmentality, it is necessary to account for power, institutions, tactics, programs, technologies – and also the research that sustains these activities in the everyday. Governmentality requires *knowing* the population, and in these three points of application of healthism, the inventions being made *know* the population in particular ways (e.g. as low income, as 'socially deprived,' in need of education, etc.) that ultimately result in differential governmentality for Indigenous people. Research renders populations *knowable* and determines how they are intervened upon by other programs and technologies of healthism.

Educating Biocitizens

In this section I consider how education is employed as a technology of the healthism apparatus to educate individuals into better biocitizens. Education is integral to the process of implementing measures to promote active citizenship. In this section I provide analysis of three nodes of the healthism apparatus in Winnipeg – the Healthy Together Now program, The Wayfinders Program, and the Downtown Winnipeg Community Food Assessment – all of which prioritize educating at-risk individuals with the aim of shaping better biocitizens as a result. As we saw in the previous section, while the programs and technologies featured here are situated within the province of Manitoba and region of Winnipeg, they exist with a larger apparatus of

power relations that connects to governing rationalities of the federal government – and even international agencies.

Healthy Together Now is a program in the Healthy Equity and Prevention unit of Manitoba's Department of Health, Seniors and Active Living that operates prevention programming targeted at those at risk of chronic disease.[187] Healthy Together Now identifies supportive environments and change of lifestyle habits as effective ways to prevent chronic disease.[188] Healthy Together Now operates within Manitoba's regional health authorities and targets citizens who "are most at risk for chronic disease in rural, urban, First Nations and Métis communities" by funding projects that help citizens "tackle chronic disease risk factors" by not smoking, being more active, eating healthy food, and supporting mental well-being.[189] Healthy Together Now began as a five-year pilot project that was titled Chronic Disease Prevention Initiative and was the result of "growing awareness of the burden of chronic diseases on Manitoba society," including adult obesity rates that exceeded national averages.[190] Healthy Together Now is in line with, and indicative of, the broader rationalities of liberal governmentality that govern health in Manitoba through the prioritization of economic health over population health.

Healthy Together Now is funded through federal, provincial, and regional resources and operationalized through community organizations. Monetary funding for Healthy Together Now comes from the Public Health Agency of Canada (through partnership with the World Health Organization and federal funding) and Manitoba's Department of Health, Seniors and Active

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[187] Health, Seniors and Active Living. "Healthy Together Now."
[188] Health, Seniors and Active Living. "Healthy Together Now."
[189] Health, Seniors and Active Living. "Healthy Together Now."
[190] Healthy Together Now. "History." *Healthy Together Now*. Accessed November 9, 2020. https://healthytogethernow.net/organization/history/.

Living.[191] In-kind support comes from regional health authorities, 83 Chronic Disease Prevention Initiative communities, including First Nation and Métis communities, municipal governments, community councils, chief and councils, local educators, schools, the Canadian Cancer Society, CancerCare Manitoba, Manitoba Lung Association, Manitoba Tobacco Reduction Alliance, Health in Common, recreation facilities, Dairy Farmers of Manitoba, grocery stores, Addictions Foundation of Manitoba, seniors groups, drop-in centres, and wellness centres.[192]

Communities who participate in Healthy Together Now "develop action plans to address risk factors that affect their community," and identify "health promotion and chronic disease prevention activities focused on tobacco reduction, healthy eating, physical activity and mental wellness."[193] However, it is necessary to recognize the network of power relations at play to understand the limitations and constraints communities face when implementing programming in their communities. The Public Health Agency of Canada overly determines the design, structure, and evaluation of Healthy Together Now, whereas communities are meant to be "champions of community-led and culturally sensitive approaches to chronic disease prevention."[194] Communities decide details of what type of programing is offered and how (e.g. group fitness or healthy eating education), but they are beholden to the governing rationalities of healthism, and particularly biocitizenship, that are requirements of the Healthy Together Now programming. Even partner organizations that provide in-kind support are entangled within the matrix of

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[191] Healthy Together Now. "Partnerships." *Healthy Together Now.* Accessed November 9, 2020. https://healthytogethernow.net/organization/partnerships/. Healthy Together Now. 2005. "Chronic Disease Prevention Initiative (CDPI) – Project Charter: Final Draft Document." Winnipeg: Chronic Disease Prevention Initiative, 13.

[192] Healthy Together Now. "Partnerships."

[193] Healthy Together Now. "History."

[194] Healthy Together Now. "Partnerships."

healthism and contribute to the production of technologies of intervention – such as Dairy Farmers of Manitoba's contribution of nutrition expertise, and the Canadian Cancer Society's assistance with surveillance and risk factor knowledge dissemination.[195]

The Wayfinders Program is a Healthy Together Now funded project in the Winnipeg Regional Healthy Authority for teens (14-17 years) and young adults (18-20 years) to target risk factors through promotion of healthy eating, physical activity, school success, tobacco reduction, and mental wellbeing.[196] The Wayfinders Program grew out of research findings "published by the Manitoba Centre of Health Policy that documented the correlation between life-long health and educational attainment," and reported "staggering high school drop out rates (upwards of 50%) as early as grade 9 in low socioeconomic Manitoba communities."[197] The Wayfinder Program attempts to respond to high risk students' needs, and "targets adolescents in low-income communities in NW Winnipeg" by offering "outside-of-school mentorship programming."[198] The program assigns students with a student parent support worker as an advocate, volunteers to provide homework support and mentorship, and students "commit to 3 hours weekly of homework support, 4 hours monthly of mentorship, community service, post secondary exploration, regular school attendance and a continuous grades improvement strategy."[199] In return, students "may earn $1000 (held in trust) for each successful grade level completion and, $600 annually to support the cost of mentorship opportunities."[200] From this description, The Wayfinders Program sounds like a beneficial education mentorship program for youth.

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[195] Healthy Together Now. "Partnerships."
[196] Healthy Together Now. "The Wayfinders Program (Formerly Bright Futures Program)." Winnipeg: Healthy Together Now, 1.
[197] Healthy Together Now. "The Wayfinders Program (Formerly Bright Futures Program)," 1.
[198] Healthy Together Now. "The Wayfinders Program (Formerly Bright Futures Program)," 1.
[199] Healthy Together Now. "The Wayfinders Program (Formerly Bright Futures Program)," 1.
[200] Healthy Together Now. "The Wayfinders Program (Formerly Bright Futures Program)," 1.

The Healthy Together Now program operates to "tackle chronic disease risk factors," such as living smoking free, being more active, eating healthier food, and supporting mental well-being.[201] Aside from correlations between education attainment and 'life-long health,' a high-school completion mentorship program should have no direct outcomes for tackling chronic disease risk factors. Yet "healthy nutrition, active living and balanced life choices are significant aspects of the program's daily structures."[202] The funding from Healthy Together Now means that "a consistent healthy living framework is expected by students as regular parts of the Wayfinders Program: daily healthy snacks; daily hot meals; weekly community kitchen activities (planned and cooked by students); and daily physical activity mentorship activities."[203] The Wayfinders Program is a prime example of what Geneviève Rail and Shannon Jette identify as a biopedagogical rescue mission to save 'bio-Others' (2015, 330). Rail and Jette define bio-Others as failing biocitizens who are "dangerously undisciplined and in great need of policing" (2015, 330). The very nature of the Healthy Together Now mandate to intervene in populations of risk situates the populations receiving their programming as 'bio-Others.' Rail and Jette argue that biopedagogical missions to rescue bio-Others rely on education interventions in which "being taught to be well is often similar to being told to be well," and require individuals to be responsible for implementing lifestyle changes to effect their health (2015, 331). The Wayfinders Program seeks to imprint biopedagogies into daily programming to ensure students transition from bio-Others to biocitizens by the time they complete high school.

The Wayfinders Program highlights the constraints communities work within to receive funding for necessary programming – to receive funding for necessary programming and

[201] Health, Seniors and Active Living. "Healthy Together Now."
[202] Healthy Together Now. "The Wayfinders Program (Formerly Bright Futures Program)," 2.
[203] Healthy Together Now. "The Wayfinders Program (Formerly Bright Futures Program)," 2.

supports, they must do so within the confines of healthism. Healthism is a benchmark. To retain funding for community programs, it is necessary to buy into rationalities that require biocitizenship. In this instance, biocitizenship results in differential governance – whereas privileged youth living in higher socioeconomic neighbourhoods, like Tuxedo, receive education, social, and health services as already valued biocitizens, 'at-risk' youth acquire access to those same services because they are marked as being a risk to be managed through disciplinary healthism and active citizenship. The Wayfinder Program reifies renderings of Indigenous peoples through what Eve Tuck and Wayne K. Yang identify as "at risk" peoples (2012, 22). Tuck and Yang refer to renderings of "at risk" peoples as reifying descriptions of Indigenous students and families as "on the verge of extinction, culturally and economically bereft, engaged or soon-to-be engaged in self-destructive behaviors which can interrupt their school careers and seamless absorption into the economy" (2012, 22). The Wayfinders Program does not specifically target Indigenous students – but the Seven Oaks School Division that it operates out of has a large Indigenous population.[204] Moreover, the Healthy Together Now program operates according to particular assumptions about the population (at risk youth) being intervened upon due to their 'risk' levels.

As a final look at how education is prioritized with the aims of ensuring biocitizens self-regulate their health and nutrition in the face of food insecurity, I turn to the *Downtown Winnipeg Community Food Assessment* that was completed by Food Matters Manitoba in 2013. The assessment was undertaken in the context of a rapidly changing food environment of

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[204] For more see: Winnipeg. "2011 Census and National Household Survey Data: The Maples." *City of Winnipeg*. Accessed November 9, 2020. https://winnipeg.ca/Census/2011/Community%20Areas/Seven%20Oaks%20Neighbourhood%20Cluster/Neighbourhoods/Seven%20Oaks%20West/Seven%20Oaks%20West%20Neighbourhoods/The%20Maples/The%20Maples.pdf.

downtown Winnipeg with “fewer healthy options,” resulting in downtown being “categorized as a ‘least healthy’ neighbourhood in Winnipeg.”[205] Moreover, Indigenous community members were recognized as facing multiple “barriers to accessing healthy food and are at a higher risk for many diet-related diseases” (Food Matters Manitoba 2013, 5). The assessment included consultation with stakeholders, including “all levels of government, health care providers, schools, the private sector, and the non-profit community,” and indicated that “the time has now come to stop consulting and take action by implementing the recommendations found in this report and thereby addressing the issues of food insecurity in downtown Winnipeg” (Food Matters Manitoba 2013, 5). Given that the assessment has honed in on the deficits of the downtown food environment, it is not surprising that in all categories of recommendations (with the exception of geographic food access recommendations) education figures prominently as a response to food insecurity.

The assessment noted that “there are over thirty programs that operate in the downtown community that focus on healthy eating and nutrition education,” the majority of which are “geared towards demographic groups that face specific challenges,” including “mothers, newcomers, Aboriginal peoples, youth, and seniors” (Food Matters Manitoba 2013, 21). Moreover, the report indicates that “many downtown residents would like to make lifestyle and behavioral changes and want to consume a healthier diet” (Food Matters Manitoba 2013, 29). Without significant structural changes that address the determinants of food insecurity, further nutrition education is unlikely to result in different outcomes. Despite the preoccupation with nutrition education, “nutrition is not always a priority, as one focus group participant articulated,

[205] See: Food Matters Manitoba. 2013. *Downtown Winnipeg Community Food Assessment.* Winnipeg: Food Matters Manitoba, 4. The authors note that the “designation of being a “least healthy” neighbourhood is based on the rates of premature mortality, meaning death before the age of 75.”

'There are many barriers we face that are related to food but that's not at the top of my list. Making sure my bills are paid and I have a roof over my head is'" (Food Matters Manitoba 2013, 22). Even though nutrition is likely not a top priority for individuals struggling to merely maintain access to food, of the 34 recommendations the assessment makes, 16 involve some form of education – either school programming, skills-based programming, classes, or information resources for individuals to do their part in making downtown a 'healthy' neighbourhood.[206] This occurs in a similar vein to Rail and Jette's delineation of biopedagogical 'rescue missions' to save 'bio-Others' in which educating biocitizens assumes that "knowledge necessarily leads to desired behavior and therefore that, as this subject becomes more informed about health and how to attain it, he or she will behave in ways that lead to such health" (2015, 331). Education will not change eating behaviours that have been constrained by any number of determinants from historical to social to economic that shape how people eat.

Schools are a central site of intervention when it comes to health, nutrition, and food security. The *Downtown Winnipeg Community Food Assessment* reported that "in Manitoba there are nutrition education outcomes for every grade, from kindergarten to grade six, as well as grades eight, ten, and twelve. Nutrition education is taught in all these grades with lesson suggestions from the Province" (Food Matters Manitoba 2013, 34). In addition to in class nutrition education for students, "the Winnipeg School Division offers a half-day workshop based on *Eating Well with Canada's Food Guide* to elementary and secondary teachers," which is "co-facilitated by the Dairy Farmers of Manitoba" (Food Matters Manitoba 2013, 34). To cover additional bases, the Winnipeg School Division "also developed a parent booklet on healthy foods, *Make the Healthy Choice the Easy Choice: Information for Parents/Guardians,*

[206] See pages 51-53 for a full appendix summary of recommendations in: Food Matters Manitoba. 2013. *Downtown Winnipeg Community Food Assessment.* Winnipeg: Food Matters Manitoba.

which is distributed to all families with children enrolled in kindergarten to grade eight. If requested, parent education sessions are offered" (Food Matters Manitoba 2013, 34). In downtown Winnipeg, it is particularly troubling that neighbourhoods with high rates of food insecurity focus so heavily on nutrition education. Instead of educating food insecure children to eat healthier (and educating their parents to 'make the healthy choice easy'), increasing access to food through breakfast and lunch programs would be a better response to addressing issues of mere access. Expecting food insecure children (and parents) to make eating choices based on nutrition education indicates that the conditions of food security are only to be offered once individuals regulate their conduct as good biocitizens.

The Winnipeg School Division is not implementing nutrition education in a vacuum, on their own accord. School nutrition education is a central program of liberal governmentality and the federal healthism apparatus. As we saw in the federal healthism apparatus in chapter 5, the Public Health Agency of Canada *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights* has marked Indigenous youth as having a "significantly high combined overweight/obesity rate of 41 per cent," which they correlate to poor health outcomes and an increase in health care costs.[207] *Curbing Childhood Obesity* places a strong emphasis on early identification of at risk children, implementing physical activity and healthy eating within school environments, and raising awareness, skills, and knowledge of healthy eating among children, parents, and caregivers.[208] Interventions that occur in Winnipeg schools – like educating students in class, and parents on 'making the healthy

[207] Public Health Agency of Canada. "Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights." *Government of Canada*. Accessed October 17, 2020. https://www.canada.ca/en/public-health/services/health-promotion/healthy-living/curbing-childhood-obesity-federal-provincial-territorial-framework.html.
[208] Public Health Agency of Canada. "Curbing Childhood Obesity."

choice easy' – occur in connection with a broader governing apparatus. The Office of Nutrition Policy and Promotion develops and promotes dietary guidance, undertakes surveillance of populations to identify nutrition indicators, and provides knowledge translation through a number of programs and technologies, such as Winnipeg schools and teachers, to educate individuals into being active biocitizens.

Rezoning Bad Biocitizens

In this final section I visit another iteration of biocitizenship in Winnipeg through the *rezoning of bad biocitizens*. There has been an ongoing trend in interventions made by government sectors and not-for-profit intermediaries that identifies food insecurity as being connected with deficient neighbourhoods that hinder healthy citizenship. These interventions recommend *rezoning* to eliminate vectors of poor health like restaurants and convenience stores that are to be replaced through redevelopment of spaces into 'healthy zones.' Interventions in the form of proposed rezoning to combat food insecurity span programs and technologies of the healthism apparatus across all sectors – governmental, intermediary, and research. In this section I identify direct recommendations for rezoning, or at the very least, support for changing environments to advance public health goals in the reports by Food Matters Manitoba, Winnipeg Regional Health Authority, the federal *Curbing Childhood Obesity* framework, and in food swamp research.

Recommendations for rezoning tend either to make general recommendations for rezoning neighbourhoods to create healthier environments, or to rezone areas immediately surrounding schools to establish 'healthy school zones.' In their report *Health for All: Building Winnipeg's Health Equity Action Plan*, the Winnipeg Regional Health Authority identified rezoning as a necessary action item for responding to food insecurity. The report recommended

that stakeholders "ensure zoning, bylaws and incentives are in place to: locate quality affordable retail food outlets within easy walking distance in all neighbourhoods but particularly in low income neighbourhoods" (2013, 54). In a similar vein, Balcaen and Storie argued that "*if* food deserts and mirages coincide with food swamps, a wider breadth of policies is required for these regions," and if that is the case then "policies regarding grocery store access, pricing and type of food at convenience stores, and taxing of unhealthy alternatives . . . all need to be addressed by the Winnipeg Food Council" (2018, 17). These approaches identify zoning as an integral factor in the process of changing food environments from unhealthy, or deficient, to environments that could better support health.

In these interventions, existing food environments are featured as unhealthy or unsupportive based on population data that identifies risk through data on food insecurity, socioeconomic conditions, or poor health indicators such as obesity. The *Curbing Childhood Obesity* framework identified "supportive environments" as one of the three key priority areas for intervention.[209] The framework identifies that community design and the built environment have "a major impact on physical activity levels and access to nutritious foods" and that "regional and urban planning decisions can advance or hamper public health goals."[210] The framework prioritizes collaboration between "all levels of government and sectors" to "promote active and safe communities."[211] Improving access to food and providing added resources for communities are necessary steps in reducing food insecurity in communities. It is not necessary to require that access and resources that communities be rezoned to complete that process. It

209 Public Health Agency of Canada. "Curbing Childhood Obesity."
210 Public Health Agency of Canada. "Curbing Childhood Obesity."
211 Public Health Agency of Canada. "Curbing Childhood Obesity."

assumes that individuals solely subsist on 'swamp' foods, and it assumes that individuals do not have opportunities or zones of 'health' in their communities.

Recommendations of zoning interventions have also been explicitly tied to creating 'healthy school zones' to curb the access children and youth have to fast food restaurants or convenience stores. The *Downtown Community Food Assessment* completed by Food Matters Manitoba mapped 9 downtown schools and their proximity to fast food outlets and convenience stores (2013, 48-50). The report noted that "often schools are surrounded by fast food restaurants and convenience stores" and that "easy access to these retail outlets can have negative impacts on the health of children and youth" (Food Matters Manitoba 2013, 34-35). The report used measures of walkability up to 1km proximity to determine the walkable distance to fast food restaurants and convenience stores for Winnipeg's downtown schools, and "the results indicate that all schools are within walking distance of one or more convenience stores," and "fast food restaurants were also just as easily accessible" (Food Matters Manitoba 2013, 34). Of the food outlets accounted for, many would have 'healthy options' and some such as Subway and Vinh Long Vietnamese Fast Food could arguably be good 'healthy options' all around.[212] It is worth noting that restricting child and youth access to any affordable nearby food access point occurs in the context of school breakfast and lunch programs. In the downtown Winnipeg school zone, all of the schools "provide at least one breakfast, lunch and/or snack program that is funded through either the Winnipeg School Division or grant programs . . . there is no universal provincial or federal nutrition program that financially supports breakfast, lunch or snack programs in Winnipeg schools" (Food Matters Manitoba 2013, 33-34). If researchers and policy

[212] Vinh Long Vietnamese Fast Food is a particularly baffling inclusion given that almost all of their menu items are include protein, vegetables, and minimal carbs. Additionally, all of their menu items appear to be under $8 which would actually mean this is an accessible, affordable, nutritionally sufficient meal option.

makers are seriously concerned with the nutritional intakes of children and youth, providing universal meal programs at schools would be a much more equitable approach to food insecurity that would not subsequently do the work of rendering communities deficient.

Building off the data compiled of school proximity to fast food restaurants and convenience stores as being an indicator of potential negative health impacts on children and youth, the report goes on to recommend changes to zoning by-laws to reduce the number of fast-food access points. The report indicates that "there is increasing evidence to support healthy corner store initiatives and healthy school zones – areas surrounding schools where fast food restaurants are prohibited from locating" (Food Matters Manitoba 2013, 35). As a final recommendation, the report indicates that there should be an implementation of "zoning by-laws that encourage Healthy School Zones," with key stakeholders in such a decision being the City of Winnipeg, schools, and food retailers but not community organizations or citizens, apparently (Food Matters Manitoba 2013, 53). In order to delineate what is at stake when it comes to rezoning inner-city neighbourhoods, it is important to identify who benefits, and how, when neighbourhoods are rezoned as 'healthy zones.'

The *Downtown Community Food Assessment* advisory committee includes several members that have a markedly vested interest in rezoning the inner-city for purposes beyond accessing healthy foods. Members of the advisory committee include members of Winnipeg's Regional Health Authority, but most troubling is the inclusion of the managing director of Downtown Winnipeg Biz and the development manager of CentreVenture Development Corporation. As outlined in chapter 4, Downtown Winnipeg Biz is the same company that facilitates the volunteer civilian policing of inner-city residents to make downtown a 'safer and friendlier place,' producing another layer of criminalization that Indigenous people who live in

and move through the inner-city foodscape must endure. On the other hand, CentreVenture is a pinnacle of racial capitalism in Winnipeg – which is well documented in Owen Toews' *Stolen City: Racial Capitalism and the Making of Winnipeg*. CentreVenture undoubtedly has a deep investment in the deeming of inner-city neighborhoods as nutritionally deficient in order to economically benefit from the redevelopment of inner-city neighbourhoods. Development in the name of health is thinly disguised white possessive racial capitalism and it will certainly produce wealth for Winnipeg's white developers and will uncertainly result in health for inner-city residents. The regulation and disciplining of bodies through dominant nutrition ideologies does not always result in policies that are related to food security; however, food insecurity is always made to be an issue of health first and foremost.

Recommendations for rezoning inner-city neighbourhoods have continued with more recent policy interventions. In the 2018 report *Towards a Winnipeg Food Strategy: Policy Scan and Recommendations*, Food Matters Manitoba once again prioritized zoning interventions. The report provides directives on how to implement a Winnipeg food strategy as a response to the formation of the Winnipeg Food Council – and Food Matters Manitoba formal partnership with the council – in addition to a scan of relevant municipal and provincial policies that impact food in Manitoba (Food Matters Manitoba 2018, 1). The report reiterates recommendations made through previous community food assessments and the Future of Food in Winnipeg. The Future of Food in Winnipeg forum recommended that the priority of the Winnipeg Food Council "should be to develop a Winnipeg Food Strategy" with priority areas of access and equity, local and regional food, urban agriculture, land use and long-range planning, and food education and literacy (Food Matters Manitoba 2018, 8-10). The land use and long-range planning priority area is of particular note, and contends that "efficient land-use and long range planning can play an

important role in promoting nutritious and affordable food," which can be achieved through "healthy school zones, upgrading community garden infrastructure, and affordable housing" to promote food security (Food Matters Manitoba 2018, 10). The report also specifically notes that a community food assessment of Inkster recommended that "the City of Winnipeg can work with schools to implement zoning by-laws that encourage Healthy School Zones" (Food Matters Manitoba 2018, 16). Aside from community garden infrastructure and affordable housing, recommendations for zoning by-law changes remain focused on the 'healthy school zone.'

The healthy school zone is undoubtedly informed and supported by federal healthism policy such as the *Curbing Childhood Obesity* framework. The framework illuminates the connections between how food insecurity is imagined, educating biocitizens, and rezoning. The framework contends that when it comes to childhood overweight and obesity, "the influence of socioeconomic status is clear."[213] The framework links socioeconomic status, obesity, and education, noting that "young people in households where no members had more than a high school diploma were more likely to be overweight/obese than were those in households where the highest level of education was post-secondary graduation. The prevalence of poor health or poor health behaviours is less common at every step up the socio-economic scale."[214] Situating obesity and its corollary health risks amongst those who are poorly educated and lower on the socio-economic scale invariably determines interventions that are concerned with educating better biocitizens and improving their environments.

The *Curbing Childhood Obesity* framework identifies three key policy priorities to tackle childhood obesity – supportive environments, early action, and nutritious foods. Recommendations to establish Healthy School Zones by re-zoning neighbourhoods are

[213] Public Health Agency of Canada. "Curbing Childhood Obesity."
[214] Public Health Agency of Canada. "Curbing Childhood Obesity."

rationalized through the logics established in the frameworks' priorities of supportive environments and nutritious foods. The framework notes that "the built environment" determines "physical activity levels and access to nutritious foods" and in order to establish supportive environments, "effective partnership across health, municipal governments and urban planning are required to promote active and safe communities."[215] In conjunction with supportive environments, the framework prioritizes "looking at ways to increase the availability and accessibility of nutritious foods," while decreasing the availability of 'unhealthy' foods and given the focus on children's access to nutritious foods, "the healthy choice must be an available and easily recognizable option."[216] While the vision for the framework is having Canada be a country that "creates and maintains the conditions for healthy weights so that children can have the healthiest possible lives," it is irrational to expect that rezoning neighbourhoods will significantly impact the foods that children in low socioeconomic brackets will be able to access when an integral condition of access is economic.

Rezoning neighbourhoods – and thus rezoning bad biocitizens – as a response to food insecurity is insufficient. Rezoning as response to 'food swamps' – which is exactly how school zones are being portrayed in the multiple reports by Food Matters Manitoba and in Winnipeg's health equity action plan, regardless of whether the language is used to denote particular environments and communities as 'swamps' – is a disciplinary response to food insecurity. Moreover, rezoning is governmentality and biocitizenship through and through. Rezoning 'food swamps' is a government intervention into populations that cannot be trusted to self-regulate and be appropriate biocitizens. Rezoning interventions assume citizens only eat calorically dense, 'unhealthy' foods, that citizens do not and cannot find 'health' amidst 'food swamps,' and that

[215] Public Health Agency of Canada. "Curbing Childhood Obesity."
[216] Public Health Agency of Canada. "Curbing Childhood Obesity."

changing food retailers without changing structural determinants of how individuals access food will result in more food and nutrition secure populations.

Conclusion

In this chapter I delineated the provincial and municipal apparatus of healthism as it pertained to Indigenous health, while paying particular attention to how programs and technologies connect to and refract those identified in the federal apparatus. I turned attention to the final of the three elements of the operationalization of both governmentality and healthism that I identified in chapters 2 and 3 – *biocitizenship*. I identified three points of application of the apparatus of healthism (imagining food insecurity, education, and rezoning) to demonstrate how efforts to address food insecurity are conflated with notions of biocitizenship that result in regulatory, disciplinary, and differential governance of Indigenous populations who fail to be appropriate biocitizens. More significantly, I demonstrated that biocitizenship is operationalized to establish the conditions in which Indigenous citizens are made to be responsible for their own economic, health, and food security, and the security of the settler colonial state. Of course, the demands of biocitizenship are felt differently by different bodies and populations, and when it comes to food insecure Indigenous populations, those felt effects are more than likely disciplinary. In the following chapter – the conclusion – I revisit the implications and outcomes of governing Indigenous health and food insecurity through the differential governmentality of healthism. I pivot to think of possibilities for the future of health, food security, and what it means to be a biocitizen.

Chapter Seven – Post-Healthism

Food insecurity, despite occupying a central vein of this research, was not the sole focus. Food insecurity – how it is defined, how it is intervened upon, how research about it maintains a status quo – served as an empirical and analytic flashpoint for understanding colonial relations of power, how biomedical nutrition is employed as a disciplinary technology through an apparatus of healthism, and how Indigenous health is differentially governed through a veneer of health promotion and expectations of biocitizenship. I sought to interrupt the status quo of food insecurity research – research that invariably goes on to inform policy and interventions – a status quo that privileges the security of the settler colonial state over the food security of Indigenous people.

This research brought together governmentality, healthism, and Indigenous Studies literatures into conversation with each other to theoretically and empirically chart how Indigenous health in Winnipeg is differentially governed through healthism. Governmentality offered several integral analytical frameworks for tracing how Indigenous health is governed in Canada in the context of liberal political and economic rationalities. It also proved useful for identifying how biopower operates to govern and administer populations through rationalities, programs, and technologies that require a dispersal of government through state actors, non-state actors, and individual citizens (Rose and Miller 1992; Lemke 2002; Dean 2015). Governmentality was a natural theoretical precursor to engaging healthism given that healthism is indeed governmentality of health. Early healthism literature contextualized it as a process that worked as a form of social control (Zola 1972; Illich 1976; Zola 1977; Crawford 1977). However, a marked shift in contemporary healthism literature indicates a preoccupation with the self and how individuals buy in to healthism (Crawford 1980; Blaxter 2005; Cheek 2008; Brown

2018). By theorizing healthism alongside governmentality in this research, I was able to return to earlier theorizations of healthism to extend how healthism has been understood as a technique of social control – or what I have now delineated as *differential governance*.

Despite the productive aspects of governmentality and healthism as theoretical analytics for identifying how health is governed, both lacked in two key areas – analysis of race and/or indigeneity and empirical context. I addressed these gaps and extended governmentality and healthism literatures by engaging these undertheorized contexts. Through the empirical focus of my research, I accounted for how governmentality and healthism operate through an entire apparatus, and not just through a single program or technology. In my charting of an apparatus of healthism, I was able to "examine constellations of power" and track how healthism is operationalized through an apparatus that is comprised of 'state' institutions, non-governmental institutions and actors, and self-governing citizens in the context of Winnipeg (Li 2007a, 5-6). In examining such constellations of power through a deep empirical focus, whether it be overly surveilled and securitized grocery stores, after school nutrition programming, or city officials and developers collaborating to rezone 'unhealthy' neighbourhoods, I have accounted for a multitude of modes of governing and how it comes to bear on a specific population and locale through a focus on Indigenous food insecurity in Winnipeg. As I noted in my introduction, governmentality scholars are notedly *non-empirical*. Li has argued that scholars, like Nikolas Rose, limit their studies of governmental rationalities to hypotheticals, and not concrete practices (2007a, 5). Throughout this research I have accounted for governmentality as a concrete practice, embodied enactment, with material realities and points of application.

In my three empirical chapters I analyzed how healthism operates through the individual and the body politic, the expert and expertise, and the biocitizen, and in so doing, I loosely

mirrored Foucault's tracing of security, territory, and population, at least figuratively (Foucault 2009). Security is the focus of chapter 4, in which I theorized white possessive securitization to demonstrate how individuals operate as self-regulating agents of governmentality. While I did not literally engage territory in this research, in chapter 5 my charting of a federal apparatus of healthism is concerned with how the rationalities that determine the governing of health in Canada are preoccupied with territory in the sense that all policy directives are meant to secure the apparatus and limit risk to its territory. When it comes to the population, in chapter 6 I demonstrated how healthism operates to administer populations through interventions that seek to shape subjects into better biocitizens. These three corollary applications of power were integral for understanding how health is governed beyond liberal technologies of the self that are so often the focus of healthism: they also exist at the level of the population.

Focusing on health and nutrition as a power/knowledge nexus that produced the conditions of possibilities for how food insecurity is intervened upon served several purposes in this research. As I indicated in the introduction, I see this research as being informed by and contributing to Indigenous Studies and the emerging field of Indigenous STS. Indigenous STS, with its focus on Indigenous analytics of and production of science and technologies "that effect Indigenous *and* non-Indigenous peoples and territories" has begun to disturb colonial logics embedded in the rationalities, programs, and technologies produced through technoscientific fields (Kolopenuk 2020a, 2). Regardless of the empirical dissonances, I think alongside those working on data sovereignty (Rodriguez-Lonebear 2016), critical statistics (Walter and Andersen 2013; Andersen 2013; Murphy 2018), anticolonial and citizen science marine plastics monitoring

(Liboiron et al. 2016), and science policy.[217] The resonances I draw on amongst these thinkers are how populations are determined, how they are intervened upon, what matters (conceptually and corporeally) in research, and how to engage the twinned projects of disrupting colonial science and producing Indigenous analytics, science, and governance within a diversity of technoscientific and biomedical fields. How logics of health and nutrition have overly determined how food security is conceptualized as requiring meeting appropriate nutritional guidelines is but one way that I have tuned my analysis to "colonizing power in its multiple forms" (Moreton-Robinson 2016a, 4). Moreover, Indigenous STS is concerned with questioning the logics of scientific and political technologies – like the discursive formation and apparatus of healthism – and their impact on "bodies, peoples, relationships, relatives, and space" (Kolopenuk 2020a, 5). I have critically interrogated how the fields of health, nutrition, and food security deploy colonial logics and serve the ends of the settler colonial state, and while at times I am deeply critical, I do so with care and conversation to disrupt the reproduction and reification of relations of biopower within and through research and its material formation in apparatuses of governmentality.

Food insecurity as an analytical flashpoint for delineating colonial relations of power illuminates how Indigenous lives and populations are intervened upon in the most unassuming and everyday ways. Given that research, and the logics it reproduces, maintains and reifies apparatuses of governmentality (like an apparatus of healthism), to continue to engage in research relations that do not actively interrogate how they are implicated in reiterating relations of power is what Tess Lea would call a "failure of intellectual nerve" (2020, 157). How food

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[217] Canadian Science Policy Conference. *4th Annual Science Policy Awards of Excellence – Youth Category.* Ottawa: Canadian Science Policy Conference. See: page 7-12 for a summary of Jessica Kolopenuk's winning youth science policy proposal for "An Indigenous Approach to Canada's National Missing Persons DNA Program."

(in)security is imagined and responded to is an issue of settler governmentality, whether interventions are made directly into Indigenous populations or not, Indigenous people are differentially governed as long as the cohering logics favour health as a standard of biocitizenship and minimizing risk to the settler state rather than to the individuals experiencing food insecurity.

It has been well established that governmentality operates through dispersed forms of programs, technologies, and power (Rose and Miller 1992; Lemke 2002; Foucault 2003, 246; Foucault 2009, 108). As much as this research was invested in identifying how Indigenous health is differentially governed through governmental institutions and policies such as Canada's Food Guide and the Curbing Childhood Obesity framework, it was just as concerned with how academic research produces the "epistemic infrastructures" of governing apparatuses (Murphy 2017, 6). The expertise of quantification, problematization, and logics of intervention that are produced through academic research contribute to the administering and intervening upon populations (Li 2007b; Walter and Andersen 2013; Murphy 2017; Lea 2020). Recognizing research as co-constitutive of governing apparatuses is a necessary step in interrupting the logics that support ongoing differential and disciplinary governmentality of Indigenous bodies and populations.

I establish significant stakes in the fields of nutrition, Indigenous health, and food security policy that I have intervened upon and extended here. In earlier chapters I engaged conversations about Indigenous health policy taking place across several fields on whether there can be 'good' or 'healthy' policy (Richmond and Cook 2016; Gabel, DeMaio, and Powell 2017; Lea 2020). Having a stake in these fields and the conversations happening within and across them is an integral component of being able to recognize the limits to producing better policies

under settler colonial conditions, and whether existing policy recommendations significantly alter how Indigenous health is administered through apparatuses of governmentality. Like Lea, I argue that expecting future policy that "is magically free of state tentacles, is a failure of intellectual nerve," so if we do indeed "have to stay with the state," it will be necessary to consider how to best maneuver within those confines (2020, 157). In her dialogic work between Indigenous peoples and biopower, Dian Million posits that if colonialism can take "such pervasive effort to make life calculable, to bring it into 'management' to make it produce, in what ways do we use it, elude it, transgress it, and mobilize it" (2013, 30). In the realm of health care and provisions, I am reminded of Paul Farmer's call for "pragmatic solidarity" that rejects compassion in public health work if it is not linked to pragmatic efforts.[218] Moreover, as Donna Haraway theorizes, despite the damage and trouble of our current conditions, it is worth staying with the trouble (2016). The corporeal and material ramifications of staying with the state are significant and should not be dismissed.

Given that many opportunities for further determination over health policies by Indigenous organizations occur within existing infrastructures of liberal governmentality, it is absolutely imperative that future research continues to challenge colonial logics that result in differential burdens on Indigenous bodies and peoples. Critical engagement with statistical portraits of Indigenous populations will be necessary to interrogate how they render "deficit indigenes" or bad biocitizens, while working towards statistics that better reflect nuance, complexity, desires, and social relations of urban Indigenous people (Andersen 2013; Walter and Andersen 2013, 21). Staying with the state, and staying with apparatuses of governmentality, will require ongoing interrogations of the discursive formations that simultaneously operate to

[218] Farmer, Paul. "Pragmatic Solidarity." *The Centre for Compassion & Global Health*. Accessed December 18, 2020. https://ccagh.org/conversations/editorials/paul-farmer/.

render Indigenous people unhealthy and in need of discipline and differential governance. The field of Indigenous STS will be integral for producing Indigenous engagement with and determination of technoscientific and biomedical fields that differentially govern Indigenous health (Kolopenuk 2020a). Indigenous health scholars who are interrogating the colonial logics underlying the administration of Indigenous health are leading the way for future research, policy, and governance (Warbrick et al. 2016; Warbrick, Came, and Dickson 2018; Gillon 2019). Given the infrastructural nature of knowledge making, continued research to disrupt the logics and discursive formations of health, nutrition, and food security is a productive first step to stay with the state (Murphy 2017, 6).

Producing research from the orientation of Indigenous Studies and Indigenous STS has meant that alongside my critiques of how Indigenous health is differentially governed through an apparatus of healthism, I have simultaneously engaged with policy, technoscientific, and biomedical fields. These engagements appear throughout this research – but are also ongoing outside of this immediate project and will inform future research. As Kolopenuk has noted, "relationship-building as method is required to *do* actual stuff in an attempt to manipulate the relations of coloniality that exist as the subject of critique" (2020a, 7). For me, this has meant establishing relationships with those working in health policy, diabetes research, and nutrition sciences. While this research presupposes Indigenous approaches to nutrition and biomedical sciences that are in question here, future research will work towards this, because as Kolopenuk posits, "Indigenous STS is not anti-scientific, but rather, considers how engagement *with* technoscientific fields by Indigenous peoples and from dynamic approaches might support Indigenous ways of relating in and with localities of that which exists" (2020a, 5). Far too often Indigenous 'approaches,' or perhaps more appropriately, veneers, on health policies are limited

to the realm of adding cultural perspectives instead of altering the underlying power relations (Kimura et al. 2014, 39; Rail and Jette 2015, 330-331). Challenging the logics that simply swap Indigenous 'culture' for existing power/knowledge formations is necessary, especially in relation to nutrition science. These efforts reinscribe race by hypervisiblizing "*indigeneity-as-different*" and invisiblizing whiteness (Andersen 2009, 88; Moreton-Robinson 2016b, 115). Indigenous engagement *with* the technoscientific and biomedical fields that overly determine how health is currently governed is a necessary next step.

Post-Healthism

I produced this research as a first step to move beyond healthism when it comes to matters of Indigenous health, nutrition, and food security. As I close this research, I want to reflect on this provocation by Kolopenuk: "I charge non-Indigenous and Indigenous peoples alike to *be bad:* unpack and undermine the investments they have in propertied and rights-based individualism, state-based sovereignty and nationalism, capitalist cultures of consumption, and settler fantasies of being rightful and good" (2020b, S28). Kolopenuk notes that "any articulation of good (and bad for that matter) biocitizenship has been, at least, partly shaped by colonial thinking" (2020b, S28). In rejecting and reorienting what it means to be good or bad, Kolopenuk directs us to restructure power dynamics that determine the responsibilities and rights attached to biocitizenship (2020b, S25). A 'post-healthism' will necessarily require a reorientation away from biocitizenship. Moreover – it will be vital to ask whether 'healthy' or 'good' Indigenous health policy would actually involve *being bad*. I urge those engaging with Indigenous health policy to consider what constitutes *health* if biocitizenship, white possessive securitization, and colonial rationalities and logics of security do not factor into the equation.

I have four future research areas that I have identified to continue this work of post-healthism. The first research area is to support Indigenous created food guides, a project that will necessitate community engaged partnerships. There are existing pilot projects of Indigenous-focused food guides and given the need to focus on specific communities and locales, ongoing work in this area is crucial (Wilson and Shukla 2020). I see this research as being absolutely essential for rendering visible, undermining, and reiterating the power/knowledge domain present in Canada's Food Guide for First Nations, Inuit and Métis that merely substitutes traditional or cultural foods to adhere to dominant nutrition guidelines. I argue that food guides should move away from nutrition guidelines and instead delineate people and locale specific accountings of dignified access to food, food preferences, and peoples/regional centered conceptions of what constitutes 'health' in relation to food. For example – in Kugaaruk, it is necessary to know what foods to eat before going onto the land to keep your body warm, and in urban locales it may be important to know where to safely access preferred foods – these are examples of relevant food knowledge based on community needs and desires.

Critical diabetes research is the second future research area that I have identified. Diabetes figures significantly in studies of Indigenous food insecurity and obesity. However, how Indigenous populations are perceived of as 'at risk' for these diet-diseases is often done so through racializing logics and technologies, such as the Body Mass Indicator (BMI). Moreover, interventions are often conducted through programs and technologies of healthism by requiring individuals to manage their diabetes and/or obesity through appropriate nutrition and physical exercise, without accounting for other social, political, and economic factors that shape individual and population health.

Building on work I began while completing my doctoral research, the third future research direction is comparative Canadian and New Zealand policy. New Zealand and Canadian policies position Māori and Indigenous health according to similar logics – racism, deficiency, and bad biocitizenship (Warbrick, Came, and Dickson 2018). In focusing on similarities between how Māori and First Nations, Metis, and Inuit health is governed according to apparatuses of healthism, I aim to highlight areas where individuals' subjectivity and resistance to differential governmentality occurs. In light of New Zealand's 2019 "wellbeing" budget, it will be illuminating to determine whether a focus on wellbeing significantly alters the wellbeing of the Māori population – or whether wellbeing will operate according to liberal rationalities and be referential of state wellbeing (Roy 2019).

The final future research area I want to note is a research project I have identified based on a significant gap identified in food desert, mirage, and swamp research. As I noted in previous chapters, research that has identified food deserts and mirages in Winnipeg has done so by predominately accounting for national chain grocery stores, or local large chain grocery stores, because they have been identified as carrying the largest selection of 'healthy' foods, at the most affordable prices (Wiebe and Distasio 2016; Slater et al. 2017). I argue that if we are to have a truly nuanced portrait of urban Indigenous food security and social relations, we need to do better accounting. As it stands, Indigenous food insecurity is mapped according to a "deficit model," rather than community desires or social relations (Andersen 2013, 279). In consultation with community members, it will be worthwhile to account for other food access points and expanding logics of health that currently serve to exclude possible sites of security and health such as community organizations, small grocers, and social networks.

The research completed in this dissertation has established a necessary first step towards future community engaged research through Indigenous created food guides or food security mapping. With my robust analysis of policy and current trends in food insecurity policy recommendations, this research has implications for community organizations who are engaged in providing food security programing and services in Winnipeg. Knowing how and where food insecurity is being governed in Winnipeg, and what logics programs and technologies conform to, is useful context for community organizations that need either to operate according to those logics, or wish to subvert them. It is my hope that through the mobilization of this research, and future research collaborations with community partners, I will inform (and spur what would likely be a glacially slow change in) policy making regarding Indigenous health, nutrition, and food insecurity.

As I continue to research towards a 'post-healthism,' I will continue to think with food as a nexus for power/knowledge. There is much to be done to understand, disrupt, and reiterate the governmentality of Indigenous health. I have traversed through a multitude of intellectual and physical geographies to think about coconut crabs contaminated with strontium 90 to cantaloupes in inner-city Winnipeg grocery stores. Of course, it was never just about these foods, or lack of these foods, but the power that shapes how individuals are perceived in relation to these foods. What are they eating if they are not eating these foods? Are they being a bad biocitizen if they do not adequately act within the conditions of their existence? For me, the future of food research lies in disrupting the racialized logics that pigeonhole policy responses to food insecurity within the realm of culture and/or health to adhere to requirements of biocitizenship. And with this in mind, I will continue the pursuit I started here of *being bad.*[219]

[219] I follow my academic kin Jessica Kolopenuk's provocation to *be bad* (2020b).

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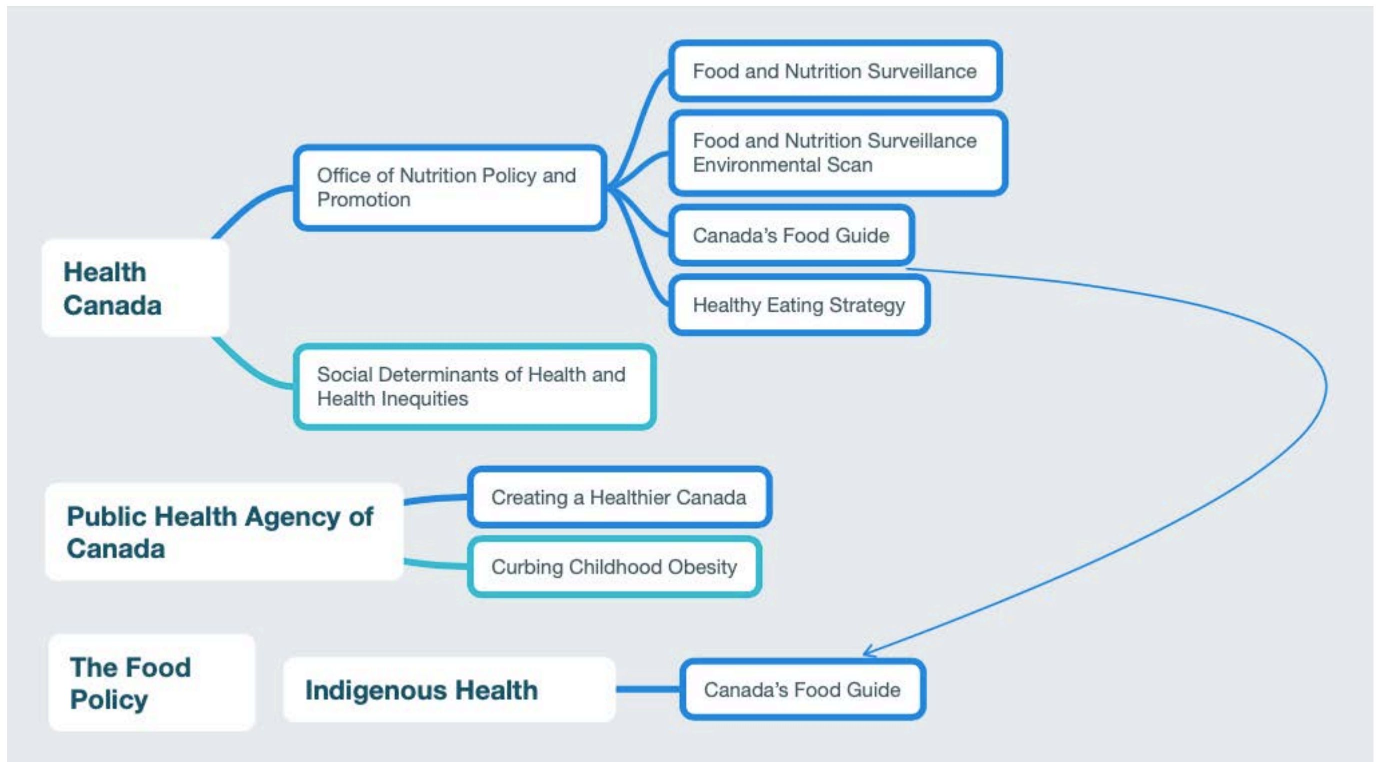
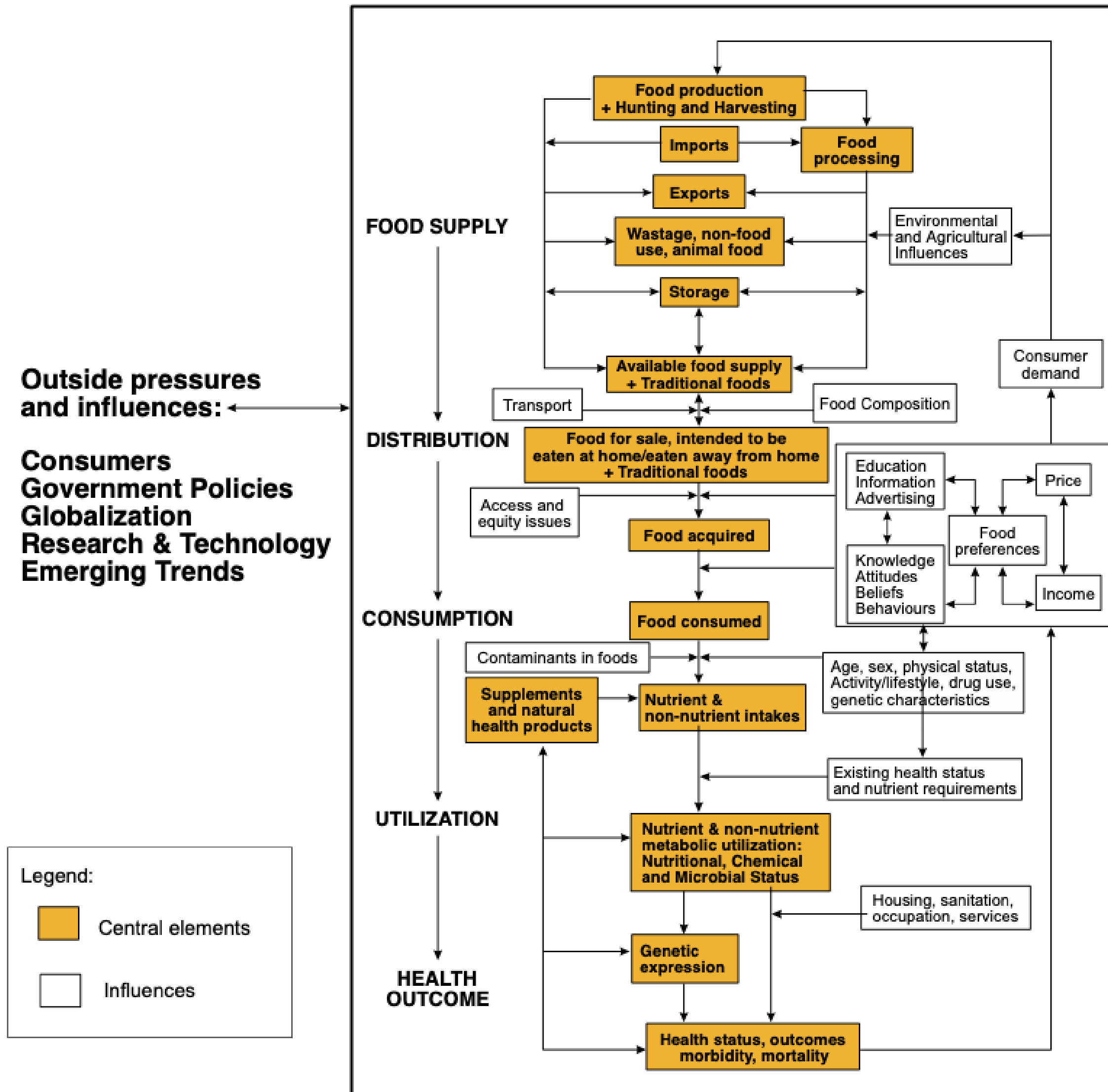
Appendix 1



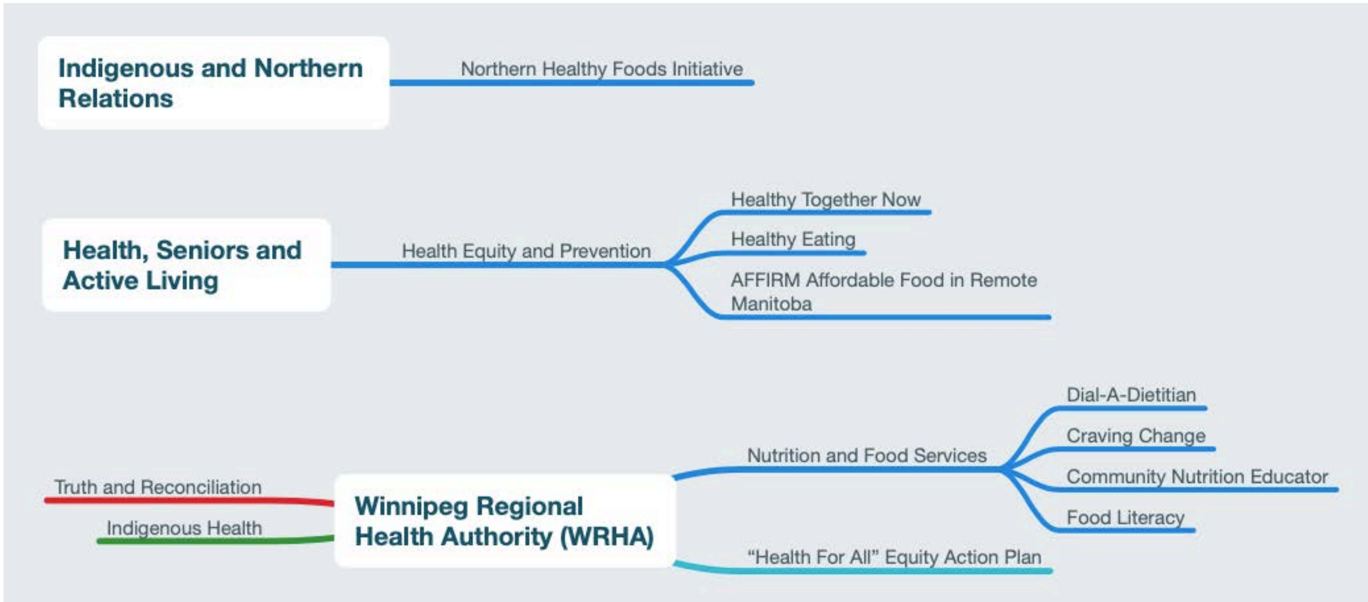
Appendix 2

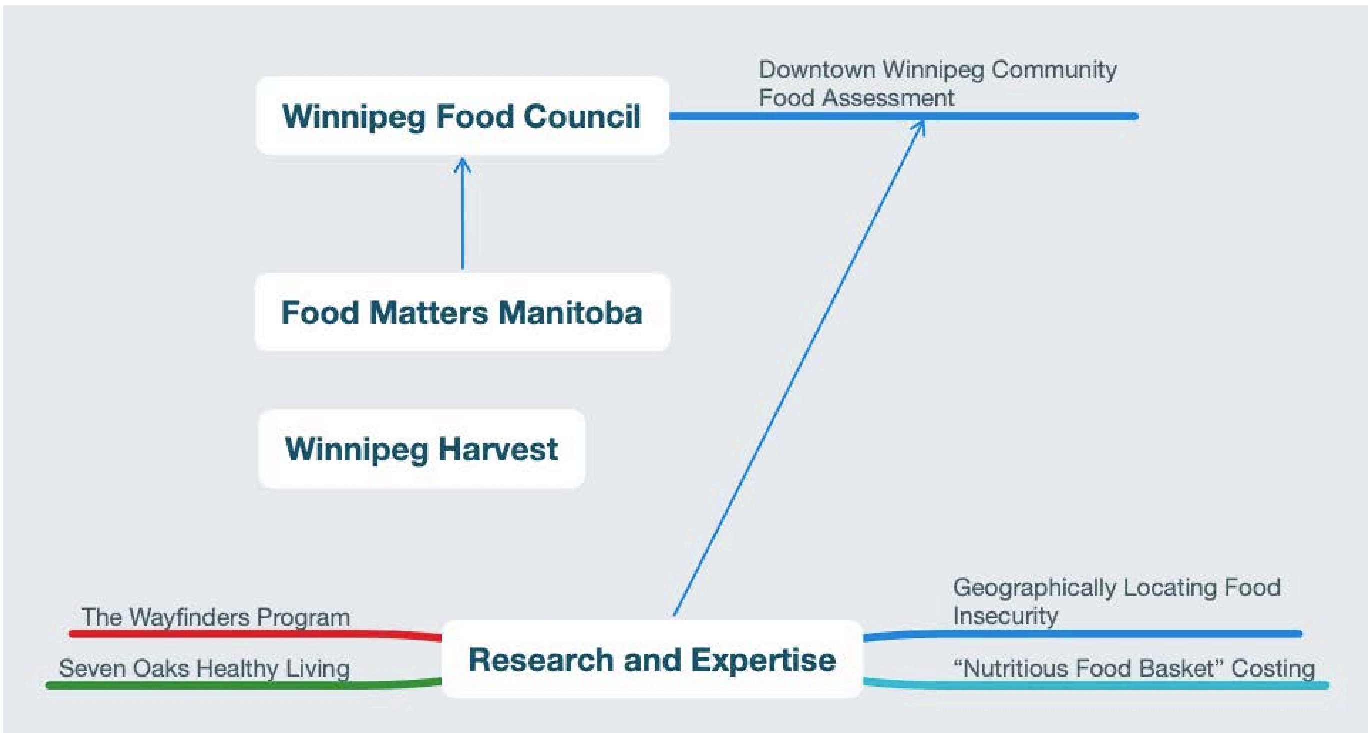
Conceptual Model for the Canadian Food and Nutrition System



Adapted from the conceptual framework of the Australian food and nutrition system
Ref: Ian H. Lester. AUSTRALIA'S Food & Nutrition.
Australia Government Publishing Service, Canberra. 1994

Appendix 3





Appendix 4

Health Canada. *The Contents of the 2019 National Nutritious Food Basket*. Government of Canada. Accessed November 20, 2020. https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/national-nutritious-food-basket/contents.html.

Vegetables and fruit

1. Green beans, frozen
2. Broccoli, frozen
3. Peas, frozen
4. Green pepper, fresh
5. Romaine lettuce, fresh
6. Spinach, frozen
7. Winter squash, fresh
8. Carrots, fresh
9. Sweet potatoes, fresh
10. Potatoes, fresh
11. Corn, frozen
12. Mixed vegetables, frozen
13. Cabbage, fresh
14. Iceberg lettuce, fresh
15. Cucumber, fresh
16. Celery, fresh
17. Mushrooms, fresh
18. Onions, fresh
19. Tomatoes, canned
20. Tomatoes, fresh
21. Apples, fresh
22. Bananas, fresh
23. Grapes, fresh
24. Oranges, fresh
25. Pears, canned
26. Strawberries, frozen
27. Peaches, canned
28. Cantaloupe melon, fresh

Protein foods

1. Fortified soy beverage
2. Tofu
3. Hummus
4. Chickpeas, canned
5. Kidney beans, canned
6. White beans, canned

7. Black beans, canned
8. Lentils, dry
9. Sunflower seeds
10. Peanuts, unsalted
11. Peanut butter, natural
12. Tuna, canned
13. Pink salmon, canned
14. White fish, frozen
15. Eggs, fresh
16. Chicken legs
17. Ground turkey
18. Pork chops
19. Beef, inside round roast
20. Mozzarella cheese, 16.5% M.F.
21. Milk, 2% M.F.
22. Plain yogurt, 1-2% M.F.

Whole grain foods

1. Brown rice
2. Quick rolled oats
3. Whole grain wheat flour
4. Whole wheat pasta
5. Whole wheat pita, roti or chapatti
6. Whole wheat dinner roll
7. O-shaped oat cereal, plain
8. Shredded wheat, plain

Unsaturated fats

1. Vegetable oil
2. Mayonnaise
3. Margarine