

THE IMPACT OF CHILDHOOD OBESITY DISCOURSES ON DOMESTIC AND
REPRODUCTIVE LABOUR FOR SINGLE MOTHERS IN NORTHEASTERN ONTARIO:
AN INSTITUTIONAL ETHNOGRAPHIC STUDY

By

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A thesis submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy (PhD) in Interdisciplinary Rural and Northern Health

The Faculty of Graduate Studies
Laurentian University
Sudbury, Ontario, Canada

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THESIS DEFENCE COMMITTEE/COMITÉ DE SOUTENANCE DE THÈSE
Laurentian University/Université Laurentienne

Faculty of Graduate Studies/Faculté des études supérieures

Title of Thesis Titre de la thèse	THE IMPACT OF CHILDHOOD OBESITY DISCOURSES ON DOMESTIC AND REPRODUCTIVE LABOUR FOR SINGLE MOTHERS IN NORTHEASTERN ONTARIO: AN INSTITUTIONAL ETHNOGRAPHIC STUDY	
Name of Candidate Nom du candidat	O`Gorman, Laurel Dawn	
Degree Diplôme	Doctor of Philosophy Science	
Department/Program Département/Programme	PhD Rural and Northern Health	Date of Defence Date de la soutenance August 24, 2018

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Abstract

Rationale: The term “healthy children” is often used to describe children whose weights are within a socially acceptable range which conflates health with thinness, often completely overlooking other aspects of health and employing body-stigmatizing language about children.

Research Questions:

1. How do single mothers who live in poverty in Northeastern Ontario define good health for their children? What role do considerations of obesity play in their definition of good health?
2. What are the implications of participants understanding of health on their domestic and reproductive labour?
3. How are these experiences mediated by the families’ social location?

Theory: Institutional ethnography (IE) is a theory and a method. IE investigates the coordination of ideologies that shape people’s experiences. Institutions made up primarily of government bodies and medical experts shape how childhood obesity is discussed in schools, the media, and in everyday life, impacting how we understand and speak about children’s bodies. This includes the amount and types of work expected of parents (primarily mothers) as well as the implications for bodies that do not meet the standard deemed acceptable in a particular time and place.

Method: The research participants were twenty women residing in Northeastern Ontario who self-identify as a single mother living in poverty. I used two methods of data collection: interviews and guided tours of key areas impacting children’s health, such as grocery stores or places children play.

Analysis: I analysed the interviews and the interactions between participants and their environment using an institutional ethnographic approach to coding. The aim of the analysis is to

link the everyday lived experiences of research participants to the ruling relations in which they are shaped.

Results: Participants talked about children's health in ways that were consistent with obesity discourses. When I asked what the term healthy child meant to them, the first response was usually 'food' followed by 'physical activity'. Mothers described a great deal of work that went into trying to make decisions that they felt were healthy. However, they also described many barriers to providing the types of healthy foods and activities they would like to provide for their children.

Keywords: Childhood Obesity, Critical Fat Studies, Institutional Ethnography, Mothering, Domestic and Reproductive Labour, Weight Stigma

Acknowledgements

I have received a lot of support over the past four years, without which this dissertation would not have been possible. I would like to extend my sincere appreciation to my supervisors, Dr. Jennifer Johnson and Dr. Diana Coholic. Jen, thank you for being available on short notice with advice, encouragement, and coffee. Diana, your guidance and quick responses were very much appreciated. It has been great working with both of you over the past four years. I would like to thank Dr. Rachel Ellaway, as without your encouragement, I may not have started on this PhD. And to Dr. Susan James, your feedback in the final stages of my work was invaluable. I would like to thank the external examiners, Dr. Yovita Gwekwerere from Laurentian University's School of Education and Dr. Deborah McPhail, Assistant Professor in Community Health Sciences at the University of Manitoba. I would also like to thank the staff within my department; Casey, you are quick with a joke when things go wrong and have all the answers to make sure they go right.

I need to thank my family for their support through this process and their patience through many evenings and weekends spent on schoolwork, particularly my children for letting me read and write on the sidelines while they were at dance, hockey, football, soccer, and various other activities. Lastly, I would like to thank the twenty women who trusted me with their stories, without whom this work would not have been possible.

Table of Contents

Abstract	iii
Acknowledgements	v
Table of Contents	vi
Chapter 1: Introduction and Rationale	1
Researcher Reflexivity	3
Research Questions	4
Dissertation Outline	4
Theoretical and Conceptual Framework(s)	6
Institutional Ethnography and Intersectionality	6
Review of the Literature	8
What is Obesity?	9
Obesity Rates	9
Fatness and Health	10
Discourses of Fatness	14
Individual and Mother Blame	16
Domestic Labour and Foodwork	19
Conclusion	21
Chapter 2: Methodology	22
Personal Standpoint	22
Ontological Perspective	24
Epistemological Perspective	25
Reflexivity in Research	27
Institutional Ethnography	30
Geographic Methods	31
Methods	33

Setting	33
Recruitment	34
Participants	36
Data Collection	38
Interviews	38
Guided Tours of the Neighborhoods	40
Data Analysis	43
Quality Control and Study Limitations	46
Chapter 3: Fatness and Moral Panic: Childhood Obesity Discourses in Health Policies in Ontario, Canada	48
Context	48
Abstract	48
Review of the Literature	49
Power, Discipline and Fat Bodies	50
Methodology	52
Results	53
The Construction of Obesity as a Global Epidemic	54
Ontario and Obesogenic Environments	55
National Standing Committee on Health Report and Surveillance	55
Ontario's Action Plan and Fiscal Responsibility	56
Healthy Kids Panel and Fatness as Dangerous	57
Patients First and the Erasure of Weight	60
Discussion	61
Conclusion	63
Chapter 4: Mothering, Geography, and Spaces of Play	65
Context	65
Introduction	65

Play and Health.....	68
Perceptions of Safety and Fear <i>for</i> Youth	70
Perceptions of Safety and Fear <i>of</i> Youth.....	74
Intersectional Connections: Race and Class	75
Conclusion	78
Chapter 5: Children’s Sports, Leisure, and Childhood Obesity Discourses: Institutional Ethnographic Interviews with Low-Income Single Mothers.....	80
Context	80
Introduction.....	80
Review of the Literature	82
Results.....	83
Physical Activity as Health	84
Organized Leisure Activities	86
Sports and Competitive Recreational Activities.....	86
Recreational Sports.....	89
Coordinating Activities as Work.....	91
Costs as a Barrier.....	93
Free Sports Programs	97
Transportation as a Barrier	98
Discussion.....	99
Conclusion	101
Chapter 6: Mothering, Fatness, and Foodwork.....	102
Context	102
Introduction.....	102
Methodology.....	103
Results.....	104
What is Health?	105
What is Work?.....	108

Food Provisioning	110
Negotiating Health and Food Costs.....	113
Shopping as Work	116
Cooking as Work.....	122
Eating.....	124
Conclusion	126
Chapter 7: Discussion and Conclusions.....	128
Summary of Findings	130
Overall Findings	133
Limitations.....	137
Solutions	141
Future Research Directions	144
Conclusion	145
References.....	147
Appendix A: Recruitment Poster	184
Appendix B: List of Initial Contacts.....	185
Appendix C: Ethics Approval.....	186
Appendix D: Participants.....	188
Appendix E: Interview Guide	192
Appendix F: Emailed List of Questions for Participants	194
Appendix G: Consent Form	195
Appendix H: Policy Summary Table	199

Chapter 1: Introduction and Rationale

In 2012, I worked with The Healthy Kids Panel on a mixed methods research project entitled The Healthy Kids Strategy. The Ministry of Health and Long-Term Care appointed this panel with the aim to reduce childhood obesity in Ontario by 20% over five years (MOHLTC, 2013). The Panel had representatives from local and provincial governments, medicine, public health, education, and the private sector. In my role as a research assistant, my task was to complete the ethics review forms, edit and administer an online survey, and coordinate focus groups in Sudbury and Toronto. I found that this work repeatedly conflated the words “healthy children” with “children who are thin.” The words ‘weight’ and ‘obesity’ are not in the title of the report or the name of the panel even though both are focused exclusively on children’s weight. Mental health, for example, is only explored in connection to obesity, such as in the relationship between obesity rates and depression or weight gain as a common side effect of medications prescribed for mental illness (Healthy Kids Panel, 2013). The framing and results of the report suggest that the most important way to keep children healthy is to manage their weight.

The final report begins with alarmist statements about childhood obesity. The Healthy Kids Panel (2013) explains that childhood obesity is “threatening our children’s future and the future of our province” (p. 2). It then states that “if our children are not healthy, then our society will not flourish” (p. 2), implying that people who are overweight cannot fully contribute to society. The report presented a shocking statistic; “by 2040, up to 70 per cent of children will be overweight or obese adults and almost half of our children will be an unhealthy weight” (p. 9). This statement uses reported increases in obesity in Canada over the past 25 years to project rates

another quarter century into the future. However, recent research indicates that obesity rates have remained constant in North America (Rao, Kropac, Do, Roberts, & Jayaraman, 2016; Starky, 2005; Statistics Canada, 2008).

The Healthy Kids Panel statistic was quoted (and sometimes misquoted) in several mainstream news sources, including reports that 70% of children will be obese by the year 2040 (Artuso, 2013; Gillespie, 2012; “‘No time to wait!’ The Ontario Healthy Kids panel delivers its report,” 2013; The Huffington Post, 2013; Ulrichson, 2013). This figure has also been reported and endorsed by various organizations that have the expertise necessary to influence public discourse such as the Toronto Sick Kids Hospital, YMCA, Sudbury and District Health Unit, University of Toronto, and the Southwest Ontario Aboriginal Health Access Centre (Healthy Kids Panel, 2013), and has even begun to influence city planning (City of Thunder Bay, 2013). The report is expected to impact the work of many Ontario organizations and it does so by using language that I have found to be consistent throughout much of the policy work in children’s health.

The focus of policy documents on childhood obesity is often on particular groups, such as Indigenous children (Greenwood & de Leeuw, 2012), rural populations (McPhail, Beagan, & Chapman, 2013; Statistics Canada, 2004) and families with low socioeconomic status (Brunner et al., 1997; Clarke, O’Malley, Johnston, & Schulenberg, 2009; Sobal & Stunkard, 1989). With so many of the texts describing fatness as inherently problematic and linking fatness to particular groups, these groups come to be constructed as a ‘problem population’ (McPhail, 2013). Programs and policies, such as the document mentioned above, are intended to improve health, but replicate these discourses by focusing on educational initiatives, such as promoting Canada’s

Food Guide or number of minutes per day children should be exercising. Such discourse further reinforces notions of individual blame and stigmatizes people with fat bodies.

Individualized blame has different implications for people from different social locations. I focused on single mothers in the context of this research. Even in sole-support parent families, fathers do less childcare and housework than mothers (Milan, Keown, & Urquijo, 2011). Single fathers have more external supports than single mothers (Hook & Chalasani, 2008), higher income (Statistics Canada, 2013) and are more likely than women to experience domestic and reproductive labour as a form of leisure (Szabo, 2013).

Researcher Reflexivity

Institutional ethnographic research is a reflexive process; “there’s no room in this method for an invisible author” (Diamond, 2006, p. 59). Almost all institutional ethnographic studies begin with the author’s own experiences (Diamond, 2006). As a parent, I am often aware of the amount of work that needs to be done in order to try to provide the healthiest options possible for my children. I am also aware of the financial cost of doing so, as well as the geographical challenges of providing food in a region that is largely organized around the use of vehicles. I have also noticed many ways that my actions are influenced by discourses of ‘good mothering’. When I was a low-income single mother, my parenting was regulated; I lived in constant fear of losing any government financial assistance that I received or being called by one of the local children’s services agencies if my parenting was not considered to be good enough. My children’s lunches, cleanliness, and appearance of health were under scrutiny from schools, daycares, neighbours, family members, and even their father, as he has tried to change custody arrangements based on his perceptions of their level of care. Based on these experiences, as well

as the research that I have done with Healthy Kids Panel, I decided to speak with low-income single mothers about their experiences of children's health.

Research Questions

I used institutional ethnographic methods to explore the impact of childhood obesity discourses on the everyday lived experiences of single mothers who live in poverty in Northeastern Ontario. My research questions were as follows;

1. How do single mothers who live in poverty in Northeastern Ontario define good health for their children? What role do considerations of obesity play in their definition of good health?
2. What are the implications of participants' understanding of health on their domestic and reproductive labour?
3. How are these experiences mediated by the families' social location?

Dissertation Outline

This dissertation consists of two introductory chapters followed by four separate articles based on my research. Finally, the results from all four articles are summarized and discussed in the final chapter. In this chapter, I explain the theoretical and conceptual framework of institutional ethnography, and I will outline some of the recent literature on childhood obesity including connections between fatness and health, the work of mothering in children's health. I discuss how an intersectional feminist approach informs these topics. In the next chapter, I present a detailed methods section, including exactly how I recruited participants, performed the interviews, guided tours and how I analyzed the data that I gathered in this research.

Chapter 3 will be submitted to the Journal of Critical Public Health. In Chapter 3, I detailed how some of the policies on childhood obesity have framed the way we talk about children's bodies. Policies include Provincial, Federal, and even World Health Organization reports. I connected these discourses to the ways that mothers conceive of health. I used quotes from participants about health and fatness to show how these discourses were seen throughout my interviews.

Chapters 4 and 5 are about children's play and recreational activities. Initially combined as one article, I separated them for publication. Chapter 4 is a short chapter for an edited book on mothering and place. I analyzed how mothers negotiated the spaces where children engage in unstructured play. Geography was an important factor in children's play, as urban and rural mothers had different ideas about children's safety and play, including whether strangers were considered to be dangerous or protective factors in children's play, and whether the biggest safety issues were crime or the built and natural environment, like trains and bodies of water. Chapter 5 is a journal article on children's participation in sports and other structured recreational activities. I am considering submitting it to the Sociology of Sport Journal. I conducted a materialist analysis of access to sports and recreational facilities for children in low-income families. While participants described sports as an important experience for children, they described many barriers to enrolling their child in sports.

Chapter 6 is a journal article that will be submitted to Fat Studies. I discussed the impact of childhood obesity discourses on foodwork and food provisioning for low-income single mothers in Northeastern Ontario. The literature showed that mothers are framed as responsible for children's health through food choices and food provisioning (Guignard & Cassidy, 2016;

Harman & Cappellini, 2015; A. M. Herndon, 2010; Maher, Fraser, & Lindsay, 2010; Petersen, Tanner, & Fraser, 2014). The mothers that I interviewed all described feeling stress and pressure from this work. They detailed a large amount of thinking, planning, and effort around food provisioning, even describing it as one of the most stressful aspects of raising children.

Finally, in Chapter 7, I discussed the ways that all the previous topics are connected through dominant conceptions of fatness as inherently unhealthy. This included the ways that neoliberal ideologies construct health as an individual task and problem, and how this effectively blames mothers for their children's fatness when the child's body does not conform to societal standards of thinness.

Theoretical and Conceptual Framework(s)

Institutional Ethnography and Intersectionality

Institutional ethnography (IE) is a theory and a research method developed by feminist sociologist Dorothy Smith. IE moves beyond a critique of social relations and takes up social research with the goal of working with people from historically marginalized or oppressed groups. IE research explores people's everyday lives, which are always connected to time and place, making spatial analyses compatible, although not often used, in IE research (Billo & Mountz, 2015).

Since IE begins with the standpoint of the individual, intersectional feminism is integral to understand while employing this method. Intersectional feminism involves engaging with the contradictions between privileges and oppressions that converge in ways to allow for common and differing experiences of oppression (Collins, 1993). For Smith (2005), an intersectional

approach means starting “from the standpoint of the oppressed and exploited [to] reveal aspects of the social that are not visible from other social locations” (p. 38). The experiences of individuals are connected to the broader social relations in which they are shaped.

Dorothy Smith uses the term ‘institution’ not as a determinate form of social organization, but to demonstrate the complexity and coordination of the intersections of ruling relations (Smith, 1987). Smith (2005) uses the term ‘ruling relation’ to refer to the way that these institutions work together. She defines ruling relations as;

that extraordinary yet ordinary complex of relations that are textually mediated, that connect us across space and time and organize our everyday lives – the corporations, government bureaucracies, academic and professional discourses, mass media, and the complex of relations that interconnect them. (p. 10)

In Smith’s (1987, p. 161) theorizing of ruling relations, institutions operate through ideologies that are “systematically developed to provide categories and concepts expressing the relation of local courses of action to the institutional function.” Ruling relations are premised on social hierarchies that shift according to time, place, and cultural context. When it comes to childhood obesity, institutions made up primarily of government bodies and medical experts are able to shape the way that childhood obesity is talked about in schools, the media, and in everyday conversations. These configurations of institutions as ruling relations of childhood obesity discourse also shape the types of research on childhood obesity that gets funded, which further influences the ways that obesity is understood.

An intersectional lens is necessary for IE research. Socioeconomic status, including poverty and level of education, have stronger correlations with health than body mass index (BMI) and health (Bacon & Aphramor, 2011). Like IE described above, intersectionality begins

with the standpoint of the research participant and the contradictions between privileges and oppressions that intersect in ways that allows for common and differing experiences of oppression (Collins, 1993). We exist in a society where we all have access to various forms of social privilege and we all have areas in which we may experience oppression or exercise power based on our social locations. When it comes to obesity discourses and experiences, I have endeavored to recognize the diverse and complex lives of participants within the ruling relations shaping experiences of obesity and foodwork. I also try to make room for discussion of disability, sexuality, gender expression and identity, and other social locations that impact where single mothers are situated. For instance, the Indigenous and racialized women I interviewed discussed culture and racism in relation to children's health; themes that did not arise in most of the interviews with white women. Women with disabilities described an array of barriers to performing health that were not described by some of the non-disabled women, such as how to cook, clean, and play on days when they have difficulty managing their pain. More broadly, I try to focus on intersectional connections between stereotypes around rurality and socioeconomic status including perceptions of rural as working class and less educated than urban dwellers (McPhail et al., 2013).

Review of the Literature

In this section, I position my inquiry within the literature on childhood obesity with attention to intersectionality. I start by exploring some of the complexities in the relationship between weight and overall health. I present research on obesity discourses, including the ways that fat bodies are framed in the media and research suggesting that weight-stigma is associated

with unhealthy eating behaviors and increased weight gain. I then put into conversation these discourses with those that blame mothers for children's bodies that fail to meet the criteria set out as "normal" and "desirable" under the rubric of maternal responsibility for foodwork.

What is Obesity?

Obesity has not always been conceived of as problematic; in certain cultures and time periods, it was considered a sign of wealth and beauty (Gard & Wright, 2005). Discourses surrounding obesity, including definitions and the notion that being thin is healthy and fatness is unhealthy, intensified during the post-war period in western countries (Gard & Wright, 2005; McPhail, 2017). Medically speaking, obesity is typically measured using the Body Mass Index (BMI). BMI does not actually measure body fat, but assumes fatness based on height and weight of the person being measured (Oliver, 2006). BMI was invented by a physician who noticed that weight tended to vary with the square of height (Guthman, 2013). It was primarily used by life insurance companies to measure risk across populations (Oliver, 2006) and was never intended to assess the health of individuals, but that is often how they are taken up by governments and medical practitioners (Jutel, 2009). The use of the BMI for individuals reflects a need to classify people, "situating all bodies on a continuum between underweight and morbidly obese" (Evans & Colls, 2009, p. 1051), thereby classifying some bodies as normal and others as abnormal.

Obesity Rates

There is a lot of research that shows the increase in BMI rates in children and adults since the 1970s (CIHI, 2004; Statistics Canada, 2004). The Healthy Kids Panel (2013) reports an increase in the prevalence of childhood obesity in Ontario by 70% between 1978 and 2004. The United States Centers for Disease Control and Prevention (CDC) reports that the rate of children

over the age of six with BMIs in the overweight or obese category has tripled since 1976 (Ogden & Carroll, 2010). However, when weight is presented in a slightly different way, weight gain in children does not seem as staggering. In comparing the National Health and Nutrition Examination Survey (NHANES) from 1976-1980 and 2007-2010 study periods, which is what the CDC uses to calculate obesity rates, the median weight for boys has increased by 3.6lbs for 8-year olds and 6.8lbs for 16-year olds. Similarly, the median weight for girls increased by 4.9lbs for 8-year olds and 2.7lbs for 16-year olds (CDC, 1987, 2012). Thus, the obesity statistics do not represent a large number of previously thin children becoming obese, but a slight increase from high “normal” to low “overweight” categories, averaging only a few pounds per child.

The increase in rates of people in higher weight categories has been described in academic literature, government documents, and throughout the media as an obesity ‘epidemic’. The word epidemic has been used in relation to the spread of contagious diseases for approximately 2,500 years and has only begun to refer to non-infectious diseases in the second half of the 20th century (Martin & Martin-Granel, 2006). However, critical health scholars are objecting to the use of the term epidemic to describe a change in population weights. For instance, childhood obesity has been referred to as a “postmodern epidemic” in which “unevenly medicalized phenomena lacking a clear pathological basis get cased in the language and moral manic of traditional epidemics” (Boero, 2007, p. 42).

Fatness and Health

Even if one accepts that obesity rates have increased for children, it does not necessarily mean that children are less healthy now than they were 40 years ago or that all children are impacted in the same ways. Obesity rates in Canada are reported as being higher in rural areas

than in urban areas, although very few of the results were statistically significant (Statistics Canada, 2004). McPhail (2013) argued that discourse linking rurality and obesity is often informed by classist and colonial notions which associate both obesity and rurality with the working poor. These discourses perpetuate class stereotypes that need to be challenged.

In the Healthy Kids Panel research, rurality was stated as a barrier to accessing healthy foods and leisure activities, especially when families have limited financial resources (Healthy Kids Panel, 2013). At the same time, literature on rurality has emphasized some of the strengths of living in rural areas when it comes to health-maintenance behaviors. For instance, it might be easier to grow fresh food in rural areas than in urban areas (McPhail et al., 2013), and it is perceived as safer for children to play outside (Beagan, Chapman, D'Sylva, & Bassett, 2008). Further research is needed to bring together both the strengths and the barriers associated with rurality.

Racialization may be associated with obesity in many ways. The attribution of blame for obesity has been found to be racialized; American news media articles on obesity in non-white populations were eight times more likely to blame obesity on food choices and 13 times more likely to blame sedentary lifestyles than those reporting obesity in general (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2005). Even the measures used to categorize bodies have been shown to have racial bias. A study by Flegal et al. (2010) found BMI rates higher in non-Hispanic black girls than in non-Hispanic white girls but found no difference when measuring fat between the two groups.

Almost 11% of the Northern Ontario population identified as Aboriginal on the 2011 census (NE LHIN, 2016). Researchers reported a statistically significantly higher number of

Indigenous children categorized as overweight or obese than children without Indigenous ancestry in Canada (Kolahdooz, Sadeghirad, Corriveau, & Sharma, 2017; Seto, 2006; Willows, 2005). These differences are often attributed to the social determinants of health. Social determinants of health include disability, early life experiences, education, working conditions, food security, health services, housing, income and income distribution, race, social exclusion, social safety net and unemployment and employment insecurity (Dennis Raphael, 2007). For Indigenous populations, social determinants of health also include colonization, dispossession of traditional lands and assimilation policies as well as a lack of access to culturally appropriate care (Greenwood & de Leeuw, 2012; Willows, 2005; Willows, Hanley, & Delormier, 2012). Critical medical scholars have shown that medicalization served as a political tool in Indigenous communities, used to rationalize colonial intrusion under the guise of protecting Aboriginal people from disease (Craddock, 2000; McPhail, 2017). In the case of obesity, citing fatness as a health risk and Indigenous people as at higher risk serves to justify increased surveillance and intervention into the lives of Indigenous people. At the same time, Indigenous researchers and health care professionals emphasize the importance of healthy weights within their communities as part of a holistic understanding of health and to cope with complex health issues that arise in this population (Kerpan, Humbert, & Henry, 2015; Willows, 2005; Willows et al., 2012).

The relationship between health and weight is more complex than current discourses suggest. There are studies that indicate that there are relationships between health and weight; correlations and even causal relationships between obesity and health issues like diabetes and heart disease have been well documented (CIHI, 2004). However, researchers have also found that correlations between obesity and health have been overstated (Bacon & Aphramor, 2011;

Campos et al., 2005; Evans & Colls, 2009; Gard & Wright, 2005). Contrary to the dominant conception that thin bodies are inherently healthier than fat bodies, a growing body of research has shown that BMI only weakly predicts morbidity or mortality except for those categorized as underweight or morbidly obese (Arndt, Rothenbacher, Zschenderlein, Schubert, & Brenner, 2007; Durazo-Arvizu, McGee, Cooper, Liao, & Luke, 1998; Fontaine, Redden, Wang, Westfall, & Allison, 2003; Janssen & Mark, 2007; Lisko et al., 2011; McAuley, Kokkinos, Oliveira, Emerson, & Myers, 2010; Takata et al., 2007; Troiano, Frongillo, Sobal, & Levitsky, 1996; Uretsky et al., 2007). Bodies that are categorized as overweight or moderately obese are associated with longer survival than those categorized as normal from conditions like diabetes (Ross, Langer, & Barrett-Connor, 1997), hypertension (Barrett-Connor, 1985; Uretsky et al., 2007), cardiovascular disease (Cambien, Chretien, Ducimetiere, Guize, & Richard, 1985; Flegal, Graubard, Williamson, & Gail, 2005; Kang et al., 2006; Morse, Gulati, & Reisin, 2010), among other health issues (Gruberg et al., 2005; Lavie, Milani, & Ventura, 2007; Schmidt & Salahudeen, 2007; Weinsier et al., 1976). Older adults who are categorized as obese live longer, on average, than those who are thin (Kulminski et al., 2008).

Further complicating the relationship between weight and health are confounding variables. For instance, there are correlations between stress and health (Alterman, Shekelle, Vernon, & Burau, 1994; Chandola, Brunner, & Marmot, 2006; Kivimäki et al., 2002; Rosengren et al., 2004) as well as relationships between stress and obesity (Berset, Semmer, Elfering, Jacobshagen, & Meier, 2011; Block, He, Zaslavsky, Ding, & Ayanian, 2009; Brunner et al., 1997; Mouchacca, Abbott, & Ball, 2013; Nishitani & Sakakibara, 2006; Rosmond & Björntorp, 2000). Researchers found stronger relationships between health, poverty and marginalization

than health and weight (Brunner & Marmot, 2006; McDermott, 1998; Raphael et al., 2010; Wamala, Lynch, & Horsten, 1999). As such, intersectionality is particularly important to the research, as it can begin to explain the impact of some of these variables. Causal relationships aren't always clear in the research, but what is clear to me is that the relationship between BMI, perceived weight, stress, coping behaviors, health indicators, and mortality is often more complex than the media and public health discourses suggest.

Discourses of Fatness

Despite all of the complexities in what fatness means, which bodies are categorized as fat, and what the health implications of fatness might be, discourses surrounding fatness are simplified to produce simple and universal truths about obesity. These truths are produced by combining medical and lay discourses with “common sense” knowledge about fatness (Evans, 2006a), which is seen throughout government policy and the media (see example from Healthy Kids Panel). Another example of this is the images in news stories on obesity. Harrison (2012) compared the dehumanization of fat bodies in contemporary media to circus freak show images; faceless bodies meant to invoke fear and repulsion, whereas thin-bodied success stories are depicted as smiling and fully human.

Discourses of fatness are constructed within neoliberalism in Western societies. Neoliberalism draws from liberal ideas of freedom and takes the term neo from neoclassical economics. Neoliberalism “proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade” (Harvey, 2007, p. 2). Some of the key concepts that come out of neoliberal ideologies in health care policy are notions of individual

responsibility for health and less government spending on health care (Mullaly, 2006). Neoliberal ideologies are thought to impose responsibility for ill/good health on people despite their social location; blaming people who are overweight for making unhealthy choices regardless of their actual health and encouraging people to regulate themselves to be good social citizens and internalize social values bound up in middle class assumptions about families, work, and health. Cultures that emphasize individual responsibility for health are much more fat-phobic than cultures with a more collectivist orientation (Lebesco, 2004).

Fatness is reported to cost tax-payers money for health care. For example, within recent news articles, the claim was made that obesity costs the government more money than terrorism (Kirka, 2014; Tumulty, 2006). However, there are many methodological problems with the studies cited in these news stories. Cost estimates fail to account for confounding variables such as socioeconomic status, discrimination, weight cycling, and other factors that have been found to influence health (Bacon & Aphramor, 2011). Also, the medical focus on health risks associated with obesity has been found to lead to people categorized as overweight being subjected to more medical tests than people whose bodies are categorized as normal, regardless of their actual health. Increased testing leads to BMI increased health care costs, regardless of whether BMI itself is problematic (Bacon & Aphramor, 2011).

Gender plays a complex role in ideas of fatness. Contrary to the belief that contemporary women have more freedom than women in previous generations, Naomi Wolf (1997) described an association between increased economic freedom and stricter body regulation for women. Several studies have shown that women experience more weight-based stigma than men. Fat stigma has been found to impact women more harshly than men in job interviews (Jasper &

Klassen, 1990; Pingitore, Dugoni, Tindale, & Spring, 1994), promotion and discipline at work (Bellizzi & Ronald, 1998), income (Averett & Korenman, 1996; Baum & Ford, 2004; Mitra, 2001), and political candidacy (B. J. Miller & Lundgren, 2010). Male job applicants have even been judged more harshly if seen with a fat woman before the interview (Hebl & Mannix, 2003). Clearly, gender is an important factor in understandings of fatness.

Individual and Mother Blame

When somebody becomes ill from a virus, they are generally not blamed for their illness. When it comes to obesity, however, individuals are blamed. Elisabeth Harrison, a scholar of critical disability studies, writes what I find to be a powerful statement about this tension:

Fat people are told that our fatness is an individual problem that could be solved with the judicious application of willpower, physical activity, and caloric restriction. At the same time... we are part of the 'obesity epidemic,' the tidal wave of fat that many medical experts claim threatens to engulf us all, unless we exercise extreme vigilance, monitoring, and disciplining our bodies so as to stem the tide and keep ourselves thin. If we are not successful in doing so... a dystopian outcome is guaranteed, with virtually all of us becoming obese. (Harrison, 2012, p. 325)

Despite the use of systemic language, which would suggest the need for broad systemic changes in order to address it, obesity is considered to be a problem that needs to be addressed privately. If individuals are blamed for fatness, individual children's bodies are targeted for judgement and interventions.

There is a widely held belief in neoliberal societies that a little bit of discrimination against people with fat bodies is a good thing – that if people who are overweight feel bad about their bodies, it will encourage them to lose weight (Heinberg & Matzon, 2001). The idea that weight stigma leads to weight loss is a misconception, as research shows that bullying and

feelings of shame about one's body actually leads to more weight gain (Major, Hunger, Bunyan, & Miller, 2014; Neumark-Sztainer, Paxton, Hannan, Haines, & Story, 2006; Puhl, Moss-Racusin, & Schwartz, 2007). For example, teens who report being teased about their weight were more likely to engage in unhealthy weight control and binge eating behaviors than teens who were not teased, even when controlling for BMI (Neumark-Sztainer et al., 2002). Accordingly, girls with higher body satisfaction in 1998 gained less weight by 2004 than those with low body satisfaction (van den Berg & Neumark-Sztainer, 2007).

People with fat bodies are described as bad citizens (Alexander & Coveney, 2013) who “put themselves and others at risk because of their irresponsibility” (Harrison, 2012, p. 329). The notion that obesity is a threat leads to the idea that we are all at risk and need to be extremely vigilant in order to protect ourselves and our children (Boero, 2007; Harrison, 2012). However, the responsibilities associated with protecting our children from obesity fall disproportionately on mothers, as does the blame for not providing the right food and recreational activities if children are perceived as overweight.

There has been a lot of research on the possible causes of childhood obesity, often associating children's bodies with the child's mother. For instance, various studies have associated obesity in children and youth with a multitude of factors, such as maternal employment in the paid workforce (Coley & Lombardi, 2012; Datar, Nicosia, & Shier, 2014); breastfeeding (Gibbs & Forste, 2014; Lefebvre & John, 2014; Reynolds, Hennessy, & Polek, 2014); the quality of parent-child attachment (Bahrami, Kelishadi, Jafari, Kaveh, & Isanejad, 2013); maternal depression (Morrissey & Dagher, 2014); mother's age (Farajian, Panagiotakos, Risvas, Malisova, & Zampelas, 2014); mother's age at menarche (Ong et al., 2007); maternal

smoking during pregnancy (Rooney, Mathiason, & Schauberger, 2011; Suzuki, Sato, Ando, Kondo, & Yamagata, 2013); eating “junk” foods during pregnancy (Wen, Simpson, Rissel, & Baur, 2013); parent’s BMI (Farajian et al., 2014; Rooney et al., 2011); mother’s own weight concerns (Markey, Markey, & Schulz, 2012), and marital status, as children whose mother has been without a partner for two or more years were more likely to be overweight than those with “stable married parent families” (Schmeer, 2012).

The term ‘responsibilization’ explains how mothers are being framed as primarily responsible for their children’s weight, which previously would not have been recognized as something a person would be responsible for (Petersen et al., 2014; Quirke, 2016). Responsibilization for children’s weight explains that mothers have been constructed as the “object to which fears and anxieties [about fatness] are projected” (p. 177). Since mothers are constructed as responsible for nutrition, mothers are blamed if their children’s bodies do not conform to a specific standard. Social, political and economic factors are overlooked (p. 178), further blaming women who live in poverty for not being able to get the right kinds of food for their children.

Public health documents on childhood obesity are written as expert-driven advice directed primarily towards mothers and entrenched in neoliberal assumptions about individual responsibility for physical activity (Alexander & Coveney, 2013). These discourses maintain that obesity is caused by individual family decisions that take place in the home. Parents of obese children, typically the mothers, are blamed for indulging their children with unhealthy foods and not supporting children in active play (Boero, 2007; Harrison, 2012). Research shows that mothers are aware of this scrutiny. Women interviewed by Petersen et al. (2014) often used the

term “concerned” “stressed” and “worried” when talking about their children’s diets. In interviews about the gendered household division of foodwork within their families, men, women and teens expressed that women ensured the meals were healthy, whereas if they had to shop and cook for themselves, “her husband and son would never eat vegetables” (Beagan et al., 2008).

Domestic Labour and Foodwork

When investigating the work involved in caring for children and maintaining the household, I use the terms domestic and reproductive labour, which are common to Marxist literature (Dalla Costa & James, 1975; Hartmann, 1979). Domestic labour is the practice whereby women reproduce labour power for capitalist societies by taking care of the home and socializing children, and without this work, capitalism as we know it could not exist (Dalla Costa & James, 1975; Fox, 1980; Hartmann, 1979). In more recent literature, it is sometimes referred to as housework, carework, or household work (Eichler & Albanese, 2007). According to Eichler (2008), this work has four dimensions; physical, mental, emotional, and spiritual work. Similarly, Dorothy Smith (2005) advocates for using a generous notion of work when engaging with the work women do in the home. Work, in a generous sense “refers to anything done by people that takes time and effort that they mean to do, that is done under definite conditions and with whatever means and tools, and that they may have to think about” (p. 152). Using a broad definition of work allows us to better understand what women are actually doing on a day to day basis.

Domestic and reproductive labour is done primarily by women; although some men do some housework, any change towards men taking on more responsibility for housework has been

minimal (Milan et al., 2011; Waring, 1999). In Canada, women reported spending twice as much time as men on unpaid housework¹ (Milan et al., 2011; Statistics Canada, 2005). According to the United States Department of Agriculture, on any given day, on average, 20% of women are grocery shopping compared to 10% of men and 75% of women are preparing food and cleaning the house compared to 40% of men (Hamrick & Shelley, 2005). When men are involved with foodwork, they tend to experience it as a form of leisure (Szabo, 2013).

The links between obesity discourses and domestic labour are apparent in foodwork. The term foodwork has been used in literature on domestic labour over the past ten years to describe the work associated with food (Bove, Sobal, & Rauschenbach, 2003). Foodwork is far more than just cooking dinner. It can include activities such as planning meals; making grocery lists based on a budget, health considerations, as well as a family's likes and dislikes; getting to and from the grocery store; looking at flyers for sales, comparing prices, cutting coupons, and driving to multiple grocery stores; shopping for groceries; carrying groceries into the house and putting them away; remembering to take food out of the freezer to defrost ahead of time; preparatory work and cooking; setting and clearing the table (or supervising children in doing so); breast and bottle-feeding; ensuring that children are eating; cleaning up, putting away leftovers; and doing it again the next day and the day after that. Many women have to do all these activities while simultaneously supervising young children.

Some of the types of work described above have been researched for many years. For instance, grocery shopping has been studied as a (rather romanticized) gendered form of

¹ Data on unpaid work is no longer collected by the Statistics Canada census

ritualistic sacrifice (Miller, 1998); as an example of how the political economy has changed in the past 50 years under neoliberalism (Humphery, 1998); and as a form of economic labour in which everyday activities move from the paid labour force to women's unpaid work (Glazer, 1993). Shelley Koch pulls many of these ideas together, describing grocery shopping as a form of domestic labour that is deeply gendered. She described three dominant discourses influencing grocery shopping. The discourses of cost saving and efficiency, where women are expected to look for sales, cut coupons, and spend as little as possible on food; discourses of individual responsibility for nutrition, involving reading labels and choosing healthy options; and discourses of consumer control, in which the food industry actively tries to influence consumers' purchases (Koch, 2009).

Conclusion

Some of the themes that have emerged throughout this literature review are that there do appear to be health implications related to weight, but they are more complex and multifaceted than the media and public health discourses often suggest. Also, researchers have found that discourses shaming people for being overweight might lead to unhealthier eating behaviors and weight gain. If parents are largely blamed throughout dominant discourses, and most of the public health literature is geared towards mothers, then I determined I should interview mothers about how this affects their everyday lived experiences including whether they make these same associations between weight and health, and how it impacts the work that they do in the home every day.

Chapter 2: Methodology

In writing about children's bodies, fatness, and medical discourses, I first position myself within these discourses. I then explain my ontological and epistemological perspectives before reflecting further on how it connects with the theory and method I am using, which is institutional ethnography. I will then explain the methods that I used in this research, which include interviews and guided neighborhood tours, including participant recruitment, data collection, analysis, as well as study limitations, and how they connect to institutional ethnographic research.

Personal Standpoint

While neither myself nor my children have bodies that are considered "normal" by BMI standards, we do have thin privilege. My teenage daughter has been categorized as "underweight" her entire life, which is largely ignored by medical professionals once they establish that she does, in fact, eat regular meals. My son and I are both categorized as "overweight" though we have very athletic builds, shop in regular clothing stores, and have rarely, if ever, been labelled fat by others. Still, I have had a very complicated relationship with my body weight for most of my life.

When I was a child, I was a competitive figure skater. I thought I was going to make it to the Olympics. Two of the people I skated with have accomplished this feat and another two have competed at national championships. There was constant pressure from parents, coaches and other skaters to stay thin. I saw judging scorecards with comments on the size of the skater's body. I remember lining up with all of the other skaters to be measured for costumes and being congratulated by my coach on having a 23-inch waist as though it was some kind of major

accomplishment. I remember hearing various comments about the size of my thighs and spending long stretches of time standing on the ledge of the bathtub so that I could see my body in the bathroom mirror and thinking that I looked like a freak. This started when I was only ten years old.

I exercised for hours almost every day, running and doing ballet-inspired conditioning to make sure that my muscles never got bulky. I went through stages where I would eat very little or would purge what I did eat in order to ensure that I didn't gain weight. It didn't matter that I placed at provincial figure skating competitions because of my powerful leg muscles that allowed me to jump high and skate fast, or that I could lift more weight than any of the boys in grade nine gym class on the leg press, or that in grade eight I was able to beat all of the kids from a dozen schools at the 1500-meter race. It didn't matter what my body could do; all that mattered is what it looked like. It took me a long time to move past this with help from feminist theory and the body-acceptance that I have found in the sport of roller derby.

Documents like the Health Kids Strategy (described in the introduction) are framing health as a simplistic representation, where thin means a healthy "good citizen" and fat means an unhealthy "bad citizen." This false dichotomy is further perpetuated by the media and leads to even more stigma. I refuse to accept that "helping kids lose weight" is the best we can do, as it further emphasizes that certain bodies are not good enough. And I have hope that we can see a range of normal in human bodies and that we can end this idea that you can tell whether or not someone is healthy by looking at them or seeing a particular range of numbers on a scale.

I am focusing on childhood obesity in this research in part because of how pervasive the childhood obesity discourses have become, but also in part because of my own children. When

my daughter was 8 years old, she looked at my 140-pound body and said “mom, if I were your size, I would go on herbal magic” as she raised her shirt, and pinched her stomach, examining the flesh that she refers to as “fat.” I think back to my daughter at the age of 2, ready to go outside to play, proudly wearing her fireman’s hat, sunglasses, and no clothing at all over her diaper. Toddlers delight in their bodies and have no concerns over their chubby thighs or stomachs, which indicates that body shame is learned, and if we can learn it, I hope we can unlearn it.

Ontological Perspective

Dorothy Smith (2004) describes the social as “the ongoing concerting and coordinating of individuals’ activities” (p. 6). She developed this ontology from her reading of Karl Marx. Although Marx is often interpreted as a structural theorist, I do not think that this ontological perspective is incompatible with his work. Marx (1888/1994) describes the world as being made up of “sensuous human activity” (p. 99). The social world is produced by people through their everyday activities.

Structures are recurring patterns of behavior and interaction (Scott & Marshall, 2005). These structures can be constraining and largely invisible, but they make social life predictable, orderly and familiar, similar to how rules for a sport make it possible to join a game with any team and know what it is you are supposed to do based on what game and what position you find yourself in. This definition suggests that structures are created by people. Still, I hesitate to use the word structure because if the world is made up of structures, they may seem concrete, unchanging, unconnected to individuals, and therefore, what is the point of trying. If it is entirely agency, we end up losing the ways that people’s experiences are shaped by the world around us.

But, if we think of these structures as ruling relations, we can always see the ways that they are produced, and constantly reproduced, by people in their day to day lives. In analyzing the data that I collected, I tried to always keep in mind that the participant's experiences were shaped by these structures. It can be difficult for an individual to see the structures that shape their experiences. It was my job, as a researcher, to try and see the ways that individual's experiences were shaped by larger ruling relations.

Epistemological Perspective

My epistemological perspective is reflexive, which is the epistemological perspective that is used in institutional ethnographic research. Reflexivity is described as “the mutually determined character of the social world and knowledge about it” (Frampton, et al., 2006, p. 36). George Smith (2006) advocates for using a reflexive epistemology in sociological research because “the sociologist cannot know her world from outside, but only from inside its social organization” (p. 47). When conducting research, knowledge is not linear, but researchers learn from each other and the people they are working with and learning from.

For reflexive theorists, knowledge about the social world is “produced interactively between someone entering into a social setting and those who are already experts about how this setting is socially produced” (Frampton et al., 2006, p. 37). Hart and McKinnon (2010) use a map as an example of how this works. Two people can look at a landscape and create a map together that represents a version of the truth of that geography. Similarly, the researcher and informant can discuss experiences and come to some kind of truth about the social world, grounded in language and produced in a specific time and place. Attempts to hide behind

objectivity, or the ‘expertise’ of the writer, can uphold the status quo and maintain capitalist, racist, and patriarchal power relationships.

In *Writing the Social*, Dorothy Smith (2004) writes “the site from which issues relevant to women have been brought into view is at the margins and not at the centre” (p. 41). I believe that this sentence is integral to understanding her work and understanding the standpoint of women and other marginalized groups within society. Ruling relations were constructed almost entirely by (and for the benefit of) men – but not all men benefit equally from them (Smith 2005). Heterosexual, white, able-bodied, middle and upper-class men tend to be at the centre of ruling relations. Being male is necessary but not sufficient to take part in this construction of power relations, but all men benefit from male privilege.

It is very important to link social relations to the historical conditions under which they developed as they did not arise naturally or spontaneously. The shift in forms of consciousness and agency that accompanied capitalist forms of organizing led to the kinds of ruling relations that we experience today in Canada. Ruling relations objectify consciousness by giving the appearance that objects are “produced as independent of particular individuals and particularized relations” (Smith, 2005, p. 14). Whereas previously, it was possible to see the people involved in power relations (such as the rule of the monarch), ruling relations are reified in that they appear to have an existence separate from the people and social relations involved in constructing and maintaining them. Ruling relations do not arise “spontaneously out of people’s everyday lived relationships... they are the product of the work of specialists occupying influential positions in the ideological apparatus” (Smith, 1987, p. 325).

It can be difficult to see the ways in which we have internalized the voice of the oppressor. Women internalize dominant discourses about their bodies. The voice of the oppressor tells us that we aren't thin enough or pretty enough and we believe it. The media tells us that to be thin is to be healthy, successful, and desirable. It tells us that fat bodies are lazy, have no will power, and are a drain on society through the medical system. Representations of fatness are also connected to intersections of class, race, ethnicity, ability, sexuality, geography, and so forth. For instance, research on rural obesity has shown that discourses surrounding rurality and obesity are both bound up in stereotypes about poverty and the working class (McPhail, 2013). These stereotypes linking rurality and obesity persist even though data suggests youth obesity rates may be higher in rural areas, but the difference is not statistically significant for most groups (Statistics Canada, 2004).

Reflexivity in Research

I think I used reflexivity throughout this research. Reflexivity can be described as “self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as researcher” (England, 1994). For Smith, there is always a continuum between the researcher and the researched that is shaped in part by the biography of the researcher (1987). Cresswell (2013) advocates for the use of two different kinds of reflexivity. In the first, researchers should start out by writing about their personal connections to the topic, which “involves relaying past experiences through work, schooling, family dynamics, and so forth” (p. 216). In the previous sections, I have tried to state some of the ways that my own history has impacted my relationship with this topic.

In the second part of reflexivity, researchers must discuss how their experiences have shaped their interpretations of the phenomenon being studied (Creswell, 2013). As an educated white woman doing research with Indigenous women, women who live in poverty, racialized women, and women from other marginalized groups, there are power dynamics that do come into play. I tried to remain aware of my privilege throughout this work and to keep participant experiences at the centre of the research. I also tried to mediate some of this power dynamic by allowing the women I interviewed as much decision-making as possible while still getting to the research questions that I set, such as letting them choose the interview time, date, and location and allowing them to guide the neighborhood tour.

I began by writing about policies because I believe that social policy helps to set the discourse and frame what we consider to be problems, how we talk about them, and ways that we think that problems could be fixed. Next, I wrote about play and organized sports because it is what came up most often in my research from participants. Lastly, I wrote about food because it was what I expected to be the primary focus of this research.

There were a few times that reflexivity was particularly prevalent in my research. The development of research questions was done very carefully. When I worked in public health conducting focus groups for the Ontario Healthy Kids Strategy, the research plan and even the questions asked to participants were developed by the Healthy Kids Panel. I was able to provide some input, but mostly had to proceed with the questions as they were asked. This research explicitly referred to the *childhood obesity epidemic*. The consent form included the aim of the Healthy Kids Panel, which was to reduce childhood obesity by 20% in five years. The wording

of consent forms, focus group questions, and even the final report very much align with the dominant discourses around obesity.

In my research, I carefully tried to avoid speaking in ways that upheld these discourses, which was not always easy to do. My consent form does speak to the media's focus on childhood obesity, but I tried to explain my research before I began in a way that was not stigmatizing towards any body size. I tried to watch the language I used throughout the interviews and neighborhood excursion to talk about fatness or bodies categorized as overweight or obese. When asked about the language I was using, I was very open about the position of critical fat studies and several participants asked a lot of questions about it and seemed quite interested, which probably impacted some of the answers that they gave. Instead of asking what they thought about childhood obesity, I asked what they thought about the *term* childhood obesity. Some answered as though I had asked what they thought about children whose bodies were categorized as obese. Others spoke to their own mothering anxieties around their child's bodies or to the ways that society categorizes people (see chapter 3 for some of these quotes).

I was concerned that people would be uncomfortable during the neighborhood excursions. Before the interviews, I had blue and pink hair and dressed somewhat eccentrically by some standards (or was totally embarrassing, if you ask my teenager!). I cut my hair and dyed it a natural color, and I tried to dress in ways that would approximate what people in that community might wear while still feeling comfortable, which generally meant jeans and a plain t-shirt. In small communities, I didn't want to be drawing attention to myself or to the research participant. Similarly, I tried to be cognisant of how I would look, as a white settler, walking with Indigenous women in small First Nations communities. I didn't want to dress professionally

enough to look like a social worker. As a result, I think that the participants were quite comfortable walking around the neighborhood, but most did not want to enter the grocery store, which is something I discuss further later in this chapter as well as in Chapters 4 and 6.

Institutional Ethnography

I used Institutional Ethnography (IE) as both a theory and a method in this research. IE draws from ethnographic methods that are typically used in anthropology. Ethnography is the study of how people both produce and make sense of their own social world. In order to do this, ethnographers use bracketing, which involves setting aside preconceived accounts of the social in order to try to better understand other cultures without being influenced by the way that the researcher's own culture understands the world around them (Garfinkel, 1967). In IE, Smith (2005) suggests using this methodology against ruling relations in our own society to interrogate taken-for-granted assumptions about the way our social worlds are produced (Frampton, Kinsman, Thompson, & Tilleczek, 2006). However, while bracketing can be a useful exercise to attempt, it is impossible to fully achieve, as researchers are so immersed in their culture that it is impossible to fully set aside biases about the social world (LeVasseur, 2003). This is not to say that we cannot use bracketing at all, but that I, as a social researcher, should think of bracketing to disrupt my understanding in a reflexive way in order to cultivate curiosity and question my own assumptions about the social world.

IE turns from studying the other to studying institutional relations in our own society. Rather than focusing on the institutions themselves, IE is based on the assumption that "it is through the daily struggles of everyday life that we see the structural constraints of the institution emerge, and the processes through which people work to challenge or subvert those structures"

(Billo, 2012, p. 48). Social relations are explored as actual practices connected to the lived experiences of individuals connected to time and place, rather than as abstract relations. Thus, IE aims to explore some of the ways that people use social norms in their everyday lives in order to see how ruling relations coordinate the experiences of individuals across time and space.

A critique of ideologies is important to institutional ethnographic studies. In this case, ideology refers to knowledge that is uprooted from the social relations in which they are produced (Frampton et al., 2006). Ideologies are produced by ruling relations instead of being grounded in people's everyday experiences. For instance, in the introductory chapter, I showed how media reports and policy papers suggested that childhood obesity is growing at such a rate that it will soon affect the majority of children even though research grounded in the actual experiences of people has shown that the rates have plateaued. In my research, I questioned these discourses throughout my analysis in an attempt to problematize the ways that fat bodies are talked about and connect this analysis back to people's experiences.

Central to this research are discussions with single mothers who live in poverty in Northeastern Ontario. However, "we can only see so much without specialized investigation" (Smith, 2005, p. 161). People's experiences are the starting point for IE research. They are not a substitute for analysis; they are the area from which the analysis will be developed. The researcher looks for similarities and differences between the stories of research participants, which points to the social relations that coordinate these experiences.

Geographic Methods

Since institutional ethnographic research "relies on, explores, and explicates linkages that are lived, brought into existence in time and space by actual people doing actual things"

(Campbell & Gregor, 2004, p. 98), geographic methods can be compatible with institutional ethnographic research. Feminist geographers “engage with a range of topics via negotiations of time, space, mobility, health outcomes, identities, and feminist praxis” (Moss & Falconer, 2008). Combining geographic methods with IE allows us to make sense of ruling relations within and beyond institutional spaces (Billo & Mountz, 2015). Geographic approaches embedded within IE can move past seeing institutions simply as a repressive body to seeing them as complex, woven through time and space, and embedded in the histories and everyday activities within these spaces (Billo & Mountz, 2015).

I used two of the method typologies identified by Billo (2015) in her genealogy of IE geographic research: following and interviews. In this context, following “refers to the tendency of researchers to follow institutional actors in their daily work” (p. 10). For the sake of time constraints, instead of following mothers as they moved through their neighborhoods, I asked them to take me to specific places using the means they would usually use to get there. Despite Smith’s (1987; 1999) emphasis on unpaid work, my literature search and Billo’s genealogy of IE geographers failed to find an instance of “following” applied to women’s unpaid labour. Women’s labour is often measured through time use surveys (Waring, 1999), but I think that following does more to connect the work to time and space. Interviews are the most commonly used research method for geographers using IE (Billo & Mountz, 2015). Interviews typically focus on trying to understand how work is socially organized, and involves talking to participants about how they understand, negotiate and resist ruling relations (Goldman, 2005; King, 2009; Perreault, 2003).

Domestic and reproductive labour are spatially located. The work happens in physical spaces such as in homes where food is prepared and eaten, children are looked after, laundry is washed, floors are scrubbed; in playgrounds where children are being watched carefully by caregivers; in stores where food is purchased; as well as many other spaces as families move through their day. This work is always and necessarily situated in time and space. When rurality is discussed as a factor in childhood obesity, especially as a barrier to maintaining healthy weights, it becomes even more important to situate the topic geographically. In this research, I went on a geographic excursion with participants in order to see the physical locations that they describe as well as the barriers to access and to situate the work that they described in the physical space where it takes place.

Methods

Setting

The setting for this research is Northeastern Ontario, as defined by the Local Health Integration Network (LHIN) boundaries (“Local Health Integration Network (LHIN),” 2014). Northeastern Ontario is diverse, made up of one large city, several smaller cities and towns, remote communities accessible only by train or plane, and a large unpopulated marshland. Southern Ontario, on the other hand, is made up of many large urban centres with rural communities that are part of an extensive road network connecting them to urban centres. Previous studies have interviewed families in the City of Greater Sudbury (the largest urban centre in Northeastern Ontario) as a representative of all of Northern Ontario (Healthy Kids Panel, 2013), or people in smaller townships near southern urban centres as representative of

rural contexts (McPhail, 2013). But very little research on this topic has been done in the rural areas of Northern Ontario, even though previous studies have shown that rurality is an important aspect of childhood obesity (Beagan et al., 2008; McPhail, 2013; Statistics Canada, 2004).

It is important to note that this research took place on the traditional territories of the Atikameksheng Anishnaabeg, Nipissing First Nation Anishnaabeg, Ojibway/Chippewa, Oji-Cree, Mushkegowuk, and Algonquin peoples. Five participants were of First Nations descent and two lived in First Nations communities. First Nations people in the territories we now call Canada can have very particular relationships with the land and with government policy. In the case of children's health, Indigenous children have been described as a “priority population” due to high levels of “childhood obesity” and illnesses that are considered to be associated with obesity such as diabetes (Anderson et al., 2010; Fee, 2006; Greenwood & de Leeuw, 2012; Healthy Kids Panel, 2013; Seto, 2006; Willows et al., 2012).

Recruitment

I used several recruitment methods. The first was to circulate posters online through social media. Facebook has community websites for many small Northern Ontario towns and I posted a recruitment poster for interviews on these sites (see Appendix A). Second, I contacted local organizations frequented by single mothers who live in poverty such as food banks, family drop-in centres, and the local health units to post the invitation for participants. The list of organizations I emailed is found in Appendix B. I asked each organization for other contacts in the area that might be interested in putting up a poster or distributing information about my research to potential participants.

My phone number and e-mail address were in the recruitment material. I did not intentionally prioritize any participants over others, but tried to book research appointments in the order that emails and phone calls were received based on the dates that I was able to travel to various locations. Because I live in Sudbury, interviews within about an hour's drive from Sudbury were spread out over the three months of data collection. During this time, four women who contacted me cancelled before the interview. In one smaller town, four women called to participate. I scheduled interviews over the course of one weekend. Three of the interviews took place and one was cancelled by the participant, who would have been interested in rescheduling if I were staying in the area longer. In another small town, I met with two participants in one day and had one cancellation. A food bank located in one of the larger northern cities put up my recruitment poster and within an hour I received calls and emails from nine women. I booked appointments with the first five women and had two on a "waiting list" in case of cancellations but the women all participated as scheduled. The reason for all cancellations was related to parenting responsibilities; children were sick or had appointments or events that came up. Overall, I was contacted by 30 women and 20 participated in the research. Of the 20 who participated, seven were recruited through physical posters put up by various organizations, seven were recruited through word of mouth (four from other participants, three from acquaintances of mine), and six were recruited through social media including posts in neighborhood community groups and an interview I did with a local radio station which circulated on Facebook.

Participants

I interviewed twenty low-income single mothers living in Northeastern Ontario. IE research does not specify an ideal sample size, as the number of people needed in the research fluctuates based on the topic and study design (Campbell & Gregor, 2004). In a study on sample size for more than 500 PhD dissertations, Mason (2010) found that sample size varied widely, but 20 and 30 were the modes for PhD dissertations using one-time qualitative interviews. Smaller sample sizes are used with longer or repeated interviews, as the information collected from each participant can be more in depth than a shorter one-time interview (Patton, 2001). I met with most of the participants only once, but for several hours using two different methods, which I believe has generated a richer understanding from each participant than is likely to be obtained from a single interview.

Inclusion in the categories of ‘low-income’ and ‘single parent’ need to be problematized and were deliberately defined in a broad manner for the purposes of this study. Low-income is a difficult concept to define, and Canada does not have an official measure of poverty, but the Low-Income Cut-Off (LICO) is often used as such (“Table 2 Low income cut-offs (1992 base) before tax,” n.d.). However, using any large-scale measure of poverty can be problematic because it is based on a theoretical abstraction and fails to consider things like the increased cost of goods in northern communities or individual circumstances faced by certain families, such as health care costs or debt payments. Similarly, families with extended familial support may be below an income threshold but not consider themselves to be living in poverty.

Similarly, given the emphasis of public health obesity messaging directed at mothers to the exclusion of other parents and guardians, I was interested in finding out about the

experiences of women doing reproductive labour essentially on their own most of the time. This research did not exclude women beyond biological female parents to include transgender parents and parents engaging in mothering work who are not the biological parent (O'Reilly, 2004). It also included mothers who have full custody, shared custody, are divorced, never married, or currently have a partner that lives far away. What is important to the research is the experience of caring for children without the support of a partner present in the household. Women interested in participating had to reside somewhere accessible to me by car and be able to participate in the interview primarily in English.

Participants ranged in age from 26 to 42 years. They had between one and four children each ranging in age from six months to sixteen years. Each participant had the child in their care most of the time, although half had some involvement from the child(ren)'s father on a regular basis, most commonly every other weekend. I tried to recruit participants that represented various geographies and demographics found in Northeastern Ontario. Eleven women were from urban areas; six from the City of Greater Sudbury (population approximately 160,000) and five from Sault Ste. Marie (population 73,000). Nine participants considered themselves rural and were from small towns and rural areas throughout the Northeast. Five of the participants identified as Indigenous and two lived in First Nations communities. One identified as Black, three were Francophone and two were part of the LGBT community. Interestingly, all of the women I interviewed had completed high school and obtained at least some college and several of them had multiple universities degrees. Still, all were living in low-income situations. For more information on each of them, see Appendix D.

Data Collection

This research was submitted to the Laurentian University Research Ethics Board for a full ethics review, as people who live in poverty are considered a vulnerable population (Government of Canada, 2016). Ethics approval was obtained in the Spring of 2016 and research took place during the summer and fall of 2016 (see Appendix C for ethics approval document). The data collection process involved an interview with each of the twenty participants followed by a guided tour of key areas impacted children's health, such as grocery stores or places children play.

Interviews

Interviews conducted through institutional ethnographic methods can be described more as a conversation than what is typically thought of as semi-structured interviewing (DeVault & McCoy, 2006). Researchers talk with people to find out how things work within the framework of the ruling relations under investigation. DeVault and McCoy (2006) quote an interview with Gary Kinsman, a researcher who uses institutional ethnographic methods, in which he describes it as co-investigation or “a fully reflexive process in which both the participant and the interviewer construct knowledge together” (p. 24). I tried to do this by giving the participant more control over the interview process than typically done in interviews. I let them choose the location of the interview as well as the day and time, when possible. I followed their lead when they were answering questions and probed based on what they seemed interested in, even if it veered considerably from the interview guide.

In institutional ethnographic interviews, knowledge is built piece by piece (McCoy, 2004). As such, rather than using a standard set of questions for each participant, interviews are

based in part on what is learned from previous participants. In an interview with Liza McCoy (2004), Dorothy Smith explained that “sometimes you don’t know what you’re after until you hear people telling you things... Discovering what you don’t know - and don’t know you don’t know – is an important aspect of the process” (p. 24). As such, I developed and refined questions on an ongoing basis. The interview guide can be found in Appendix E. This guide was used as a list of potential areas of focus on if the conversation was not flowing, not as an exhaustive list of questions to ask each participant.

Interviews took place in an area that was decided upon by the participant during our initial contact. Eighteen interviews took place in the home of the participant. Two participants preferred to meet at a local coffee shop, which was not ideal because of background noise and because I found participants were less forthcoming about some aspects of their lives in these situations. For instance, one single mother talked about her involvement with Children’s Aid services on our walk through the community after we left the coffee shop. I tried to find quiet places for interviews to take place, but local libraries didn’t have meeting rooms available for groups of two and many of the neighborhoods did not have other options. I sent the participants I could reach through email or Facebook a few questions to think about one week before the interview to give them the opportunity to prepare for the topics I planned to bring up in the interview, but only one participant looked at the questions before the interview (see Appendix F for the list of questions). The interviews began with participants reading and signing the consent form (see Appendix G). Interviews averaged about 90 minutes each but varied from 45 minutes to two and a half hours plus the guided tour. They were recorded using a digital audio recorder and then transcribed. Some of the participants asked to be sent a copy of the transcript, but none

made any changes. One participant sent me a text the next day to clarify some of her answers, which was added to the transcript.

Guided Tours of the Neighborhoods

Mobile methodologies have been employed by qualitative researchers to better understand the connections between research participants and their community (Anderson, 2004; Dubé, Schinke, Strasser, & Lightfoot, 2014; Evans & Jones, 2010; Jones, Bunce, Evans, Gibbs, & Hein, 2008; Ross, Renold, Holland, & Hillman, 2009; Rothe, 2000). Participants get to set the research environment, which gives them more power and influence in the research process than inviting them to a university setting to be interviewed (Elwood & Martin, 2011). They could add locations that were meaningful to them in the context of the research, such as other food/grocery stores, children's play areas, schools, or anywhere that they think might show me the context of their mothering work and their child's environment. In my research, most participants opted to go to playgrounds or spaces where children play instead of going to grocery stores. Participants were able to direct the route, choose the locations, and the mode of transportation to get to these locations, as well as the duration of the excursion. Often, we went on foot, which gave us time to talk and look around at the neighborhood. However, some of the locations I was interested in were quite far from the participant's home in rural areas, and a car was needed for four of the neighborhood tours.

I had anticipated that these would take longer than the interviews, but most of them did not. They ranged from twenty minutes to two hours in length. Participants were largely not interested in going to a grocery store. Only three participants took me inside the grocery store, several took me to the grocery store, stopping at parks and schools along the way to show me

where their children play. I asked a few of the participants about why they didn't want to go into the grocery store. One wasn't sure, another said the playground was more interesting, and another indicated that they weren't sure how it would work to be in the store when they weren't buying anything. Feminist methodological approaches frequently suggest that research participants can be considered experts in their own experiences (Smith, 2005). As such, I let the participants set the location. After this had come up a few times, I changed the instructions from asking them to take me on a food excursion. I told them that I had initially set out to go where they usually go to get food, but that some participants wanted to take me to a park, trail, schoolyard, or somewhere else instead and that was fine. From here on, participants set the terms of our interactions. The most common destination was to go through playgrounds, schools, and rec centres while on our way to and from the grocery store, but not actually entering the store. Still, participants would talk about why they chose these particular stores and what some of the problems were with them, with organizing shopping, and with getting to and from the stores.

For this part of the research process, data were collected in several ways. I had an audio recorder and intended to record the parts of the guided tour that are conversational and not too public, however, this did not happen. I had planned to take extensive notes during and immediately following the excursion. I took very few notes throughout in order not to look conspicuous, which seemed to be a concern of the participants. I did bring my phone with a note taking app and was able to jot down notes on my phone as we walked. I told the participants that is what I was doing so they didn't think I was texting while they spoke. As soon as I got back to my car, I took detailed notes about where we went, what I saw, and what the participants said. I had a personal GPS tracker turned on to record the route we took and the distance that we

travelled. GPS data were not used to collect information on the participant's whereabouts, but to account for our movement through space and time during the research. Any location data acquired through the GPS is reported only as de-identified measures or mapping methods, such as reporting distance travelled. GPS data was only touched upon in this dissertation in terms of distance to grocery stores but could be further developed for future papers. I also had a camera which I used to take photos for field notes and presentation purposes. The photos did not include images of people or of places that I thought could be identifying.

Safety is considered to be the main drawback of using mobile methods (Carpiano, 2009). I visited many of these women in their homes and went with them and their children through Northern Ontario neighbourhoods where these families live. As such, this research did not pose many significant safety concerns. However, I was going into people's houses and I did ride along in their vehicle, which always has an element of uncertainty. The participant's vehicle was determined to be the safest option when a car was required because they often had car seats that would have been complicated to move. In order to protect myself, I shared the location of the interview with one of my supervisors and checked in with her after the interview was completed. I also had a cell phone with GPS locator on me at all times.

I believe that an incentive is important for participants to reflect how valuable their contribution is to the research. As such, I offered to pay for any associated costs (such as the cost of public transportation) and provided each participant with a \$10 coffee shop gift card for the interview and a \$20 gift card to a local grocery store for the guided tour.

Data Analysis

Thematic coding is often used in qualitative research to make sense of and organize a large quantity of information. Smith explained that “some [researchers] use qualitative data analysis software to group chunks of transcript, sometimes pages in length, by theme or topic; others contend that the logic of these programs runs against that of the institutional ethnographic approach” (McCoy, 2004, p. 38). Even with the most careful interview procedures, the audio recording erases facial expressions and non-verbal cues, the transcriptions further erase intonation, other than a few comments that can be described such as laughter or crying. The coding can further abstract the final product from the original interviews, as specific words or sentences are removed from the story in which they occur.

Dorothy Smith (1987) is in favor of thinking of coding like the index of a book. Coding is needed to make sense of the amount of information. I started the coding process using NVivo software but moved to paper for most of the coding. It was important to me to try to ensure that participant’s experiences were captured in the coding system by trying to keep the codes and the quotations I am using from the women grounded in the experiences that they shared with me. IE research rarely involves coding in such a way that categorizes pieces of transcripts into themes the way that grounded theorists might (Rankin & Campbell, 2009). IE coding focuses on preserving the indexical and reflexive character of the research and getting at the social relations involved (Kinsman, personal communication).

In response to this issue, Walby (2013) wrote an article describing one way to go about reading and coding IE interview transcripts. The transcript itself is an edited representation of the research process where the researcher had to continuously make decisions about who to speak to,

what to ask, what to record, what observations to note and what to omit (DeVault, 1999). Coding can be thought of as a secondary dialogue between the researcher and the transcripts and field notes (Smith, 2005). Walby (2013) suggests four different readings of the data in order to understand the role of the researcher, the experiences of the participants, the extent to which they have a shared understanding of these experiences, and the influence of ruling relations.

The first reading was entirely reflexive; the aim is to understand the role of the researcher in the research and the impact that the power and privileges afforded to the researcher has on the resulting data. The notes from this first reading are not used as extensively throughout the chapters that are being published as articles as the findings from the second to fourth readings, however, I am considering the possibility of a methods paper on it, particularly in terms of language and communicating ideas around health and fatness. The second reading involved listening for “the voice of the I” (Walby, 2013, p. 146) or how the participant narrated their own thoughts and experiences. In the third reading, I looked for “contrapuntal voices” (p. 147) or multiple voices within one story including shared experiences by participants across stories. The third reading comes closest to a thematic analysis in that commonalities emerge between the experiences of participants and are coded as a potential pattern. And in the fourth reading, I watched for the linkages between the narrative and broader discourses and ruling relations, such as class, gender, ethnicity, ability, age, and sexuality. I also watched for the impact and influence of ruling relations in this fourth reading, including when they noted the impact of institutions or discourses. I identified shared and differing experiences among participants and then attempted to further investigate how these are shaped by ruling relations. This involves an analysis of texts,

policies, legislation, and even media discourses because participants do not always see how their experiences are shaped by these relations.

The first reading, for reflexivity, was done through audio recordings with me taking detailed notes. In this reading, I tried to note the language that I used, the questions I asked (and those that I did not ask), and the impact this might have had on the interviews. For instance, I was careful about the language that I used around fatness and children's bodies, and there were times that I think participants' language reflected that, such as noting that it is often not the children's fault if they are overweight, that their bodies might just be that way. The second reading, which looked at the participant's experiences on their own, was done and coded on the transcripts themselves. For the third reading, I used audio recordings and transcripts, going over the interviews multiple times, in order to look for shared experiences between participants. As commonalities and differences between the interviews emerged, I moved into the fourth reading, which aimed to connect those experiences to wider social relations.

It can be difficult to balance the need to maintain the informant's position as experts in their own lives with the need to take the role of the researcher in order to connect these experiences to relations of ruling and institutional practices (Scott, 1991). The role of the institutional ethnographic researcher is to explain these connections between people's experiences, not just collect and describe them (Campbell & Gregor, 2004, p. 86). As a researcher engaging in IE, I endeavored to use reflexivity throughout the process to show a representation of what I was told and what I discovered about people's every day experiences while noting what I included and how research decisions were made.

Quality Control and Study Limitations

Institutional ethnography differs from positivist methodologies, which depict knowledge creation as something that happens through systematic forms of research following the principles used in the natural sciences. In qualitative research, potential biases can be mitigated using a reflexive approach.

Social desirability bias may also occur, with participants responding in less than honest ways because they feel it is more appropriate, such as by overestimating the amounts of fruit and vegetables that they eat or not admitting to behaviors that are less desirable such as smoking or drinking alcohol. By relating my own parenting experiences that are not always the most socially desirable, showing understanding, and carefully wording questions in ways that do not further stigmatize single mothers who live in poverty, the women I interviewed seemed quite comfortable discussing these experiences. This is a strategy and genuine attitude that I employ in the present study.

According to Dorothy Smith (1987), sociologists often point out social norms and the way that people's behavior is impacted by these norms. What is sometimes missed are the ways that these norms are coordinated by relations like gender, social class, colonialism, racism, and other forms of power and oppression. IE research does not involve attempting to generalize the behavioural patterns of individuals to a population, which would require more systematic sampling methods. Instead, I investigated the ways that we use norms to *do* class and to *do* gender in order to see how ruling relations coordinate the experiences of individuals.

The most important part of quality control for institutional ethnographic research is building trust and rapport with the research participants to obtain information from them that

accurately reflects their experiences. On the consent form, I offered to send participants their interview transcripts to revise so they can make whatever changes they wish. I offered to send participants the quotes I plan to use as well as the context around how I am using them, giving them the opportunity to provide input into the process by further contextualizing quotes.

In the following chapters, I discuss some of my research findings. I show how participants often talked about children's health in ways that were consistent with the childhood obesity discourses explained in the introductory chapter. However, most participants did question these discourses in some ways, such as by using examples of children whose fatness is not perceived as being caused by poor food choices or sedentary behaviors. The mothers I interviewed described a great deal of work that went into trying to make decisions that they thought were healthy, and many barriers to providing healthy foods and physical activity options for their children. In the final chapter, I connect Chapters 3-6 together to show common themes and try to use reflexivity to discuss some of the findings in relation to the research methods as well as some of the things that can be done to begin to change obesity discourses.

Chapter 3: Fatness and Moral Panic: Childhood Obesity Discourses in Health Policies in Ontario, Canada

Context

This article was initially written as an essay for my social policy course. It was further developed with interview data and then submitted to the Journal for Critical Public Health. The results were presented at the Weight Stigma conference in Prague, Czech Republic in June 2017.

Abstract

In this paper, I conduct a textual analysis examining government policies on childhood obesity in Ontario, Canada. I describe some of the key government policies that refer to childhood obesity as a part of (or as the primary component of) children's health. Indeed, the term "healthy children" has been used in academic research, public health, and the mainstream media to describe children whose weights are within a socially acceptable range. I use Foucault's theorizing on power and the concept of moral regulation to reflect on the assumptions underlying the policies and suggest that these are unduly influenced by neoliberal ideals of individual responsibility for health. The implications of these assumptions for people whose bodies deviate from what is considered to be normal is demonstrated with results from my analysis of qualitative in-depth interviews with twenty low-income single mothers in Ontario Canada. I argue that although families often accept these discourses, they also negotiate and frequently reject them as well. However, even those that reject these discourses still describe feeling impacted by feelings of shame and stigma ascribed to dominant discourses of fatness.

Keywords: Fat studies, Mothering, Mother blame, Stigma, Childhood obesity

...if you are not like everybody else, then you are abnormal, if you are abnormal, then you are sick. These three categories, not being like everybody else, not being normal and being sick are in fact very different but have been reduced to the same thing

-Michel Foucault, *Je suis un artificier*, 1975

In this paper, I conduct a textual analysis of government policies on childhood obesity as part of a larger study on the strengths and barriers of rurality on raising healthy children for low-income single mothers in Northeastern Ontario, Canada. I describe some of the key government policies that refer to childhood obesity as a part of children's health. I reflect on neoliberal assumptions underlying the policies and the implications of these assumptions on people whose bodies deviate from what is considered to be normal. I argue that neoliberal discourses on health position (fat) children's bodies as a threat to society that must be strictly monitored and controlled through policies advocating for individual-level behavioral changes that mothers are held responsible for implementing.

Review of the Literature

Critical obesity scholars have disputed the evidence linking health and weight to show that the relationship is far more nuanced than policy and media discourses suggest (Bacon & Aphramor, 2011; Beausoleil & Ward, 2009; Colls & Evans, 2009; Ellison, McPhail, & Mitchinson, 2016; Flegal, Graubard, Williamson, & Gail, 2008; Gard & Wright, 2005; Guthman, 2011; McPhail et al., 2013). Researchers have further nuanced this relationship by exploring connections between weight, stigma, stress, and morbidity (Berset et al., 2011; Block et al.,

2009; Brunner et al., 1997; Mouchacca et al., 2013; Rosmond & Björntorp, 2000). However, most of this work focuses on adult bodies.

There has been a considerable amount of research on mothering work including how ideas of normalcy are formed around white, middle class families and negatively affect the lives of people who are not able to (or do not wish to) meet this standard (Elliot & Mandell, 2001; Little, 1998; Smith, 1987, 2005). An analysis of the connections between the forms of power governing the work that women do in the home and the forms of power that regulate people's bodies is still being developed. This connection becomes most apparent in the groups that are most stigmatized.

Power, Discipline and Fat Bodies

Foucault's theories on power are relevant to understanding how fat bodies are positioned in social policy. For Foucault, sovereign power is tied to the monarchical rule, and corresponds with basic notions of how power operates in western society (Foucault, 1977): it is not exercised continuously, but intermittently as something negative which prevents and prohibits, such as in the law and judicial systems. There are instances of this form of power, such as when children whose bodies are deemed "overweight" are removed from their parents' home by children's services because fatness is seen as a form of child abuse (Jeffreys, 2007). However, this way of thinking about power is not sufficient to capture the complex power relations governing bodies.

Foucault argued that disciplinary power emerged as the predominant form of power in the 17th and 18th centuries. Foucault (1984) stated that "disciplinary power "makes" individuals; it is the specific technique of a power that regards individuals both as objects and as instruments of its exercise" (p. 188). This form of power operates more as social norms, prescribing ways that

people are expected to behave. Armstrong (1995) described a shift from hospital medicine (which resembled a monarchical top-down rule of physicians over patients) to surveillance medicine, in which everyone in a given population was a potential patient responsible for monitoring their own health and wellbeing. Such a move brings all people under the medical gaze and reconfigures notions of health and risk in a way that makes obesity as an epidemic possible.

Foucault identified bio-power as using the population itself as a resource for power. Using statistics to come up with a concept of “normal” and observation to ensure that people are conforming to that standard alongside a normalizing judgment to dissuade deviance, discourse and power/knowledge regimes produce people who largely conform to this idea of normal (Foucault, 1977). Combining Foucault’s notion of disciplinary power and bio-power allows us to describe how bodies are being governed through policy documents, and how people, in turn, learn to govern themselves. BMI is used by the authors of these policies to categorize certain bodies as normal and others as abnormal. In this chapter, I show how language surrounding the dangers of fatness went from describing health risks to the individual to being a societal threat, stigmatizing those whose bodies do not conform to the measure of normalcy and producing a culture where fatness is penalized.

The policies I analyzed were written by people who work within the context of neoliberal governments. Neoliberalism is “a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade” (Harvey, 2007, p. 2). Some of the key concepts that come out of

neoliberal ideologies in health care policy are notions of individual responsibility for health and less government spending on social services (Mullaly, 2006). Neoliberal states tend to transfer care to corporate citizens in the form of tax cuts and deregulation of state borders, whereas human citizens are told that this will help them through job creation and economic growth (Harvey, 2007). However, these ideologies are used to impose values on people; blaming people who live in poverty for not having work even when there are few available jobs, blaming people who are overweight for making unhealthy choices regardless of their actual health, and encouraging people to internalize social values bound up in middle class assumptions about families, work, and health. Following Foucault, this reconfigures the relationship between the governed and the government as well as the relationship between government and knowledge. Fatness becomes a problem requiring solutions instead of a point of view taken by a specific group of experts with specific relationships to governments. However, power is not a simple, one-way relationship; the women I interviewed sometimes accepted these discourses, but often resisted them as well.

Methodology

I used Institutional ethnography (IE) as a theory and method for this research. IE starts at the standpoint of people who are part of a marginalized group and look outwards to investigate the ruling relations that are organizing their everyday experiences of oppression and resistance. IE uses methods from ethnography but turns from studying the other to studying institutional relations in our own society. Rather than focusing on the institutions themselves, IE is based on the assumption that “it is through the daily struggles of everyday life that we see the structural

constraints of the institution emerge, and the processes through which people work to challenge or subvert those structures” (Billo, 2012, p. 48). Textual analysis is common in IE, as ruling relations are often mediated by various texts, such as legislation, social policy, and media (Smith, 1999). Therefore, I critically analyzed some dominant themes from several government policy documents on childhood obesity.

Then, to show how these policies relate to people’s everyday experiences, I include quotes from interviews that I conducted with low-income single mothers residing in Northeastern Ontario in the Spring and Summer of 2016. Twenty women responded to a call for participants for a children’s health study that was circulated through social media and posted in Northeastern Ontario communities. I conducted Institutional Ethnographic interviews to find out more about how they conceived of children’s health and strengths and barriers to raising healthy kids in their community. Then, they took me on a guided tour where we explored some of the areas in their community that they felt impacted their children’s health, such as local parks, schools, and grocery stores. The research was approved by the Laurentian University Research Ethics Board.

Results

In this section, I refer to International, National and Provincial policy reports to demonstrate the shift towards neoliberal discourses within health policies. I present six key documents chronologically to show how neoliberal discourses have permeated health policy over the past fifteen years (see Appendix H for summary table). I have incorporated quotes from participants in order to show the ways that some of these discourses were reflected in the interviews. I will show that these discourses have intensified in the past five years and discuss

some of the implications that these discourses have on the everyday lives of those who are implicated in the policies.

The Construction of Obesity as a Global Epidemic

Childhood obesity became a social policy priority after the World Health Organization (WHO) report entitled *Obesity: Preventing and managing the global epidemic* (2000). When somebody becomes ill from a virus, they are typically not blamed for their illness. When it comes to fat bodies, however, there is a lot of individual blame despite the use of structural language like epidemic. Fatness is often viewed as a sign of laziness, poor individual choices, and bad parenting. The WHO (2000) began by defining obesity as “a condition of abnormal or excessive fat accumulation in adipose tissue, to the extent that health may be impaired” (p. 6). Note that this leaves the possibility that people with excess fat may be healthy. The paper also addressed differences in normal weights between individuals and in different cultures, as well as different levels of health risk associated with fat distribution within the body. The report noted even more problems with classifying obesity during childhood or adolescence because height is still increasing and due to differences in the age of the onset of puberty in children (p. 11). However, it concluded the section on defining obesity by asserting the importance of classifying obesity for the purposes of assessing health risks and evaluating weight loss interventions (p. 7).

This policy document has a section on the costs of obesity that begins with the cost to individual’s physical, mental, and emotional wellbeing. The report described individual causes of obesity, such as changes in diets and increased sedentary behavior, but obesity is mostly attributed to cultural factors. The report stated that although there are correlations between high BMI scores and sedentary lifestyles, “it is difficult to be certain whether obese individuals are

less active because of their obesity or whether a low level of activity caused the obesity” (WHO, 2000, p. 112). While still positioning fat bodies as less desirable than thin bodies, this report is quite nuanced in the definition of fatness and points to societal factors as a main cause of increasing rates of obesity.

Ontario and Obesogenic Environments

In Ontario, the 2004 Chief Medical Officer of Health report entitled *Healthy Weights, Healthy Lives* used BMI as well as a waist circumference measure of abdominal fat to define obesity. It listed limitations of BMI as a measure, including that it did not work well for youth who are not finished growing in height (CMOH, 2004). Still, the report justified using BMI to monitor weight across to identify individuals and groups with increased risk of morbidity and mortality. This report blamed the environments, communities, workplaces, schools, and homes in which people live and work for the ‘obesity epidemic.’ The report described society as “obesogenic” and explained that “young people do not have the opportunity to be physically active every day” (CMOH, 2004, p. 2). While still using language related to choice, and still positioning fat bodies as unhealthy, the report clearly assigned blame to societal factors. The language used assumes that parents want to make ‘healthy’ choices but are not being provided with the resources necessary to do so. It is not entirely the fault of the individuals with fat bodies or the parents of children deemed obese; it is a societal flaw that needs to be addressed on a societal level.

National Standing Committee on Health Report and Surveillance

The Canadian Federal government’s Standing Committee on Health (2008) released a report entitled *Healthy Weights for Healthy Kids*. The report described the increased rates of

obesity without mentioning how the data was obtained. Obesity is not defined in the document, but it does question the use of BMI for classifying children's bodies. The causes of obesity are presented as multifaceted, linked to circumstances such as family income, education, culture, social and physical environment, but each category points back to food intake and physical activity.

In the interviews I conducted with low-income single mothers, I asked them each to explain exactly what children's health meant to them. For all but two participants, the first thing they mentioned was food followed quickly by exercise or play. Only one participant talked about not having an illness as an aspect of health without me probing. None of the participants discussed access to health care as a component of health despite several of them not having a family physician or having to travel several hours to receive medical care until I specifically asked about medical care. None of the participants explicitly said that a healthy child is a thin child, but the focus on food and exercise is reminiscent of the association between fatness and health seen in the policies above.

While the documents I have described mentioned the importance of measuring obesity to assess health risks, the *Healthy Weights for Healthy Kids* policy suggested that in order to better understand childhood obesity, surveillance and monitoring of children's weights is necessary. Fat bodies become more visible for the sake of protecting the State.

Ontario's Action Plan and Fiscal Responsibility

In 2012, the Ontario government published their new plan for health care entitled *Ontario's Action Plan for Health: Better patient care through better value from our health care dollars*. It is at this point where neoliberal discourses surrounding "fiscal responsibility" become

the focus of health policy documents. The report is short and uses catchy phrasing such as “the right care, at the right time, and in the right place” (p. 7) without concrete examples of what this actually means.

The top priority was “keeping Ontario healthy” with the development of a “Childhood Obesity Strategy” (MOHLTC, 2012, p. 7). The report did not define obesity. It linked childhood obesity to chronic disease without citing any sources for this research, which suggests that this link is so widely accepted that it no longer needed to be cited. The report also avoided having to cite data by using phrases like “some experts suggest” (p. 7) when referring to the possibility of shorter life expectancies for children who are overweight. If the data is no longer being cited or even presented, it appears as a truth and is more difficult to critique.

Healthy Kids Panel and Fatness as Dangerous

The Healthy Kids Panel released their report in 2013 entitled *No Time to Wait: The Healthy Kids Strategy*. Note the urgency in the language of the title of this report, insisting that action is needed immediately. Obesity was defined in a footnote below a graph on obesity rates as a calculation involving an individual’s height and weight.

This report repeatedly conflated the words “healthy children” with “children who are thin.” The words weight and obesity are not even included in the name of the panel even though it is focused exclusively on children’s bodies. Mental health, for example, is only mentioned in the ways that it is connected to obesity, such as in the relationship between obesity rates and depression or weight gain as a common side effect of medications prescribed for mental illness (Healthy Kids Panel, 2013). Using the word healthy to mean thin implies that the most important, or the only way, to keep children healthy is to manage their weight.

When I asked participants what they thought about childhood obesity, many of the responses were framed in such a way to make it clear that fatness was seen negatively. More specifically, when asked about childhood obesity, one participant said, “it’s sad” (Sara). The language used by mothers about fatness makes it clear that fat bodies are not seen as desirable. Natalie, whose children have various health conditions including severe ADHD, said “I’m lucky because my kids are average” referring to their size.

The Healthy Kids Panel (2013) explains that childhood obesity is “threatening our children’s future and the future of our province” (p. 2). It then states that “if our children are not healthy, then our society will not flourish” (p. 2), which implies that people who are overweight cannot fully contribute to society. These quotes go beyond the previous assumptions that fatness is damaging to individual people’s health and positions fat bodies as a danger and a threat to the sustainability of our society.

While some of the mothers that I interviewed seemed to accept dominant discourses surrounding childhood obesity and blame, others questioned it. One participant completely rejected the messaging, although she explains that it took years of learning to love her own body as it is to come to this realization. Stacy said,

I struggle with labels. I think labels are what divides society. And I think that labels are what makes the affluent in society – it gives them power. And it leaves the non-affluent in society powerless and scapegoats and something for people to point at and look at and say ‘this is what you should look like, and if this is your situation, then you’ve failed as a human being. (Stacy)

In this participant’s experience, being categorized as fat was the same as being told that she wasn’t a successful human being and having a child whose body is categorized as fat made her feel like she was not successful as a mother.

The report presents an alarming statistic; “by 2040, up to 70 per cent of children will be overweight or obese adults and almost half of our children will be an unhealthy weight” (Healthy Kids Panel, 2013, p. 9). This statement projects the rise in obesity in Canada over the past 25 years another quarter century into the future. However, research indicates that obesity rates have stagnated in North America (Rao et al., 2016; Starky, 2005; Statistics Canada, 2008). The above statistic was misquoted in several mainstream news sources, with reports that 70% of children will be obese by the year 2040 (Artuso, 2013; “‘No time to wait!’ The Ontario Healthy Kids panel delivers its report,” 2013; The Huffington Post, 2013).

Although this report does acknowledge the need to change the food environments and communities, it prioritizes individualized solutions aimed primarily at mothers. Of the five recommendations to “start all kids on the path to health” (Healthy Kids Panel, 2013, p. 28), four of them target mothers including educating women of child-bearing age on the importance of their health and weight, pre-pregnancy health checks, prenatal education, and breastfeeding support. Other solutions that are meant to be gender-neutral still target mothers due to their role in the household, such as serving family meals.

Emily, a single mother with four children between the ages of two and nine, said “there are just a lot of little fat kids and I think it’s just awful because it’s not really their fault.” The idea that someone was at fault came up throughout the interviews. Sometimes, it was seen as the fault of the mother or parents; “I’ve seen [child] dropped off in the morning with a chocolate bar for breakfast, for example. Or [donuts]... it’s laughable” (Lyne). Others put the blame on more structural issues like poverty:

I find that when kids are obese, it's the food that they take. All the processed foods and stuff. And the parents are so busy that they can't really make meals or afford them. (Chantal)

If the ways to prevent obesity are presented as individual and mostly falling on the mother, then it will be mothers who are blamed when their children's bodies do not conform to the standard set out by the definitions within these policies.

Patients First and the Erasure of Weight

Recently, the Ontario government developed a new report on health care entitled *Patients first: Action plan for Health Care* (2015). This report presented a further stage in the removal of bodies from the discourse on fatness. The Ontario Health Care report from 2012 used the term "childhood obesity" to talk about fat bodies. The Healthy Kids Panel (2013) began to erase the term obesity from the texts using the term "health" but referring exclusively to weight, fatness and children's bodies. This report has further erased words describing weight and bodies. Instead of referring to obesity, this report encouraged "supporting Ontarians in taking charge of their health" and promoting "healthy behaviors" (MOHLTC, 2015, p. 13). Although a shift from talking about weight could be beneficial, I find this one quite disconcerting. Using the word "health" but referring exclusively to weight is indicative that the ideology that thin bodies are healthy bodies has become such a common-sense truth in our society that it no longer needs to be stated at all. When health exists under the domain of diet and exercise, what becomes understood is that healthy means thin and fat is undesirable.

Several participants reflected on how they, as mothers, felt as though they were perceived as being to blame for their child's bodies. Anne discussed the fat-shaming her son received from his father and how it reflected back to her parenting:

The last time [my son] was a little more on the pudgy side, [his father] was very hard on him. It was ‘stop eating bread.’ It was ‘you always get fat at your mother’s [house].’

She discussed her experiences reconciling her academic work in women’s studies and food production in university with the shame that she feels as the mother of a child who is categorized as overweight. She said,

If your kid’s fat, you’re a bad mom... it’s really upsetting because intellectually I see that [it isn’t true], but I feel it. Because we get controlled as women. Because you shouldn’t be fat or skinny. Like the battle ground that is our bodies gets translated to our children. And the narrative around childhood obesity is bullshit. (Anne)

I find this point particularly important because even when participants rejected the dominant discourses about fatness (or tried to reject it), the conversations we had were largely framed by these discourses.

Discussion

The policy documents and participants described an association between children’s bodies and mothering in ways that reflect the concept of moral regulation. Moral regulation builds on Foucault’s ideas, combining disciplinary power and more repressive forms of punishment (Glasbeek, 2006). Moral regulation encourages certain behaviors while discouraging others by establishing “disciplinary regimes, including a system of rewards and punishments” (Brock, 2003, p. XXVI). Norms that are described as middle-class family values are imposed on families through legislation, policy, and normative judgment (Little, 1998). In the case of childhood obesity, middle class norms can include things like the idealization of family meals as a solution to problems like poor academic performance and even youth drug use (Kinser, 2017). Family meals can be expensive and difficult to coordinate for a single mother, particularly if they have a

job with shift work or have evening classes, further marginalizing mothers who cannot always meet these criteria. Through ruling relations such as medicine, government policy, and the media, thin bodies are seen as ideal and fat bodies are subject to various forms of punishment.

Much of this punishment is social stigma. In 2006, the American Surgeon General called obesity “a greater threat than terrorism” (Tumulty, 2006), and *Fortune* magazine called obesity a “threat to the world economy [that rivals] war and terrorism” (Smith, 2014). The media further entrenched the ideology that fat bodies are a threat to the state, reporting that many young people do not qualify for military service because of their weight (Jordan, 2014). According to these articles, “childhood obesity isn’t just a public health threat, it’s not just an economic threat, it’s a national security threat as well” (Gardner, 2010) which leads to the perception of fatness as an almost criminal result of personal deviance (Seid, 1989). Fatness has gone from being understood as an excess of adipose tissue to a sign of immorality requiring surveillance for the protection of children and the state.

Mothers are still seen as primarily responsible for care of children, and it is typically mothers who are blamed when children are categorized as deviant (Robson, 2005). Most of the participants described experiencing feeling that stigma themselves, and sometimes even unknowingly perpetuated it by commenting to me on what children they describe as overweight eat. Other forms of social deviance tend to compound this stigma. Boero (2007) has shown that women, especially racialized women or women who live in poverty, are targeted. They are also blamed as “bad mothers” for passing their lifestyles on to their children (Boero, 2007). Classist, racist, and colonial relations are often upheld through public health interventions aimed at curbing childhood obesity and the social determinants of health are often overlooked.

The link between fatness and morality within dominant discourse is used as justification for monitoring people's bodies through surveillance medicine. Whereas hospital medicine is concerned with the patient and their illness, surveillance medicine targets everyone through concepts of normal and abnormal (Armstrong, 1995). As bodies became sites for surveillance medicine, the medical gaze shifts away from illness and the distinctions between health and illness become blurred (Armstrong, 2011). Such surveillance allows health professionals and health policy to "leave the hospital and penetrate into the wider population" (Armstrong, 1995, p. 398). Under this conceptualization of health and medicine, bodies become pathologized by potential for illness, which is internalized through disciplinary and bio-power. What is particularly troubling about surveillance medicine is the way that we come to govern ourselves (Foucault, 1984). For instance, in the interviews, mothers described feelings of shame and stigma if their children's bodies did not conform to standards of thinness, whether or not they internalized dominant discourses about obesity. They described feeling judged by family, friends, strangers, and society more generally. Some participants also made judgements about other children's health based on their bodies, such as noting that a child they see as overweight eats donuts for breakfast or saying that fatness is caused by the food the parents provide for them. In this way, participants are governing themselves and each other, maintaining obesity discourses, and further stigmatizing people with fat bodies.

Conclusion

In this paper, I have argued that the discourses within key health policy documents impacting Ontario families have shifted in the past fifteen years, positioning fat bodies as deviant

and even as a danger to the nation state that needs to be carefully monitored and controlled through policies advocating for individual-level behavioral changes. I have used Foucault's theorizing on power along with the concepts of moral regulation and surveillance medicine to show some of the potential implications of this on people's everyday lives, with a focus on gender and social class. The single mothers I interviewed often made the same associations between children's health and their bodies. They sometimes challenged and rejected this messaging, but still felt the impact of the discourses in terms of feelings of shame and stigma, particularly when their child's body was categorized as "obese."

The policies that were analyzed in this paper were written by people in specific contexts. It is particularly important to remember that social contexts behind the policies because if they were written by people and implemented by people, they can also be changed. It might be implausible to ask policy-makers to abandon all talk about body size given the focus on obesity over the past 15 years, but a starting point could be to hold governments and media accountable to simplistic statements about bodies and health that are not backed by evidence. Beginning to disrupt the simplistic narrative that fatness is inherently unhealthy could lead to a more nuanced, complex discourse regarding children's bodies and health.

Chapter 4: Mothering, Geography, and Spaces of Play

Context

This chapter was originally combined with the following chapter as an article on recreational activities. However, there was a lot of material on play that didn't always fit with organized leisure activities, so I separated it into two chapters. This chapter was submitted for an edited book entitled *Mothers/Mothering: In and Out of Place* with Demeter Press.

Introduction

After graduating from university, my first job was doing public health research designed to help 'combat' childhood obesity. I went into this work quite enthusiastically. After six years of studying, I finally had a real *grown up* job. However, throughout the research, I kept seeing instances where mothers were being blamed for their children's bodies, and I began to distrust the data linking fat bodies to an array of health conditions. After doing extensive research on the subject, I realized there was an entire body of academic literature that found substantial evidence that fatness has many complex causes, that bodies are meant to come in all sorts of shapes and sizes, and that the links between fatness and health are much more complicated than the public health discourses suggest (Boero, 2007; Flegal et al., 2005; Gard & Wright, 2005; McPhail, 2013).

Government documents on childhood obesity often focus on specific groups, such as Indigenous children (Greenwood & de Leeuw, 2012), rural populations (McPhail et al., 2013; Statistics Canada, 2004), and families with low socioeconomic status (Brunner et al., 1997; Clarke et al., 2009; Sobal & Stunkard, 1989). When fatness is seen as a social problem, and

when particular groups are deemed to be more at risk, these groups get constructed as a “problem population” (McPhail, 2013). The research and policies implemented to prevent and “combat” childhood obesity end up replicating these ways of understanding the issue by reinforcing these discourses. For instance, they reinforce mother blame by focusing on the mother’s role in providing specific types of food, limiting screen time, and enforcing daily exercise (Bell, McNaughton, & Salmon, 2009). In my doctoral research, I wanted to investigate the ways that these understandings impacted mothering work for low-income single mothers in Northeastern Ontario, Canada.

In order to better understand how single mothers experienced mothering work in the context of childhood obesity discourses, I did interviews and neighbourhood tours with twenty low-income single mothers who resided in Northeastern Ontario. I recruited participants through social media, contacted local organizations and put up posters in grocery stores, community centres, and food banks throughout the region.

When I began this research, I was expecting the focus to be on food and foodwork. While I had questions about play and physical activity, such as “Tell me about the spaces where your children play,” I had prepared far more questions about meal planning, grocery shopping, and cooking than on children’s play activities. Similarly, for the second part of the data collection, which involved going out into the neighborhood with participants, I asked them to take me where they usually go to get food. Participants were not interested in going to grocery stores. The first two participants to bring me to a grocery store asked if we had to go inside. I spent a lot of time thinking about why this was; I questioned whether they were concerned about being judged by me or by the other people in the store. Fear of judgements may have been part of it, but when I

asked the next participant about her reluctance to go to the grocery store, her response was that she hated being there and preferred to avoid it.

The participants who were reluctant to go to a grocery store were more than happy to take a slightly different trip, bringing me to the neighbourhood park, arenas, and community centres. They showed me which playgrounds their children liked and did not like and explained some of the reasons why. They talked about areas that they felt were safe for their children and areas that were not. As part of my feminist research methodologies, I let the participants guide the areas we visited to show me what they thought was relevant to the study. As a result, a lot of the focus of my research shifted from food to the spaces where children play. In these public spaces, mothers must negotiate the areas that are considered adequate for play and the ability of children to play free from safety risks (Valentine & McKendrick, 1997). Because mothers are primarily responsible for the reproductive labour involved in raising children, they are ultimately considered to be responsible for negotiating the spaces where children play (Mitchinson, 2016), which has increasingly shifted from something that children did on their own to another task that mothers had to coordinate and supervise.

In this chapter, I discuss some of my findings on how low-income single mothers negotiated the spaces where their children played, including how understandings about health and obesity, social norms, and perceptions of risk and safety regulate and organize the places where children play. For low-income single mothers, this negotiation is impacted by geography, particularly whether the area is rural, urban, or something in between. It is also impacted by racism and other forms of discrimination in public play spaces.

Northeastern Ontario has a few cities, many small towns, and a lot of sparsely populated rural areas. Of the 20 participants interviewed, 11 lived in cities of 50,000 people or more (three of whom previously lived in rural areas), three lived in smaller towns (5,000-49,000 people) and six lived in rural areas or towns with fewer than 5000 people. Ontario government research describes rurality as a barrier to accessing healthy foods and leisure activities, especially when families have limited financial resources (Healthy Kids Panel, 2013). However, academic literature on rurality has also emphasized some of the strengths of living in rural areas when it comes to health-maintenance behaviors. For instance, it might be easier to grow fresh food in rural areas than in urban areas, and it is perceived as safer for children to play outside (Beagan et al., 2008; McPhail et al., 2013). It was important to me to demonstrate some of these strengths in my research as well as describing some of the barriers for rural participants.

Play and Health

When asked what it means to be healthy, physical activity was raised by all participants. It was typically the second thing mentioned, after food. The idea of unstructured play or play free from the rules and constraints of organized sports and activities, came up in every interview. There were few barriers to play, the main one being perceptions of safety. Screens and electronics as competing interests were also mentioned as a barrier to play, and the presence of friends and playmates in the area as a facilitator to play.

Play and exercise were sometimes used interchangeably by participants, but they were often seen as distinct, with play being something that children do for fun. When asked what is involved in raising a healthy child, Sara, a childcare worker from a rural community, said “I don’t want to say exercise, but play.” She was clearly noting the health benefits of physical

activity, but also acknowledging that physical activity can be fun. Laura's son does not like sports or exercise, and she struggles to get him moving as much as she feels that she is supposed to. However, a week before our interview he was playing at the park. She said,

He probably didn't realize he was getting exercise because it's fun. And it wasn't a chore. He wasn't doing it because 'I have to do this' or 'I'll be healthier if I do this.' That takes the fun out of it. (Laura)

Clearly fun is an important part of play for participants.

Several participants discussed a shift from unstructured play that they experienced as children to the pressure for more participation in organized recreational activities now. The idea that many children do not just play outside like "we used to" was a common theme in my interviews. Chantal described her own childhood,

We were raised by the streetlights... whether it was at the park or with our friends in the yard. Doesn't matter, we were outside playing. We weren't sitting in front of TVs. (Chantal)

A lot of participants described having more freedom to play outside as children than their own children do now. Several participants discussed wishing their children could experience this type of freedom, but they felt as though the culture has shifted, particularly in urban areas:

I gave him my phone once to play Pokémon Go and he was gone for an hour. And I got nervous. How do you not be a helicopter parent? I remember being gone for hours and hours and hours. Literally. Being gone forever, playing around, making clay pots in the woods, climbing trees. There is so much anxiety around parenting now. (Amanda)

It was difficult for the mothers I interviewed to reconcile wanting their children to have the same free-range childhood as they had with their own perceptions of safety and their understanding of what neighbors thought was appropriate in terms of children's play. It is important to note that memories of one's childhood can be influenced by recall bias and by the blending of memories

and re-telling of memories and common childhood narratives over time (Göttlich, 2013). Still, mothers felt that they needed to be more involved in deciding where and when their children could play than their mothers were when they were young.

For almost all participants, having friends that live nearby for the children to play with facilitated outside play. Lyne, who lives in a rural neighborhood where there are a lot of children who are the same age as her two boys, said,

They are playing with their friends, which is very big and it's intense and they do it for a long time, like they're out there more than they're in the house in nice weather. (Lyne)

For Lyne, living in an area filled with young children playing together was a benefit of living in her neighborhood that helped make up for some of the drawbacks, like having to drive for 45 minutes to get to sports complexes and grocery stores. When there were other children playing outside in the neighborhood, children were far more likely to play outside.

Perceptions of Safety and Fear *for* Youth

In his book on children's participation in sports, Messner (2009) suggests that cultural fears surrounding childhood are typically either fear *of* youth or fear *for* youth. Fear of youth is the idea that young people, especially teenagers, are destructive or dangerous. Fear for youth is the idea that children are inherently more vulnerable than adults, especially to strangers. Both of these fears came through in my interviews, but in different ways for rural than urban areas.

While most participants had some access to safe spaces for their children to play outside, such as neighborhood parks, school grounds, or a backyard, many also discussed safety concerns with respect to unstructured outside play. For many of the participants in urban centers, safety concerns centered around strangers as potentially dangerous and neighborhood crime. For many

rural participants, safety concerns had to do with the physical environment, such as a highway, train, or body of water. This chapter refers to mothers' perceptions of safety and danger with respect to children's play, not of actual risk.

Participants in urban centres with populations of between 50,000 and 160,000 people described safety concerns such as strangers, drug use, and violent crime. Some of the urban mothers were hesitant to let their children play outside without adult supervision. Vanessa explained using an example of what she described as a dangerous situation at the park:

We had an incident yesterday with a boy who was like 10 [years old] flipping a knife out at some girls. (Vanessa)

Vanessa did not want her 9-year-old to go outside without her, even to the park down the street, because she didn't feel it was safe. Similarly, Stacy recently moved from what she described as an unsafe neighborhood to a much safer one:

We lived in a horrible neighborhood. Horrible. Like crime every other day. Sometimes I wouldn't even let them play in our own yard because there was just so much stuff going on. (Stacy)

Stacy and her family were adjusting to the new freedoms of being able to send the kids outside without supervision, now that she felt the neighborhood was safer, but still experiences anxiety when they are walking to the corner store or going to the park without her. While drugs are often thought of as an inner-city problem, several participants have found drug paraphernalia in their neighborhoods in smaller urban-centres. Sylvia noted,

The kids couldn't play [at the park] at all... [there is] lots of drug paraphernalia on the ground, needles, everything. (Sylvia)

Sylvia said that local organizations try to keep the needles picked up, but that they are often unable to keep up. Mothers I interviewed frequently talked about wanting their children to play

outside, but not feeling it was safe. In urban areas, strangers, crime, and drugs were often mentioned. Not all urban participants described this type of fear, but it was a common theme throughout urban interviews.

Participants in small towns and rural areas were more likely to describe the environment as a danger and people around them as protective factors. Several participants said that their children could not ride bikes to get around the neighborhood because their town was built into a large hill:

We have bicycles and they tried to ride, but the hills here, they can't ride a bike... They fall and give up. I wish they'd learn how to ride a bike because they'd have more freedom, but with the hills and stuff, they won't do it.
(Natalie)

The means by which Natalie's children are able to move through and between spaces of play are impacted by the natural environment; in this case, a large hill. Similarly, some mothers described ways in which their children's spaces of play were impacted by the built environment. Sara lives near train tracks and most of the town is on the other side of the tracks. She recounted times that she was 40 minutes late because of the train and her concerns about her kids being trapped on the other side of the tracks when they are coming home from the park. She stated,

[S]ometimes in the morning we are waiting an extra 40 minutes, because the bus is stuck on the other side of the train. (Sara)

While Sara lets her son explore the neighborhood with his friends on their own, she isn't comfortable with him crossing the train tracks because she doesn't want him to be stuck without a parent. Lyne described how her children must cross a busy highway to get to the area where they like to play:

In order for the kids to get to a park quickly, they need to be on the highway and we don't have a crosswalk. Our community centre is across the highway... our corner store was across the highway up there. The launching dock where the kids go swimming, some of them go fishing, is across the highway. (Lyne)

She sometimes lets them cross the highway in groups but will not let her children go alone. The built environment was a substantial consideration when mothers are setting the terms for children's play.

Whereas many of the more urban participants described a fear of strangers (although, not all of them did), many participants in small towns (under approximately 5000 people) and very rural areas described other people in the community as protective factors, making them feel safer about their children being outside. Lyne talked about some of the ways that her neighbors helped keep her kids safe. She said,

And other people, like the guy two houses down, he doesn't have little kids, but he's sent my kids home because he isn't happy with their footwear while they're riding their bikes or something like that...It is fabulous, everybody is kind of looking out for one another. (Lyne)

Several participants talked about neighborhood children playing together or other adults in the neighborhood doing things together with their children like going for walks or playing sports. Natalie, a low-income single mother living in a more middle-class neighborhood talked about neighbors helping provide opportunities for her children that she might not be able to provide them herself:

It's a really nice area. There are lots of kids around and we know our neighbors... yesterday, my neighbor came over with tickets [to the circus] and she said let's go. (Natalie)

Few urban participants described this kind of close relationship with their neighbors.

Perceptions of Safety and Fear of Youth

Several participants discussed how spaces for children's play were used by teenagers as something that regulates where and when their children can play. While Adrienne said that the teenagers were always accepting of their children in the shared space and even helped her son learn to ride a skateboard at the skate park, others experienced teenagers as a barrier to play. For instance, Paula said,

[This park] doesn't look like teenagers are hanging out there at night smashing bottles and stuff. The other park down by the water tower is a little bit more like that. You can see more older kids hanging out there and stuff, so I try not to take them there that much. (Paula)

Paula chose which of the two nearby parks she visited based partly on whether and how teenagers use the park. One participant brought me to a park near her house where she said teenagers like to hang out. She didn't find it safe for young children to play at because of the condition the park was in; there was broken glass throughout the park, including on the slide. The park was covered in graffiti. There was a skate park area that had several large holes on the paved ramps. These holes would be very difficult to avoid on a skateboard, bicycle, or scooter, making it too dangerous to use the skate park. She suggested that there may be less broken glass if there were more things for teens to do in the area, but the nicer facilities are on the other side of town. There was an old trailer next to the park that was covered in spray paint that she said is going to become a youth drop-in center at some point but isn't sure when or if that is happening. It was clear that perceptions of safety, including the physical environment, perceptions of crime levels in the area, and whether the people around them were considered potentially dangerous or

protective of the children, all factored into which spaces mothers allowed their children to play and whether adult supervision was required.

When I asked Kimberly, who had moved from a small First Nations community to one of the larger cities in the north, if she found the area safe, she challenged my ideas about safety in a really interesting way. She discussed how, in the small community, her children were outside playing and walking from her house to her parents' or other friends' houses, or just playing in the woods:

Some people may think letting them venture in the woods would be unsafe with bears and whatnot... My son has a couple of pellet guns, so he will take cans from the recycle bin, he'll pack ... his lunch box with snacks and he'll go to the bush... Now if he said he was going to the mall with a couple buddies, I'd be worried. I don't know what it is, other people would be like ok, go hang out at the mall. I'm more concerned about what's going to happen there or who's going to say something or whatever it might be. Whereas in the bush, I know it's him and the bush and I know he's ok out there. (Kimberly)

This story exposes how ideas around safety, including what activities are considered to be safe, and which are not, are culturally constructed and vary in different families, cultures, and communities. She mentioned that racism in her current community influences the decisions she makes with respect to parenting her children in many ways. When he is at the mall or in other public spaces, she was worried that he may be judged negatively by people around him including peers, mall employees, and even the police.

Intersectional Connections: Race and Class

There were many intersectional factors that impacted some of the ways that mothers negotiated spaces of play for their children. In particular, in this section, I will focus on racialization and social class and the implications described by some of the mothers I spoke to.

Natalie, a Black woman from a small, predominantly white town described issues with play, safety, and racialization:

My oldest son said to me this year, 'I don't want you to come because people are going to make fun of me because you're brown, so stay outside.' So now I don't go to the school on behalf of my son.... As they're getting older, the racism is getting worse and worse and worse. You can't come to my birthday party because my mom doesn't like your colour. So that's another huge issue in this community. (Natalie)

She mentioned other difficulties that she faces, as one of the only people of colour in her town, such as being followed around at stores, being refused service at a restaurant, and her concerns that her sons may get in a lot of trouble for things that their white friends might get away with as they get older. She also talked about her biracial children not fitting in with the other kids; when she asked her children why they don't play outside with the other kids, they responded that "the kids are saying I can't play with you because you're brown" (Natalie). She is trying to negotiate watching them more closely because of the racism they are exposed to with trying not to be too visible to her children's friends. She tries to take them to the closest urban centre as often as she can where they can be around other racialized children.

In both urban and rural areas, participants commented that children in lower income neighborhoods seem to be more likely to play outside than those in wealthier neighborhoods. Vanessa, who grew up in a wealthy urban neighborhood but now resides in low-income housing with her daughter noticed a different culture of play in her new neighborhood. She said,

I don't know if all low-income neighborhoods are like this because this is the first one I've ever lived in, but the kids know how to play. They are outside from sun up to sun down, and beyond sometimes which I don't necessarily agree with. But it's a huge community thing. We have a road in the middle, and the kids play area is unfortunately the middle of the street, but it's also nice to see at the same time. (Vanessa)

Like several other participants, she had mixed feelings about children playing outside. On one hand, she says that it is nice to see the kids playing outside, while, at the same time, noting that she doesn't always approve of when or how the kids are playing. Another participant noted the difference between how children play in her (rural, low-income) neighborhood compared to her ex-husband's (urban, high income) neighborhood:

Their dad and stepmom live in a very rich neighborhood. And kids just don't seem to be encouraged to go play outside. I have been booting my children out since they were very young, mainly because I needed a break from them. I need to clean my house, you're in my way, please go play outside. (Lyne)

While children in her neighborhood are outside playing most days, in her ex-husband's neighborhood, she thinks that the kids spend their time inside and doing organized sports rather than playing outside. The ways that children play outside was impacted by feelings of judgment. Participants described not letting their kids play in certain areas because they do not want neighbors to judge them. For example, Claire talked about taking all four of her children to play outside in her small community:

We play on the street and they do their bikes and stuff, but I have to be out there and watching because of cars. And it's not really that enjoyable for me. I always feel like people are staring at me. (Claire)

In neighborhoods where there are always children playing outside, it might be less conspicuous for mothers to just let their children go play on their own.

Perceptions of safety have also impacted the ways that children can play in certain communities due to policies. For instance, some cities have banned road hockey due to safety concerns. Two participants discussed rules governing play that were implemented by their housing co-ops:

We recently received a letter stating that children are not allowed to scooter in the parking lot, play sports with balls, or pretty much do anything... And I personally am not following these rules because I find them ridiculous.
(Rachelle)

These participants described getting letters from the housing's Board of Directors about things like leaving children's toys outside, kids playing too roughly, or playing with balls outside. They both described this as not having a lot of impact on how their children play, because they ignore the policies in a lot of ways. However, one of the letters I was shown said that if they do not change the behavior, the potential consequences they may face include eviction, so kids playing outdoors in the wrong ways could lead to serious consequences for the family, such as eviction or even homelessness, particularly since it was geared-to-income housing, which is difficult to find in Northeastern Ontario.

Conclusion

In this chapter, I have described some of the ways that mothers negotiated children's play spaces, including the locations where they play, when they play, and how they play. Far from being a simple practice of just letting children go outside to play, mothers actively negotiate which spaces children can use for play, at which times, and for what specific activities. Play has increasingly shifted from something that children did on their own to another task that mothers had to coordinate and supervise.

I have also demonstrated some similarities and differences between rural and urban mothers in Northeastern Ontario, including whether people around them are seen as a threat or a protective factor. These spatialized practices are so taken for granted, that they are not typically explicitly thought about, but are still made based on many assumptions about children's safety,

understandings of health, normative judgement from people around them, the built and natural environments, and various other considerations. In doing institutional ethnographic research on how mothers negotiate the spaces where children play in the context of childhood obesity discourses, I have endeavored to make visible some of the taken-for-granted assumptions and practices that mothers engage in every day. In recognizing this domestic and reproductive labour as work, it is my hope that we will increasingly see mothering as work.

Chapter 5: Children's Sports, Leisure, and Childhood Obesity Discourses: Institutional Ethnographic Interviews with Low-Income Single Mothers

Context

This chapter was written as an article for submission to a peer-reviewed journal, likely the *Sociology of Sport Journal*.

Introduction

Childhood obesity has gained a lot of attention from media, governments and health professionals over the past decade. The idea that our way of life is being threatened by an increase in adipose tissue has been challenged by many critical health scholars. While media reports that today's children will "die younger than their parents," there is actually little evidence linking obesity levels to life expectancy and most of the evidence that does exist is critiqued heavily for its methodologies and data interpretations (Bacon & Aphramor, 2011; Campos et al., 2005; Colls & Evans, 2009; Evans & Colls, 2009; Flegal et al., 2005; Gard, 2011, 2016; Gard & Wright, 2005).

When fatness is seen as a problem that can be controlled with rigid systems of diet and exercise, fatness in children is often blamed on parents (Mitchinson, 2016). However, parents do not seem to experience this blame equally. Fatness in children has been linked to a multitude of factors, such as maternal employment in the paid workforce (Coley & Lombardi, 2012; Datar et al., 2014); breastfeeding (Gibbs & Forste, 2014; Lefebvre & John, 2014); the quality of parent-child attachment (Bahrami et al., 2013); maternal depression (Morrissey & Dagher, 2014); mother's age (Farajian et al., 2014); mother's age at menarche (Ong et al., 2007); maternal

smoking during pregnancy (Rooney et al., 2011; Suzuki et al., 2013); mother's own weight concerns (Markey et al., 2012), and marital status, as single mothers were more likely to have children categorized as overweight than married mothers (Schmeer, 2012). There is little to no research linking fatness to fathers.

Sports and recreation are also increasingly tied to labour markets, with the average Canadian family paying \$953 per child per year for organized sports (Community Foundations of Canada; True Sport Foundation, 2015). About 75% of children aged 10-13 years old participate in organized sports. However, participation is not distributed equally among children of all income brackets. For low-income families, it is about 60% compared to 85% for children from families with incomes over \$80,000. Rural families reported limited options compared to urban families (Community Foundations of Canada; True Sport Foundation, 2015). So, while physical activity is recommended by most children's health experts as a way to control body weight and keep children healthy (Healthy Kids Panel, 2013; Standing Committee on Health, 2008; WHO, 2000) factors such as income and geography as well as the structure of socially acceptable physical activities for children may limit participation.

In this paper, I use findings from individual research interviews to argue that sport and recreation have become a defining site for consumer markets due largely to the discourses surrounding childhood obesity and individual responsibility for health. However, the cost of accessing these activities can be quite prohibitive for low-income families. The mothers I interviewed wanted their children to participate in sports and recreational activities, in part for health reasons, but described many barriers to doing so.

Review of the Literature

Children's play can be hard to study because it is ambiguously defined, consists of many different types of activities, is not regulated by a specific act or government body, and is performed differently by children in very similar situations. Still, central to institutional ethnography is understanding the ways that ruling relations such as government, media, health care, and so forth, normalize and organize many of the things that people do on an everyday basis. As such, in the following sections, I will use the voice of participants to show how the types of physical activities and play that children participate in are governed by ruling relations such as sports policies, program requirements, and social expectations.

Childhood, as we understand it in contemporary Canada, is a relatively new phenomenon, especially when it comes to leisure time and recreation. Over the past century, "the child emerged as a fundamental political and social concern" with children viewed as innocent, vulnerable, and in danger, requiring adult control and protection (Gleason et al, 2010, p. 9). Some materialist theorists studying childhood in capitalist societies study the role of children and notions of childhood to the maintenance of capitalism as an economic system. For instance, Seabrook (1985) describes how children's labour in the factory was critical to the development of capitalism until the 19th century. Similarly, Langer (2002, p. 78) posits that "children still work for capital, but as consumers." Instead of working in factories or on farms, children in western countries largely contribute to capitalist economies through purchases and consumption.

Chudacoff (2008) traced the history of children's play from being considered relatively unimportant and often a cause of trouble in the 1600s in North America, to an important part of character formation in the late 19th and early 20th century. He describes play as increasingly tied

to consumerism in the 20th century, as play moved from unstructured leisure time requiring few, if any, store-bought tools to a time where play was highly regulated through scheduled activities and sports. The description of play throughout the book includes many different types of play, such as imaginary play (such as pretending to have a tea party or playing house with dolls and friends), active play (such as sports), solitary play which often requires toys instead of friends, constructive play, with adults pushing children into more productive pursuits (p. 118). Much of the research on play in the 1980s and 1990s focused on the shift from unstructured play to structured activities and perceptions of safety in play (Chudacoff, 2008; Rogers & Sawyers, 1988; Valentine & McKendrick, 1997).

Similarly, there has been a shift in how we conceive of health. Attributions of health have shifted from genetics or luck to something that is thought to be achieved through hard work and self-discipline (Quirke, 2016; White, Young, & Gillett, 1995). While the promotion of “healthy behaviors” is likely well-intended, unequal access to resources reinforces classist ideologies (White et al., 1995). When health maintenance is seen as the job of the individual (or parent), those who do not appear to be healthy enough are stigmatized for what is considered to be poor lifestyles choices (Boero, 2007; Evans & Colls, 2009; Lupton, 2015) regardless of their actual health or behaviors.

Results

In this section, I present some of the findings of my research as it relates to sports and recreational activities. First, I will show that participants saw exercise and physical activity as a necessary part of health maintenance for children. I will then describe some of the activities

participants' children participate in and some of the barriers to participation including costs, scheduling, and transportation. I expected free activities to be popular for participants, but there were many more barriers to participation than I had anticipated, making even free sports not well-attended by most participants.

Physical Activity as Health

When asked what it means to be healthy, physical activity came up in every interview. It was typically the second thing mentioned, after food. Participants emphasized the role of exercise in maintaining children's health. For instance, Laura said,

The term healthy child would probably mean a child that gets exercise on a daily basis. (Laura)

Like Laura, Paula also thought that exercise was essential to a healthy childhood. She said,

Exercise. Because they see their mom exercise every morning and they're like I want to be strong like mommy... If you want to be big and strong like mommy and daddy, you gotta eat your veggies and you gotta work. (Paula)

The use of the word exercise is important. Exercise is often thought of by adults as a chore, it is not something that we necessarily do for fun, but to remain healthy. It is also not something that tends to happen in groups, the way sports and play are social, but is frequently done alone. This focus on exercise stigmatizes individuals who do not participate in physical activities in the "correct" ways (Petherick & Beausoileil, 2016). In this way, it becomes a moral obligation for mothers to ensure their children engage in physical activity (Mitchinson, 2016).

The type of activity that children participate in may be a choice, but there is considerable pressure to ensure that they are participating in a variety of activities. According to Maguire (2008), the "calls to better discipline one's non-work time ... ironically reaffirm the equation in

the popular imagination of leisure with freedom of choice” (p. 66). Leisure is often conceived of as a time where we are free from work and school obligations, however leisure time was described as being full of expectations and requirements that mothers feel they should be meeting. Of note was how often participants talked about things that they thought they *should* be doing. For instance, Stacy explained that her family was not getting as much physical activity as she thought they should:

And we're not as active as we should be. Like we're not out, they're not doing sports every other night or dance every other night because I can't afford it, but we do try to go hiking on the weekends and in the winter we slide and in the summer we walk the track at [the park] now. (Stacy)

Like most participants, Stacy did not say how she knew that physical activity was something that they should do, or how much exactly was needed, but there was an overall general idea that exercise was important. Participants described feeling pressure to have their children participate in physical activities for health reasons as opposed to doing so for fun.

Rather than calls for collective solutions that would imbed more physical activity into everybody's daily activities, much of the discourse surrounding children's physical activity was within the realm of parental responsibility and health. Physical activity for health was described as something that one must actively work to achieve, as opposed to spontaneous play.

The rhetoric about children's physical activity as a moral obligation goes beyond individual health requirements to position an individual's exercise (or lack thereof) as having global implications (Gardner, 2010; White et al., 1995). According to Featherstone (1982), “the subjugation of the body through bodily maintenance routines is presenting within consumer culture as a precondition for the achievement of an acceptable appearance” (p. 18). Couture

(2015) goes on to add that it not only teaches people to maintain their own bodies in this way, but “it teaches them to expect the same of others” (p. 51). Health concerns are framed as being (1) the fault of individuals, and (2) controllable through increased consumption of leisure activities (Couture, 2015).

Organized Leisure Activities

The participants in my research described different kinds of organized sports and leisure programs that I grouped into four categories based primarily on cost and expectations around skill and commitment. These are competitive sports, recreational sports, and low to no cost activities. Low-income mothers all described barriers to access even with low to no cost activities and little to no access to the higher tiers of sports. While I thought that school sports or free activities would provide some access to sports, the mothers I interviewed described many barriers to accessing these activities. For instance, school teams were filled with students that had heavy sports backgrounds, and free activities required transportation to sports fields, many of which were not accessible by public transit.

Sports and Competitive Recreational Activities

Sports are increasingly viewed as something that every child should take part in, as opposed to something that is optional for those who are interested (Wilson, 2002). Sports are assumed to be good for children’s bodies (Wilson, 2002), enjoyable for children (Bartky, 1997), and teach valuable lessons that benefit individuals as athletes and society as a whole by teaching things like teamwork and proper citizenship (Couture, 2015; Maguire, 2008; White et al., 1995). For instance, Abrams (2011, p. 32), who advocates for equal access to sports for children, wrote that “no other activity outside of the home and schools holds greater potential for influencing the

next generation.” In the following section, I will outline these tiers of activities including some of the barriers described by participants.

Participation in some competitive sports in Northern Ontario cost up to about \$10,000 CAD per year when coaching fees, venue fees, travel expenses, equipment or costume expenses, and other costs are combined. A survey commissioned by Hockey Canada found the average cost per child for hockey was \$3,000. Competitive divisions were often \$8000-\$10,000 and some private hockey boarding schools were as much as \$40,000 per season (Doiron, 2013). Even dance fees, when listed on a website, are more than \$2,000 per year plus travel, costumes, and private lessons for dance solos (Dance Evolution, 2018) which can bring costs to upwards of \$10,000 per year. Many of these organizations hold tryouts to find the most skilled and competitive athletes, which benefits those who have access to years of experience and in some cases even personal training. Participation requirements are often four to five times per week.

Sylvia’s daughter was able to join dance classes, paid for by her ex-husband, but found the cost to be prohibitive:

Her dad put her in dance. \$500 for two months! Plus, an outfit! Like, are you kidding me? I couldn’t even afford to go watch her recital because of how bad the tickets were because it meant that \$30 wouldn’t be going in the house for food. (Sylvia)

She said there were many students in this dance program that attended multiple classes at that price, year-round, and travel to competitions throughout Canada and the United States. If her daughter wanted to continue dancing, she could access low-cost classes at the local YMCA, but the dance experience is very different because you aren’t building towards a routine, recital, and/or competitions.

Horne (2005) describes a shift in the relationship between identity and sports over the past twenty years. Increasingly, sports and leisure activities have come to take on greater significance in that they have become a major shaper of personal identity. Sports have gone from something children *do* to part of who they *are*. This sport specialization is described as having “dramatically changed youth sport experiences over the past two generations” (Coakley, 2011, p. 8). Many young athletes aspire to develop elite-level skills and use sports to pay for post-secondary or even as a career path (Coakley, 2011). Some of my participants described wanting to ensure that the time and money they put into sports will pay off in some way. Emily said.

[My daughter] really liked gymnastics but it’s \$250 for a 6-week session, and it doesn’t seem like it’s going to go anywhere. It’s not one on one, it’s not intensive training. It’s just kind of for fun and it’s a bit too much money for that. (Emily)

For Emily, due to the high cost of gymnastics it wasn’t enough that the sport was enjoyable for her daughter. It is possible that a lower-cost recreational program would elicit a different response from Emily, but there are no lower cost alternatives in her town.

In the interviews, participants described a hockey culture in Northern Ontario that several of them felt excluded from, although some did find ways to participate such as by getting financial assistance from parents or from their child’s father. One participant described the costs for what she described as one of the least expensive leagues. She can keep her child in hockey this year, but struggles to keep him in the sport despite having a full-time job and working part-time on weekends that he is with his father:

Hockey is not affordable... For registration, almost \$400 and we have to sell mandatory fundraising tickets for \$150... And then you add on a travel fee, and then hotels... They do three out of town tournaments. (Karen)

Karen was not sure how they were going to afford all of the equipment this year because her son had a growth spurt, but it was a priority for her so she knew she'd find a way. Hockey in particular as a sport that is inaccessible to people on low-incomes also came up in the interviews I did in 2012 for my Master's research (O'Gorman, 2012):

He wanted to join hockey and this and that, so even if I could beg and borrow hockey equipment, I didn't have a car. Some of those lessons were at 6:00 in the morning, there weren't any busses. No, we couldn't, I wanted to so much and I think that's another reason why he was in and out of trouble. (Lisa)

She felt that having access to activities like hockey for her son could have had a huge impact on his life by making him feel like he belonged somewhere. When hockey is thought of as part of the culture of the Canadian north, not being able to afford to play can make children feel left out.

Recreational Sports

Many participants described recreational-level programs that their children attended. These were lower cost, did not require tryouts, were generally open to first-time players, and had little to no travel requirements in most circumstances. Examples included soccer, baseball, swimming lessons, and dance classes. The costs were described to be around \$30 to \$50 per child per month, including the uniform and generally required only minimal equipment such as soccer cleats and shin guards. The main barriers to participation were finding the time to participate, and the cost of activities, especially for mothers with more than one child.

Programs that I classified as low to no cost activities were typically community-based and offered at little to no cost. Some were run by parents or teachers who wanted to start an inclusive activity in the area; others by non-profit organizations or local community centres.

Most participants described having access to one or two of these activities in their community, but that their child often wasn't interested or they often could not find transportation to the programs.

However, there were a lot of positive comments from parents about these activities. Several participants were part of a low-cost track and field program. Karen said,

[T]heir goal is to provide these track clubs to people who can't afford it. It's \$30 per kid, you should see what they get, it's amazing. They all get a T-shirt too. The amount of time and all the activities [the organizers] do for this club. And eventually they want to lower the price to allow every single kid. And if you can't afford it, let them know and you're in. (Karen)

Karen is a runner and her children really enjoy track and field, however, she acknowledged that it isn't necessarily for everyone. Kayla, who lives in a First Nations community, said that most of the activities are no cost, which makes it easier to participate:

Here in the community, the majority of the organized activities have no fee. And then sometimes, to promote the activities, they go as far as providing transportation... my daughter and I try to jump in on everything we can, just to get her more social. (Kayla)

Kayla's daughter has tried a lot of new activities in this way. When the activities are free, it can be easier to try something out because you are not out any money if you do not like the activity. It also allows anyone who can physically access the space and meets the registration requirements to participate.

Many participants said that their families did not participate in free or low-cost sports. There were many reasons for this lack of participation. Sylvia's daughter just doesn't want to go to the activities. She said,

There's the [community centre], which is just over there. For some reason, my daughter doesn't like participating in it much. (Sylvia)

She tries to encourage her daughter to participate but doesn't want to push her. Vanessa's daughter did participate for a while in a free soccer program, but no longer meets the age requirement so she cannot continue:

She's been involved with soccer for the last couple of seasons. That was amazing, it was all free for 3 and 4-year-olds to play soccer all summer... just up the street from us at this point so it was really nice. That's the only thing I've come across that would be accessible to her because of age. (Vanessa)

Vanessa could not afford to move her daughter into the nearby soccer program for older children as the costs were too high. Laura said that her son stopped participating in swimming lessons because he was uncomfortable with his body, having recently put on some weight. Overall, many of the reasons seemed to be linked to there only being one or two activities within a specific age group to choose from. When families can pay for leisure activities and have access to transportation, the variety of sports to choose from can seem endless. When there are only one or two low-cost activities that are run by volunteers and not as well-funded as paid sports, it can be harder to find something that children are interested in doing.

Coordinating Activities as Work

Institutional Ethnography investigates the time and effort that go into everyday activities as a way of studying work. Dorothy Smith (1999,) uses a generalized notion of work, which she describes as “anything done by people that takes time and effort, that they mean to do, that is done under definite conditions... and that they have to think about” (p.152). The amount of effort required by mothers for children to participate in sports and leisure activities was unanimously described as a barrier by my participants.

Coordinating schedules and activities is a type of work that is often not thought of as work, or even really considered at all (Smith, 1999). Participants described difficulties around this work, including scheduling meals and bedtimes around activities, parenting their other children during activities for one child, and accessing programs and services that help pay for sports. Every participant described just how hectic evenings can be when they have activities to coordinate. After driving home from work, picking kids up from daycare, and cooking dinner it can be a rush to get to their activities, and even when the activities end relatively early, they can interfere with bedtime routines. Sara described what an evening with soccer can be like for her family:

[The nearest town] is only a fifteen-minute drive away, but when soccer ends at 7:15, it wraps up at 7:30, by the time we get home, shower, bathe, they aren't in bed until 9 or later... So, it cuts into the next day, and they're cranky and tired because they haven't gotten enough sleep. (Sara)

This schedule can be impossible for one person to coordinate, particularly when they have more than one child, or if they have to be up the next morning for work, school, or daycare.

Even for activities that are not organized sports, a quick trip to the park can take a lot longer than expected, especially if they have to pack up a diaper bag and snacks, prepare children for the weather conditions (sunscreen, hat and mittens, etc.) and do not have transportation to get there. Sara explains,

If we want to walk to the park, it's a 20-minute walk... So if you want to go for half an hour, it's turned into an hour and a half excursion to go. And sometimes you don't have that hour and a half so there are a lot of times that we would love to take them to the park, but we don't. (Sara)

Sara's description of the time it takes to get to a park shows that even unorganized activities can take time and may need to be scheduled in.

Mothers with more than one child mentioned that it can be difficult to keep the other kids occupied while at activities for one child. Emily has four young children and finds it difficult to keep the youngest kids occupied while she is at practices for the older ones. She said

...it ends up being a pain in the butt to pack up all the kids and drive them to go do something for an hour and the other ones watch. (Emily)

Some sports facilities have nearby playgrounds or an extra field for the younger siblings, but it can be a lot of work to keep a toddler or preschooler occupied and off the sports field during a game. The time and effort required to coordinate activities can be a strain for single mothers and provide barriers to activities even when they can afford to put children into programs. However, they all described this work as being necessary and not a deterrent to enrolling their child.

Costs as a Barrier

All the women I interviewed described the cost of sports and leisure activities as a barrier to participation. Costs included registration fees, equipment, transportation, and sometimes even travel. Stacy felt that her children were missing out on experiences beyond just the health benefits of sports:

I wish I could afford for them to know what it is to commit to a team and to be accountable to a team and that feeling of like “we did this together, we worked for it” and stuff... I wish that I could have afforded them that experience.
(Stacy)

Stacy expressed guilt for not being able to afford to enrol her children in sports, as she clearly felt it was something that she was supposed to be able to provide them. Several studies have found that lower income children are less likely to participate in sports. Sports participation is higher for children in two parent families, those whose parents have post-secondary education, those from higher income brackets, families living in suburban areas, as opposed to urban or

rural, and white children are more likely to participate in sports than children of colour (Messner, 2009).

There are many programs in place designed to help make sports more affordable for low-income families, but few of my participants accessed these programs. Many of the programs were originally designed to target urban children from low-income families, on the premise that “participation in active recreation contributes to the reduction of hooliganism and delinquency among young people” (Department of the Environment, 1975). In Canada, cuts to social programs since the 1990s have made sports less available to low-income families by promoting the privatization of leisure and downloading sports programming from national and provincial policies to individual municipalities and even neighborhood community centers (Pitter & Andrews, 1997).

Most participants knew that there were programs that could provide funding for sports but didn’t access these programs for a variety of reasons. Rachelle explained that she didn’t know how to access the programs:

I don’t find anyone tells you anything, you have to find them on your own.
And it’s very hard if you don’t know where to go to go look for this stuff.
(Rachelle)

She was already spending time trying to access services for mental health and for food, she didn’t have the energy to dedicate to looking into sports funding as well. Several participants were surprised to find that the income to qualify was even lower than their income. Lyne said,

I looked into having the kids put into the Canadian Tire Head Start program for hockey. And I wasn’t even close to their criteria in terms of my income was way too high and I was like holy jeez, and I never considered myself to have a high income by any stretch of the imagination. (Lyne)

Some families with multiple children might be able to scrape together registration fees for one child, but not for three or four kids. Stacy said,

If [my oldest child] wants to take art classes, [my middle child] would love to play soccer and [my youngest child] would love to take dance. But I can't even afford art classes. So, how do you choose between the kids? (Stacy)

Sophie was able to access funding for sports initially but was not able to maintain this funding.

She said,

She was involved in skating and swimming...I wanted to put her in skating [again this year] but jumpstart got cut in half, so before you would be able to apply for \$300 which would have covered most of it. But I only got approved for \$150 so I'm not sure how I'm going to get her in skating. (Sophie)

Sports like figure skating require skaters to come every year in order to keep improving and keep up with the other kids in terms of skills, testing and competition. Similarly, team sports can be difficult if funding is not stable, as children could lose their spot on the team or seem less dedicated than those who are able to participate every season.

The income threshold for these programs is often not actually stated and determined on a case by case basis (YMCA Sudbury, 2017). When it is stated, it varies widely, for instance, the PLAY program in Sudbury advertises a maximum income of \$26,000 for a family of three to \$40,000 for a family of six (The Human League, 2017). Many of these programs do not consider costs such as tuition, student loans, or other debts when they calculate income (The Human League, 2017; YMCA Sudbury 2018). These guidelines are sometimes based in poverty measures such as Canada's low-income cut off or low-income measure (JumpStart, 2017) but are sometimes relatively arbitrary income amounts set by charities and even by multinational corporations. The programs funded by corporations are often used as advertisements by these

companies. For instance, Tim Hortons implemented “camp day” where a small amount from each coffee sold on a specific day goes towards summer camp, leading to an additional 20,000 kids attending camp in Canada this year (Tim Hortons, 2017). Their Timbit hockey program, providing a small subsidy for each child aged four to nine enrolled in house league hockey with participating leagues (Tim Hortons 2018), is featured in many of their commercials. This benefits the companies by making them look like responsible corporate citizens and leading those who play the sport or who see the commercials to have positive associations with the company (Low & Pyun, 2016; Svyantek, 2017).

Participants also described the amount of work and planning that goes into getting approved as a barrier, since you have to find the information, sign up for sports well ahead of time so you can make it through the wait list before the season begins, obtain and complete all of the necessary forms and accompanying documentation (birth certificates, health cards, pay stubs, government income receipts, and rent receipts) and coordinate the payments from the funding organization to the sports program. Several participants discussed feelings of guilt and embarrassment associated with trying to access these programs, which was a barrier in and of itself. For instance, Karen said,

[My friend] said I should apply. And sometimes I’m kind of embarrassed but I can’t afford it. I don’t know where to go for that or anything. (Karen)

Karen did not access any funding despite having an income low enough to qualify. The instructors and/or administrators of the sports programs know which children are receiving this form of assistance, if cheques are paid directly to the sports league from the charitable organization, thereby contributing to more stigma for the child and parent.

Sylvia described having to fight with her social worker to get a membership for the YMCA approved:

It's hard to get welfare to pay for your membership. Before, they had no problem paying for a geared to income membership but now its very hard to get them because you need to explain why you need to go all the time, what benefits would be in it for you. In the end, if I had the geared to income membership, gymnastics would be free for them and swimming lessons would be free for them. It's just getting there. (Sylvia)

Even when programs to help cover the cost of sports is available, there are still barriers to participation in recreations sports and leisure activities including the work involved in participating in activities, as well as difficulties accessing funding for programs.

Free Sports Programs

I thought that school sports could provide a free alternative for some of the older kids to participate in sports, but none of my participants' children were on school sports teams. Several discussed tryouts but not making the team:

[My son] did try out for soccer. But he's the only kid in his class that didn't get chosen. And I'm like why? Why do that? If everyone in the class except one kid because he's the smallest... Just let him be on the team. It's not like they're fighting for the FIFA cup, just let the kids have fun. (Stacy)

Stacy's son has not tried out for any other sports teams since. For others, it was due to age requirements, as sports teams begin in grades 5-7 depending on the school board and many of the children whose mother I interviewed were younger. Transportation was also a barrier to participating in school sports, especially in rural areas, as there are no school buses for after school activities, and many participants do not have vehicles or access to public transportation.

Only two participants mentioned unorganized/pickup sports. One, a coach for several of her son's sports teams, described how she gets folks together and plays baseball and soccer with

her children, friends, and neighbors. Another mother described the difficulties she has trying to get her kids to participate because they are not athletic:

Even if we're all at a park with their friends and their friends break out into a game of soccer and stuff my kids will be on the sidelines watching because they're not as good. And you know kids... if they can't get it right away, they want nothing to do with it. (Stacy)

She even mentioned that it was hard for their child to make friends at school because the boys all played soccer at recess and he was not comfortable joining in. In this way, athletic abilities can be a form of social capital for school-aged kids.

Transportation as a Barrier

Many of the organized activities required transportation to arenas, fields, or other venues. About half the women I interviewed did not live on bus routes and several of them did not have a vehicle or even access to taxi services. They relied entirely on rides from friends and family to get places when they could not walk. Paula relies on taxis for transportation because there is no public transit system in her area. She said,

Like I'd like to get them registered in soccer, but the smaller fields are all the way across town and like I said, public transportation, that's the one thing that hard for me. (Paula)

Paula could cover the registration fee but had no way of getting to the sports field. Kayla, who lives in a community without public transit or taxi service, relied on her parents to drive her daughter to and from dance every week:

I did have her in ballet and that was pretty hefty because I paid I think it was \$400 and it was in [next town] once a week... about an hour and ten minutes [drive]. (Kayla)

Unfortunately, her parents were not able to continue driving every week. Natalie has a car but is often unable to drive because of her health. She said,

Everywhere I need to drive...the busses are horrible. Every hour or two. They don't run very much. (Natalie)

Difficulties with transportation was a common theme throughout interviews. Similarly, transportation is a barrier in rural areas for many different types of activities from medical appointments to grocery shopping to just going to the park. Rachelle explains,

When I had a vehicle, it was much easier to go to the park or to the beach, but since I've lost my vehicle, it's harder. I have health problems and chronic pain, so it's very hard to walk far distances... I could be gone a full day to go to a doctor's appointment. (Rachelle)

Rachelle often had to stay home because she found it too difficult to get around town without a car. Even when sports programs exist and are affordable, it can be difficult for families to access if they do not have reliable transportation.

Discussion

Moral regulation is a term used to describe the ways that state and class relations can perpetuate inequalities by holding the middle class nuclear family as standard and punishing those who do not fit into this standard (Little, 1998). Pitter and Andrews (1997) link the fitness movement of the 1970s with current ideologies around obesity to show how the "healthy body has been rendered a conspicuous symbolic expression of life-style choice, morality, and thereby status" (Pitter & Andrews, 1997). One possible explanation for this is that as previously class-exclusive goods such as televisions, computers, and cell phones are increasingly available to more and more people, middle and upper classes are "becoming more sophisticated in their

search for class distinction, especially with regards to the advancement of differing lifestyle patterns” (Pitter & Andrews, 1997)

Sports and leisure are not only governed by class in various ways, but they are also governed by things like gender, race/racialization, ability, and other social locations. Whereas participants discussed putting their daughters in a variety of sports like dance, hockey, soccer, basketball, track and field, and so on, none of the participants put their son in traditionally female sports like dance or gymnastics. The literature shows that boys get more vigorous physical activity than girls (Brockman et al., 2009; Inchley, Currie, Todd, Akhtar, & Currie, 2005; Sallis, Zakarian, Hovell, & Hofstetter, 1996), however, I did not ask parents to quantify how much activity their children did.

There is some debate over the impact of this moral regulation on individual freedom and choice during leisure time. According to Maguire (2008), “the governing of populations in a neo-liberal society relies on the governing of leisure, such that individuals enact their freedom and make choices in keeping with broader social agendas” (p. 66). While families are free to choose which sports to participate in, after considering what is available in their geographic area, price range, and schedules, parents do feel pressure to put their children in sports and to encourage them to participate in active play. While the commodification of play impacts how children play, children still actively engage in imaginative play on their own terms in a lot of ways. According to Langer (2002):

[M]arket penetration of the everyday life world of childhood ... means that the symbolic resources for children’s self-formation are increasing commercial in origin, and children’s capacity for spontaneity and creativity is exercised within a commercially constituted life world (p. 260).

This is not a one-way relationship with children merely internalizing these messages and doing only as they are told; they actively work within and even sometimes against the parameters that are set for them to play.

Conclusion

In the context of what is being called a “childhood obesity epidemic,” sports and leisure have become a defining site for consumer markets through the cost of privatized leisure activities and organizations, as well as through individual responsibility for children’s health that puts pressure on mothers to ensure their children are participating in physical activities including organized sports. When children’s bodies do not conform to dominant standards of thinness, or when it seems as though children are not performing health and physical activity sufficiently, it is the mothers who are held responsible. However, the cost of accessing these activities can be quite prohibitive for low-income families and barriers such as lack of transportation or the child’s interest in available sports can make it difficult to participate. The mothers I interviewed want their children to participate in sports and recreational activities, in part for health reasons, but described many barriers to doing so. It is not possible to perform health in the right ways all the time; to get the *correct* amount of exercise and to keep stress levels down. Thus, no matter what mothers are doing to ensure that their children are happy and healthy, there is always more they could be doing leading to feelings of inadequacy and the possibility of motherblame.

Chapter 6: Mothering, Fatness, and Foodwork

Context

This chapter was written for submission with a peer-reviewed academic journal. The exact journal is to be determined, but I was considered Fat Studies.

Introduction

In the context of what is often referred to as a childhood obesity epidemic, mothers are framed as being responsible for the food consumption, “and consequently the health of their young children now and in the future” (Wright, Maher, & Tanner, 2015, p. 422). The individual responsibility for health is evident in the number of texts such as government reports, health promotion materials, television shows, medical advice and even school curriculums, which provide advice and guidance directed towards mothers (Boero, 2007; DeVault, 1991; Gard & Wright, 2005; Herndon, 2010; Mitchinson, 2016; Wright et al., 2015). Talk shows, news reports, magazines, public health, and medical advice tend to provide information to mothers in order to make better / healthier decisions for their families (Herndon, 2010; Koch, 2009; Wright et al., 2015). In one article, Linda Quirke (2016) shows how discourses around feeding children whose bodies are categorized as obese has shifted since the 1980s from being primarily the fault of the child for eating too much to the fault of the mother for providing the *wrong* foods. While gender neutral parenting terms are often used, gender neutral language around foodwork is “problematic because it obscures the ways it is mother-targeted and mother-blaming” (Kinser, 2017, p. 29).

In this article, I focus specifically on how low-income single mothers understand, coordinate, and perform foodwork and how strongly these activities are influenced by mothers’

conceptions of children's health. The term foodwork describes "the practices that form the key food activities and exchanges between mothers and children" (Wright et al., 2015, p. 422). In her dissertation, Koch (2009) identified discourse used throughout parenting advice about groceries as the efficiency discourse, which "has historical roots in the home economics movement..., is contemporarily administered by federal institutions, ... and has filtered into media outlets such as television news shows, the internet, and women's magazines" (p. 78). This discourse provides advice to mothers regarding how to shop for and feed their children in ways that are cost-effective and good for the family's health, but often require extensive planning work for mothers. These discourses are also strongly influenced by notions of the Standard North American Family as a middle-class heterosexual couple in which the husband performs paid labour and the wife performs the majority of the household labour whether or not she works outside of the home (Smith, 2005). In this paper, I argue that the coordination, planning, and effort that goes into feeding children is experienced as work. Additionally, the stress mothers experience related to food provisioning is exasperated by ruling relations such as public health discourses linking healthy eating to "good" mothering.

Methodology

I used institutional ethnography as both a theory and a method in my research. Institutional ethnography starts from the standpoint of people in their everyday lives, and it is the job of the researcher to connect these experiences to ruling relations (Smith, 1987). I conducted interviews and guided tours of key areas impacting children's health, such as grocery stores or places children play to better understand experiences of mothering in the context of what is often

referred to as a “childhood obesity epidemic.” This research was approved by the Laurentian University Research Ethics Board.

I interviewed 20 women who self-identified as low-income single mothers throughout Northeastern Ontario in the spring and summer of 2016. I recruited participants through social media, contacting local family organizations, and by putting posters up at local grocery stores, food banks, and community centres. Interviews averaged 90 minutes but varied from 45 minutes to two and a half hours. After the interview, I asked participants to take me on a food excursion, that is, show me where they usually go to get food. While three participants brought me to their local grocery store without any signs of reluctance, many of them responded with statements like “Do we need to go inside?” and “There is actually a really cool park down the street – can I take you there instead?” After the first few interviews, I introduced this part of the research process to participants by saying “In order to connect what you are telling me to the actual community where it happens, after the interview can you take me to the place you usually go to get food or anywhere else that you think is relevant to what we talk about?” Most of the participants took me for a walk to a park, schoolyard, or just on a tour of the neighborhood. Most pointed out where grocery stores were but they did not want to go inside. Four of the neighborhood tours took place from the participants’ vehicle, but the rest were on foot, walking around the neighborhood.

Results

In this section, I use quotes from participants in order to explain how much coordination, planning, and effort goes into feeding children, which is experienced by participants as work. I begin with a discussion about what I mean when I talk about health and about work. I describe

the work and show how it is coordinated by broader ruling relations including discourses of fatness and ideas about what it means to be a good mother.

What is Health?

Health can be a very difficult thing to describe. When I asked what “healthy child” meant, the most common response was related to food. It was very clear in my interviews that every participant associated food with overall health. For instance, Kimberly said that when she thinks of a healthy child, “automatically I think of food, so that they have good meals, balanced meals.” One participant mentioned that her 3-year-old daughter already had an understanding of health as being related to certain foods. She said,

Her go-to seems to be about food. Her dad really preaches about not eating out at fast food restaurants and all that kind of stuff... so when I try and take her to McDonalds for a treat she said things like “I can’t, it isn’t good for me, it will make me fat.” (Vanessa)

For her, food not being good for her and making her fat were the same thing. In the context of what is being called a childhood obesity epidemic, mothering anxiety and fatness are often linked; “the weight of one’s children has increasingly become a litmus test of good mothering” (Boero, 2007, p. 113). For example, Amanda explicitly made the connection between health, food, and parenting stress:

But we don’t eat a lot of processed food, and you can hear my mothering anxiety coming out because my kid is fat... So, my kid’s body has become this location for control and a power struggle. And he’s just some kid who wants to eat Doritos and go to Tim Hortons maybe and get treats. (Amanda)

Although intellectually, Amanda knew that she was not responsible for her child’s body size, and even that her son was very healthy and his body was fine the way it was, she still felt pressure and stigma for having a child whose body was classified as overweight. During the interviews,

some of the participants accepted the mother-blame discourses. When I asked what she thought about childhood obesity. Emily said,

You are in charge of what is in your kitchen, you are in charge of what's in your cupboards. And the kids, when they're young, they aren't really eating anywhere else, so you should be able to get a handle on that. (Emily)

Emily's comment is a logical conclusion to come to based on the obesity discourses in the media, public health, and even medicine. Similarly, the literature suggests that mothers primarily use the strategies of eliminating certain foods and limiting others to try and help control their children's body weight, even though the strategy is well known to be ineffective for weight loss in children (Soto, 2015).

I wanted to find out more about how participants categorized foods as healthy or not healthy and where they got this information. In Koch's research on grocery shopping, she asked participants where they got information pertaining to food and health in the context of shopping. Many of her participants stated that it was just common sense. However, when pressed, "they suggested that they did get some information on shopping from the morning talk shows and news shows, women's magazines, and internet searches" (Koch, 2009, p. 78). Similarly, participants in my research had difficulties telling me where they learned about what foods were healthy. For instance, Emily thought that knowledge about health was just something that people generally knew:

I think most people know what's good for them and what isn't good for them. Like, I think there's been a lot of awareness since I went to school. People know what is good and what's not, they just get so stuck in bad habits. (Emily)

For Emily, people knew what was healthy but chose to eat unhealthy foods instead. Several participants talked about their parents teaching them about healthy choices. But, as Koch

described in her own interviews, when I really pressed, they also listed morning talk news shows, afternoon talk shows like Dr. Oz, social media, internet message boards, public health promotional material, books, and magazines as places they learn about food and health.

Whereas low-income mothers are “often presented as not knowing how to, or being unable to, deliver healthy food to their children” (Wright et al., 2015, p. 423), all of the participants were knowledgeable about what foods are supposed to be healthy. Much of the specific information regarding what foods were described as healthy was in line with public health discourses such as following Canada’s food guide, cooking from scratch, family meals, and avoiding “bad” foods. The consistency with which they were able to describe specific foods and habits as healthy speaks to a larger cultural, institutional knowledge regarding food and health.

Moreover, the language that participants used around unhealthy foods made it clear that there was a moral component to eating in ways that were not healthy or cost effective. For instance, Tanya, a university student and single mother of a 3-year-old, used the phrase “I’m guilty of Tim Hortons².” Note that the word *guilty* implies that purchasing food and/or coffee from this establishment is a bad thing – she explained that it was due to the cost of purchasing coffee compared to making it at home as well as the health implications of buying foods like donuts.

Foucault (1980) differentiates between what we know through experience and what we know because it is taught to us. In terms of healthy foods, my participants were largely in

agreement about what kinds of food were healthy and that these “healthy” foods are important to childhood health. However, we cannot intuitively know what is and is not healthy. When I asked Amanda what, exactly, she considers to be healthy food, she described a really important problem with conceptualizing health, being that there are always ways that you can eat healthier:

There’s no end to it. You can cut out meat and, you can be vegan, you can be raw vegan, you can be raw organic vegan, or you can be biodynamic [laughs]. Where does it end? This idea of healthy? It’s a rabbit hole of health. (Amanda)

This quote illustrates that there is really no way to eat healthy enough to move beyond the guilt of not doing a good enough job. No matter what you are actually feeding your child, you could always be doing better.

In this section, I discussed the concept of health to show that mothers had similar ideas between what is and is not healthy. I also began to link health discourses to ideas about fatness, and showed the health is something that we could all be *doing* better. In the next section, I link these health discourses with the concept of work to show that providing healthy foods for children is a lot of work for the mothers I interviewed.

What is Work?

Dorothy Smith (2005) advocates for using a generous notion of work when studying the work done by women in the home. Work, in a generous sense, refers to “anything done by people that takes time and effort, that they mean to do, that is done under definite conditions and with whatever means and tools, and that they may have to think about” (p. 151-2). Much of the work done by women in the home is invisible, as it is difficult to notice or to measure (Smith, 1987). Parts of this work can even be invisible to those who participate in it daily, as there are

gaps in the language that we have to talk about it, and it is often trivialized within dominant discourses (DeVault, 1991; DeVault, 1999; Kinser, 2017).

Mothering work is frequently understood as something that comes so naturally to women that it is seen as something that women are as opposed to something that they do (DiQuinzio, 1999). According to JaneMaree Maher (2010), “if motherhood is a state of being, then the labour women do, and the skills they employ to mother, are rendered invisible” (p. 7). Dorothy Smith (1999) advocates for making the invisible visible by investigating the work that women do everyday.

Our understandings of health have shifted from a state of being (where you are or are not healthy) to something that we do. We perform health by eating the right foods, getting the right amount of physical activity, thinking in the right (positive) ways, and avoiding activities thought to be unhealthy (such as smoking, excessive drinking, eating fast food), thus trying to be healthy is work. As health becomes understood as something that is done, it is also understood as being under the control of individual actors and largely based on decisions that they make (Campos et al., 2005; Gard & Wright, 2005; Herndon, 2010). Indeed, “mothers are led to believe that quick, cheap, healthy, and delicious food is available if they adopt particular individual tactics of shopping wise, cooking smart, and prioritizing” (Lamdin Hunter & Dey, 2016, p. 46). Mothers are thus presumed to be responsible for the health of their children largely through the food she provides for them (Beagan et al., 2008; Brenton, 2017; Maher et al., 2010). In the following sections, I describe some of the work involved in food provisioning, including planning, shopping, cooking, and eating. I show that participants experience this work as tedious and difficult, yet often invisible, labour. Then I discuss how health discourses intensify this labour.

Food Provisioning

Participants described often feeling overwhelmed by the repetitiveness and the necessity of the work involved in feeding their family. This theme came up in the literature as well, “as feeding derives from continuous, fragmented, and repetitious labour, those responsible are always on call” (Kinser & Denker, 2016, p. 13). One mother described just how much she hated the work in a humorous and interesting way:

...getting home from work and the “what am I going to make?” question. The question that makes me want to put this pen right in my eye! [laughs] I’m going to be honest and say I do devolve when I’m busy or tired or it’s hot. We will have frozen pizza. (Amanda)

Amanda used the word devolves to describe making something quick when she’s busy or tired or hot because convenience foods are not considered to be as healthy as making a meal from “scratch.” For her, making a frozen pizza is making a compromise where she chooses convenience and time over the healthiness of the foods they eat.

Other participants also described how hard it was to make meals when they are working or in school all day. Tanya enjoys cooking most of the time, but gets still overwhelmed by food provisioning work:

You go to school and then you go to work and then you come home and it’s like oh I need to cook this super healthy meal and like that takes a lot of time, it takes time, planning, effort... and if I haven’t done groceries cause I haven’t had time, I don’t have the stuff at my disposal like to make something healthy. (Tanya)

Similarly, Lyne described how hectic her evenings can be just around work and cooking, and that if meals are not quick, then mealtime gets pushed back late into the evening. She said,

I don’t really have a lot of time... I’d be working say 8:30 to 5. And in [neighboring town] if not further away from home... so by the time I would get

home at let's say 6:30, I'm in preparation for supper. Depending on what I chose to feed my kids, we may not be eating until 7:30. That puts us to quarter to 8, 8 o'clock. We're getting really close to bedtime here. (Lyne)

All of the participants described meals as stressful, time consuming, and several described it as their least favorite part of parenting. For Lyne, even thinking about foodwork was described as continuous and stressful. She said,

Meals have always been very very stressful for me. And when I'm at work, I'll dwell on it. I'll dwell on the fact that I have nothing taken out for supper, what am I going to feed my kids. (Lyne).

Even when she is away from home and not actively cooking or caring for the children, she is often thinking about it. Clearly, the participants experience food provisioning as work, yet it is so often ignored and taken for granted and not valued as work.

Almost every mother I interviewed talked about what they *knew* they should and should not do. Most of the time, it was framed as "I know I should not do this, but..." Often parents described situations where they let their children eat something that was unhealthy, but they didn't have the time, money, or energy to regulate their child's food intake more strictly. According to Wright (2015) "the most powerful effect of the medicalised discourse is the attitude of self-policing it engenders in mothers as they let it play upon their self-assessments of their own feeding practices" (p. 429).

Sometimes, participants discussed eating foods they describe as unhealthy as a coping mechanism to deal with some of the stress that they face on a day to day basis. Kimberly said,

I know it's not good, but if we're having a shitty day and we recognize the fridge is getting low, that this little added expense or something that we normally wouldn't buy kind of distracts us from how shitty life is right now. (Kimberly)

Food choices were often described as a negotiation. For Kimberly, as noted above, choosing unhealthy foods helped with stress. Participants often talked about having to negotiate between health, tastes, cost, and many other factors. According to DeVault (1991), planning a meal is like “solving a puzzle. There are special requirements stemming from individuals’ tastes and preferences, and relationships within the household, but variety is also important, so the puzzle must be solved in relatively novel ways each day” (p. 47-8).

I asked participants to go into detail about how they plan meals for their families. Flyers were important to them to save money. Sara explained,

I like flyers. So, I go through the flyers and look to see where the majority of the deals are, which is usually [grocery store in next town]. [Local grocery store] every now and then, like, we get our milk from [the local store]. (Sara)

By looking at the flyers before shopping, she could plan her weekly meals based on what was on sale, negotiating price with family food preferences. Shopping lists were also frequently used to save money and cut back to impulse spending and to save time:

I love lists, I do everything with lists. And if I don’t, I end up spending twice as much time in the store as what I mean to. (Sophie)

Participants had different ways of organizing lists, from putting a piece of paper on the fridge and writing items down as they run out, to an elaborate system of smaller lists organized by the grocery store layout, but they all said that these lists helped save time and money. Some participants described trying to follow these habits of using flyers and making lists, as described in Koch’s (2009) efficiency discourse, but struggled with it. As Tanya notes,

I’m a very sporadic person, so when I’m on that kick, I’m gonna plan my meals, I see what I need, and I try to choose things that are in a common theme, and I have a list of what I need ... So, when I’m doing that and use a list, it’s much more cost effective. (Tanya)

She would go back and forth from having things very planned out, to just trying to come up with something at the last minute. She found the well-planned out meals much more cost-effective, but the amount of work involved in that planning isn't always sustainable for her. Meal planning was thus another negotiation, where spending a little more money can save time.

Negotiating Health and Food Costs

The cost of healthy foods was described as a barrier to being healthy by all but one participant. Contrary to the stereotype that people who live in poverty prefer eating food that is not nutritious (Wright et al., 2015), participants described preferring healthy foods when they are able to access them. Sylvia said,

Fruits and vegetables, the price of them are so high. We get meat once a day and that's about it. They're supposed to be getting two portions, I feel bad, but you can afford what you can afford. (Sylvia)

Sylvia was referring to the meat requirements in the Canada Food Guide, which is what her doctor gave her to talk to her about healthy eating. Having the information about how to eat healthy is not the same as having the means to do so. Rachelle explained that she cannot afford some of the healthier foods either:

How am I supposed to feed my child healthy? She'd rather eat healthy stuff than the junk, but the junk is cheaper. You get more for cheaper so it's hard. Very hard. (Rachelle)

For Rachelle, and several other participants, there was a compromise between health and cost. This compromise was most apparent for the lowest income participants. Healthy foods were also described as more labour intensive. For instance, to have healthier foods in the house, shopping must occur more frequently. Paula said,

I found when I started eating healthier I was at the grocery store a lot more. I was like “why am I here every other day?” because you’re eating all the fresh stuff and the fresh stuff goes fast. (Paula)

Having to shop more frequently can be a challenge or barrier for participants on social welfare programs who are only paid once per month and there is not enough money to last until the next pay. Kimberly said,

I can purchase this big lot of fruits and vegetables once a month, or twice a month, but they’re not going to keep for the entire time. Those are things, like bananas, that you have to buy every few days. (Kimberly)

Like Kimberly, about half of the participants relied on social assistance, which means they were paid on the first of the month and most got a baby bonus around the 20th of the month. Their meagre social assistance allowance had to pay for three weeks to one months worth of groceries. The money would usually run out after the first week, and fresh fruits and vegetables do not last that long.

Some mothers described feeling judged by teachers about what their children ate. Several were very careful with what they put in lunches to make sure that teachers were not going to single out their child for not having a healthy enough lunch. Kimberly, whose children are both teenagers, said,

I go through their lunch and ensure they have enough to eat. In my mind, I always think if my kids not going to school with enough lunch, yes, they’re going to be hungry, but staff and teachers will also notice. They’re going to notice that kids aren’t going to school with proper food. I get worried when all they have is a sandwich and a juice box in their lunch when there’s no fruit because they’re going to notice, and I can’t provide fruits or a balanced meal. So, there is always that fear as a mom who is unable to fully provide, that someone is going to criticize, somebody’s going to say something. (Kimberly)

Kimberly’s fears are not unfounded, as around the same time this interview took place, there was a news story about a teacher taking banana bread away from a child because it was not

considered to be healthy enough for snack (Follert, 2016). Even middle-class parents often feel pressured to pack lunches in specific ways and describe feeling “on display” through their children’s lunches (Harman & Cappellini, 2015). The pressure that is put on low-income mothers is intensified, as the mothers I interviewed described feeling like they had to prove their fitness as a mother through “healthy” lunches.

Many participants discussed a difficult process of negotiating between what they considered to be healthy and what they found to be more cost-effective in terms of feeding their families. For instance, Kimberly said,

I’ll have hamburger and will make a huge roast pan size mac and cheese.
Terrible to eat, but the kids love it and it fills everybody up. (Kimberly)

Kimberly prioritized making enough food for her children to feel full over following the dietary requirements set out by healthy eating discourses. Energy-dense or filling foods can be a more cost-effective option for single mothers (White, 2007). Still, “prevailing media and political discourses obscure such economic constraints and blame mothers and parents for poor diets and for not inculcating appropriate attitudes to food and exercise” (Wright et al., 2015, p. 424).

One of my participants talked in detail about this cost/health negotiation being a systemic-level issue. When describing how she chooses between cost and health when it comes to making dinner, she described the contrast of having recently spent \$30 to make a nice salad with the cost of some prepared foods:

Why does it cost \$3 for a frozen pizza from Germany? I do have frozen pizza, I like it. But I gotta limit that stuff cause something that’s that cheap can’t be any good. (Amanda)

Note that when she said something that inexpensive cannot be good, she speaks to a larger understanding about the relationships between food, health, and costs. The mothers I interviewed shared a common understanding about what foods were considered healthy, and they each described some of the ways that they negotiate what foods to feed their children based on factors like costs and ideas about health.

Shopping as Work

Shopping was also experienced by most participants as a form of necessary work that was particularly disliked. Deciding where and when to shop was a complex process for participants, who would consider things like whether they could shop without children present, the cost of groceries at particular stores, and transportation to and from the grocery stores. Just how stressful shopping can be is made clear in the following quote by Lyne:

I really feel like it takes up my entire day – if you asked me “what did you do yesterday?” my answer is “I did groceries.” I did a number of things other than groceries but that would be my answer ... because that is by far the most stressful. I’ve actually gotten to the point where I almost feel like I’m going to pass out when I’m doing groceries. Like, I hate it. (Lyne)

Lyne described putting off groceries until there was little food left in the house because she disliked it so strongly, but that would cause added stress of not knowing what she was going to pack in her children’s lunches or what she was going to make for dinner.

Many participants described trying to shop when children were at school, when possible. Shopping experts and the advice provided within the efficiency discourse suggests that this is one of the best cost-saving strategies. According to one such expert, simply making this one change could save families between \$100 and \$400 per month (Steele 2007, as cited in Koch 2009). Weight Watchers (2007) specifically suggests that mothers “Plan grocery store forays

when the kids are at school or music lessons, or have your spouse mind them while you shop.”

This is not always possible for single mothers, especially if their children are not yet in school or they cannot afford a babysitter.

Not only is it costly to bring children to the grocery store but negotiating shopping with children present can be a lot of work. Karen described how she tries to coordinate shopping with three young children:

I do have the three boys and they're a handful, so I either go [to the grocery store] on my lunch but on my lunch I want to exercise, so what do I do? I bring them with me and they drive me crazy so I just get a couple of things and then leave and then hope the next day I can get more. (Karen)

Karen said that if she goes without her children, she can do all of her shopping for the week but if she brings them with her, she can be at the store as many as five times a week. Only one of my participants regularly brought her children to the grocery store with her, the others found creative ways to avoid doing so, like planning shopping trips when children were at school or daycare, even if that meant going on their lunch break at work, or by sharing childcare responsibilities with friends and neighbors.

Part of the work involved in shopping included traveling to and from grocery stores. Every participant discussed the price differences between various grocery stores, which was not something that I asked about or something that I expected to come up frequently. When I asked where they shopped, all participants discussed shopping at a budget grocery store primarily, except for specific items, such as foods required for Indian meals for an immigrant participant, and those required for vegan foods for another participant. Karen had a humorous example about shopping at budget stores when most of her married friends do not. She said,

I joke around with my friends, most of my friends are more well off, they're all married, they have good jobs. I say, "I'm going where the poor people go," I'm just joking, but at the same time, they wouldn't shop there. (Karen)

That Karen thinks her friends would not shop at a budget grocery store really points to the stigma of having a low income (or wanting to save money on food).

Hetal, a recent immigrant from India, discussed having to drive across town to do groceries in order to get the types of food that she and her family were accustomed to eating. She said,

Grocery stores often don't have the international foods for Indian cooking, so we go to the store across town to get a few items. (Hetal)

The store she had to drive to was a half hour drive away, while there were two grocery stores within walking distance from her house. It was also considerably more expensive, so she often shopped at several stores when she had the time to do so or would send her oldest child to the close grocery store for a few less expensive items.

Some participants had to shop at the more expensive grocery stores for transportation reasons. I noticed that several participants lived within walking distance from an expensive grocery store but several kilometers or more from a budget store. I calculated the distance to grocery stores for participants, and found that on average, budget grocery stores were twice as far as expensive grocery stores from participants' homes (6.5km vs 3.5km). The increased distance to lower cost grocery stores was most prominent for participants who lived in small urban communities (1.2km vs 7.8km). While this is far from a statistical analysis of distance to grocery stores by cost, it does show that for the participants in this study without access to a reliable vehicle, getting to a budget grocery store may not be feasible.

All of the participants from rural areas described driving or getting rides into town for less expensive groceries, even if that meant taking more time or spending more money on gas. Lyne would use the local grocery store for a few items, but would do the majority of her groceries in the city at a budget store:

Often, I would just stop at the grocery store in [small town] I'm not going to do a full grocery there because it's ridiculously expensive. Like, I may as well go to the gas station. (Lyne)

For Lyne, the local store was more convenient for small purchases, but the convenience was not worth the added expense if she needed more than a couple items. Several participants did not like the budget store's quality of food, especially for produce. Adrienne explains,

We have a Food Basics and I tried going there but I have to throw out half the food. It goes bad in a few days or it has already expired. It just seems like it's a waste. (Adrienne)

The lower cost was not worth it for her because the food did not last as long, thus costing more in the long run.

All participants who had a vehicle went to multiple grocery stores a week to save money. However, several participants relied on public transit and others lived in areas without public transit or even taxi service. Rachelle explained how she uses public transit to do groceries:

I have taken the bus, I just find it really hard doing groceries on a bus. So, what I'll do is bus it there and cab it back depending on my money. (Rachelle)

For Rachelle, the added expense for a taxi home was worth not having to walk to and from bus stops with bags of groceries. One participant, who didn't have a car, described just how difficult it can be to live 50kms away from a grocery store:

When [daughter] was drinking milk in a bottle still, there was no milk at any of the convenience stores around here. It's -25 outside, [daughter] needs milk... Now I need to find a ride to [nearest town] and it's like pulling teeth with

certain people and you're just constantly asking and being so reliant on other people. I literally broke down; this place is not for me. (Kayla)

Kayla has since moved to an urban centre where she can access public transit and she has enrolled in post-secondary. For her, the convenience of being able to feel independent through the use of public transit, and the possibility of financial independence after graduation, was worth living further from her family. The above quotes illustrate how choosing which grocery store to shop at is a complex negotiation between cost, convenience, transportation options, food quality, and more.

Grocery stores are not the only place that participants go to get food. A few mentioned farmer's markets, but most could not afford to shop there. Several participants described accessing the food bank to help provide more food for their families, however there were barriers to doing so including distance, policies about how often they can access food, and stigma. Lyne considered using the foodbank at one point but didn't want to go if she might be seen by someone she knew. She said,

I was talking about going to the food bank. And I was going to look it up online, how it worked – because if it was a big piece of paper that I had to give someone saying, “please give this person \$150 of groceries, love the food bank” there was no way I was going to do that at that point. Or, if it was like the front of a busy street, right on the main drag of Lasalle or whatever, with a big Food Bank sign – you know what I mean, I didn't want to do that either. (Lyne)

Lyne decided not to go to the foodbank because of her anxiety over people knowing that she needed help providing food. Rachelle described a feeling of guilt because others might need the food more than she does - this was a single mother raising a daughter on a disability pension of \$800 per month:

I just feel ashamed when I go there. Or guilty. Because I know there's people that go there that have a lot less than I do and I feel like I'm taking away from them. But, in the other sense, I feel guilty for going there because I don't want my daughter to know because when I grew up I knew, and it just made me feel less than – because I know I was poor. (Rachelle)

Self-reliance is so valued in a neoliberal society that needing assistance from a food bank made participants like Rachelle feel ashamed. Kimberly described really positive experiences with a foodbank at a local Aboriginal Friendship Centre:

My son especially loves wild meat. So, moose meat, deer meat, fish. That sort of stuff that we had back home and more access to on the reserve. We don't have it in urban areas. But by keeping involved and staying involved in these organizations, you come to find out that there is a wild meat food bank. (Kimberly)

Kimberly's experience with the food bank that connected to her culture was much more positive than women described at mainstream foodbanks.

Several participants also discussed the quality of foods that are usually available at foodbanks. Most foodbanks relied on canned goods and foods that had a long shelf life. Few of the foodbanks accessed by participants had meat or fresh fruits and vegetables. As Natalie explained,

They'd give you a big bag of food and it lasted maybe one or two days, and they say it's supposed to last a week, but it doesn't last. And there's no meat or cheese or anything like that. It's all processed (Natalie).

For Natalie, it was hard to make healthy meals when the food from the foodbank was processed and high in sodium. Some participants knew from experience exactly which food banks to go to at which days/times to get the most desirable foods and would go out of their way to do so.

Sylvia had a lot of knowledge about which foodbanks in her area were best and even on which days. She said,

I've gotten chicken legs from [foodbank 1] before. I've gotten ham pieces. which is great, that's helped, but when you go to [foodbank 2] you get more the baked goods that Walmart pushed off the shelves cause they couldn't sell them. So, you get donuts and cupcakes and stuff like that. (Sylvia)

Sylvia will walk 45 minutes to go to the foodbank with better food instead of going to the one close to her home. As the quotes above indicate, grocery shopping requires a lot of thinking and planning, coordination, and is experienced as work. For low income single mothers, specific challenges include negotiations between the costs, perceived health value, how filling the food is, how long it will last, transportation and physical access to stores.

Cooking as Work

Cooking was described as a difficult chore for many of the mothers I interviewed. Even those that liked to cook more generally found it stressful to be the only person responsible to make food for their child every day. As Tanya shared,

I love food I love to cook and honestly the biggest like the biggest thing that gets in the way of me cooking great healthy food is like mental health and lack of motivation and just plain exhaustion, being tired and like it sucks that that's what it is.

Like Tanya, participants often described being too tired to do the types of foodwork that they would ideally like to be able to do. Stacy said,

And being a single parent. I'm tired 90% of the time. And I know that's a poor excuse, and I'm aware of it, but sometimes it's just like guess what guys, we're having cereal. Mommy is too tired. I didn't get home on time; can we just have cereal or toast for supper. And it's not ideal, but that's my reality. (Stacy)

For Stacy, eating simple foods that are not typically considered to be healthy dinner foods helped with the stress and exhaustion she experienced.

Participants described ways of making food stretch for multiple meals, which saved on costs and was sometimes, but not always, less work. Laura said,

It's great if a meal can last a couple days. Like, if I make a meatloaf or whatever, if I can get two days out of a meal, I'm happy. Especially if they both like it. (Laura)

For Laura, stretching meals usually involves eating the leftovers the next day. For Kimberly, making food stretch multiple meals is a complicated process involving splitting packages of food to cook several dishes. She gave a specific example of making a pack of chicken last several meals:

This chicken maybe has 6 chicken breasts in it. Well, there's 3 of us so I can use 3 of these as a meal. And I can use 2 for chicken noodle soup or chicken stew. So, it's constantly looking at that pack of meat and if it's big enough I can get one meal out of it. (Kimberly)

Splitting a pack of meat into multiple meals means that the family can eat meat more often without spending more money, but it takes planning and effort.

Cooking "from scratch," meaning buying basic ingredients rather than purchasing items that are already assembled or pre-mixed for convenience, was described as important. This method of cooking was described as time consuming but seen as more cost-effective and healthier than buying packaged food and is a main component of the efficiency discourse (Koch 2009). Several participants discussed this at length, Lyne said,

Doing things homemade and from scratch is really really big for me. I try as much as possible - and I mean, you have to take this with a grain of salt, I do have boxes of Kraft Dinner in my cupboard and I do have ravioli that I send to school with the kids for lunches. But, generally speaking, I make homemade soups, homemade sauces, homemade pancakes. (Lyne)

Lyne even made maple syrup on her stovetop using sap from the maple trees in her backyard. In the literature, we can see a recent shift towards the valorization of "healthy home-cooked meals

prepared from scratch” (Parsons, 2015, p. 51). The narrative of home cooked meals was described as involving “a distancing from convenience/ready meals” (Parsons, 2015, p. 27).

These themes came through in my interviews, where home-cooked meals were often discussed in opposition to convenience foods.

I asked participants with older children how much their children helped in the kitchen. Several described how their children help with food preparation or with making their own lunches. However, this was not described as reducing the amount of work done by mothers, but sometimes increasing work and stress levels, as Stacy explains,

So, [my oldest child] is like “I want to make my own lunch” but I sometimes have anxiety about how much mess I will have left to clean up, because she cleans up, but it is not as clean as it should be. And what if she uses something that I need for my vegan recipe and then it is gone, and I can’t afford to buy more. So, I have to relinquish some control. Because I’ve always made their lunches for them because it is easier emotionally and mentally for me just to do it. (Stacy)

For Stacy, doing the work of packing lunches herself is less stressful. Studies on women’s role in food preparation for families have found that even when there is a spouse in the home, women continue to do the majority of the foodwork (Beagan et al., 2008). Many of the reasons why mirror Stacy’s quote, as wives and mothers often say that it is easier to do it themselves than to delegate the work to other people in the household (Beagan et al., 2008).

Eating

Throughout the interviews, mothers talked about putting their children’s food preferences ahead of their own and sometimes even prepared two meals if they knew their children would not eat what they wanted to eat. Catering to children's likes and dislikes takes work. As Laura explains,

I want to make shepherd's pie. My daughter doesn't like it, my son does. So, what do I give her? I don't want her just eating cereal or Mr. Noodles because noodles to me just aren't that great. (Laura)

Laura would sometimes make a separate meal to make sure both of the kids were eating what she considered to be good food. Stacy described how she makes herself vegan meals, but has to make a separate dinner for her three children:

I'm making basically two different meals. And I know I shouldn't, but I always have... I need to provide food because that's the law [laughs]. And I know people are like "no, you make their food and they go hungry" ... but she would never eat if I forced her to eat my food. (Stacy)

Making two meals per night is more work for Stacy and is something that she felt was frowned upon by others. However, it was a compromise that she makes so she can continue to eat a vegan diet, which she feels is important for her health and for her political opinions around animal rights.

Mothers often described going without food or eating less, so their kids could get more of the healthiest foods. Sylvia, who was pregnant with her fourth child, explained why she doesn't eat meat everyday:

I'll go without before the kids do...I have gone days without eating myself because there was no food in the house or nibbling on crackers or you know... I know I'm growing one in me, but they're alive right now, they're right there and they need those types of things. You can tell when they don't get it. (Sylvia)

She went on to describe health issues that she has from not eating, including a serious bowel disorder. The amount of sacrifice that participants made for their kids was sometimes shocking, including staying in abusive relationships because there was food in the house:

I had food in the house. Even though he was beating me, I had food all the time. And looking back, now that I have someone who cares who is around all

the time it's like wow, I didn't have to go through all those beats to get the food for the kids. (Sylvia)

Clearly, having healthy foods available for her children is a priority for Sylvia, as well as the other mothers in my study, but there were many barriers to providing the types and quantity of food that the mothers would call a healthy diet.

Foodwork is often thought of as stopping when the food hits the table, but for mothers with young children, the act of feeding/eating can be experienced as work. Many participants stressed the importance of family meals. Family meal discourses are seen throughout the media, public health, and other expert advice, as being beneficial to children and families. According to Kinser (2017), who studied family meal discourses, “few phenomena of this century have been more lauded as a social curative, or more lamented as a lost art, than the family meal” (p. 11). Many participants discussed eating together. I visited Adrienne at dinner time and even though I didn't mention it, she explained to me why her kids were eating in front of the television:

But suppers are always at the table. And they try to fight me on that one, but tonight is a very special situation that they get to eat in the living room.
(Adrienne)

Adrienne was justifying what she thought was an unhealthy eating behavior to make sure I knew that she usually didn't let the kids eat in front of the television. The special situation, in this case, was that they needed to be distracted for us to do the interview.

Conclusion

In this article, I have used interviews with low-income single mothers in Northeastern Ontario to show some of the ways that childhood obesity discourses impact the foodwork that mothers do in the home. In the context of what the media refers to as a childhood obesity

epidemic, fatness is framed as an individual failing and mothers are framed as responsible for their children's health through food choices and food provisioning. When children's bodies did not conform to standards of thinness, it was mothers who felt that they were held responsible for the shape of their children's bodies regardless of how they were actually parenting. The mothers I interviewed all described a large amount of thinking, planning, and effort around food provisioning, and several described it as one of the most stressful parts of being a mother. Mothers described this work as intensive, regulative, and stressful. They also all described feelings of guilt and shame when they were not able to follow these health behaviors perfectly, even when there were only small variations. However, a key characteristic of health discourses is that we can always eat healthier. As such, health is something that can never truly be attained.

Much of what participants said fell in line with discourses around good mothering that indicate that they understand and have often internalized dominant discourses around food, fatness, and health. Even when participants rejected these discourses, their narratives were still framed by them. According to Reimer and Sahagian (2015), "we live in a culture where mother-blame is omni-present" (p. 1). Since the 1980s, mothers are increasingly expected to develop professional-level skills such as "therapist, pediatrician, consumer product inspector, and teacher" (Douglas & Michaels, 2006, p. 620). They are also increasingly expected to be nutritionist and chef.

Chapter 7: Discussion and Conclusions

The purpose of this dissertation was to explore the impact of childhood obesity discourses on the unpaid mothering work done by low-income single mothers residing in Northeastern Ontario. In this final chapter, I integrate main points from the previous chapters of this dissertation to explore the overlapping themes and the interconnections between obesity discourses, government policies, and the mothering work involved in negotiating children's play, participation in sports, and foodwork.

Dominant discourses around fatness position fat bodies as unhealthy, problematic, and even as a threat to society (Barnett, n.d.; Beausoleil & Ward, 2009; Boero, 2007; Gard & Wright, 2005; Harrison, 2012). Fatness is considered to be something that can be controlled through hard work and self-discipline (Evans, 2006b; Giovanelli & Ostertag, 2009; Miller, 1999). Since reproductive labor is primarily done by women (Smith, 1999; Waring, 1999), mothers become responsible not only for children's health, but for the shape of their bodies (Beagan et al., 2008; Gard & Wright, 2005; Mitchinson, 2016). When bodies or behaviors deviate from socially prescribed health behaviors, mothers are blamed for this deviation. Throughout the previous chapters, I have repeatedly shown that there are many barriers to following these socially prescribed health behaviors, and that the standard for perfect health has become unachievable, particularly for people in historically marginalized groups, such as low-income single mothers.

My research questions were as follows:

1. How do single mothers who live in poverty in Northeastern Ontario define good health for their children? What role do considerations of obesity play in their definition of good health?

2. What are the implications of participants understanding of health on their domestic and reproductive labour?
3. How are these experiences mediated by the families' social location?

I used institutional ethnography (IE) as a theory and a method for this research. The goal of IE research is to work with people from historically marginalized and oppressed groups in order to understand their everyday lived experiences (Smith, 1987, 1999, 2005). The researcher begins at the standpoint of individuals and connects their experiences to the broader social relations in which they are shaped (Billo & Mountz, 2015; Campbell & Gregor, 2004; Smith, 2005). The term 'institution' refers to the complexity and coordination of these ruling relations (Smith, 1987). There is some literature already about how institutions such as government bodies, schools, medical experts, public health, and the media (to name a few) contribute to discourses positioning fat bodies as unhealthy and even as a threat to society (Alexander & Coveney, 2013; Bell et al., 2009; Dahl, Andrews, & Clancy, 2014; Ellison et al., 2016; Evans, 2006b; Gard, 2011; Harrison, 2012; Mason, 2016; McPhail, 2013; Parsons, 2015; Quirke, 2016). If these institutions are made up of social relations, or activities that take place between people, that means that they can also be changed by people (Frampton et al., 2006).

The implications of ruling relations on people's everyday lived experience can be hard to see. In her dissertation, Koch (2009) uses institutional ethnography to link shopping work done primarily by women to what she terms the "efficiency discourse" and the "nutrition discourse." She links these discourses back to the home economics profession wielded by nutritionists, dieticians, educators, government agencies, the food industry, and media publications (p. 136). Through text-based discourses such as policy documents, advertisements, and school

curriculum, these ruling relations instruct people to regulate their behaviors in specific ways, such as by exercising and eating “healthy” without addressing the evidence that does not support this discourse (Boero, 2007; Giovanelli & Ostertag, 2009; Greenberg & Worrell, 2005; Harrison, 2012; Koch, 2009; Saguy & Gruys, 2010). Another aspect that is often hidden is how much these institutions rely on unpaid labour to maintain the status quo; without the unpaid domestic and reproductive labour performed by women, corporate and government relations as we know them could not continue to exist (Hartmann, 1979; Koch, 2009; Smith, 2005). In this dissertation, I have connected these discourses back to people’s everyday lives, showing the impact that this understanding of fatness and health has on one group of marginalized women; low income single mothers living in Northeastern Ontario.

Summary of Findings

In Chapter 3, I conducted a textual analysis examining government policies related to childhood obesity. There was a shift in how policies defined obesity from fatness as a complex issue that can be a health problem (WHO, 2000) to a simple fatness as inherently unhealthy, deviant, and even a threat to society (Healthy Kids Panel, 2013; Standing Committee on Health, 2008). I used Foucault’s (1977, 1980) theorizing on power and Margaret Little’s (1998) work on moral regulation to show how health behaviors are now understood as a moral imperative that must be performed by mothers, regardless of the barriers to doing so or the quality of the data linking fatness and health. In my interviews, mothers often had similar ideas about fatness and health as indicated in the new policies. Most of my participants accepted to some extent the common-sense discourse of fatness as unhealthy and undesirable for their child. Sometimes they questioned and even rejected this discourse, but even those who rejected the discourse framed

much of the conversations we had around it. These discourses were ever-present, exerting pressures and stresses on the lives of the single mothers I interviewed.

Chapter 4 focused on children's unstructured play. Although I did not anticipate this topic to be a primary focus in my research, every participant brought it up repeatedly and most brought me to places their children play on our neighborhood tour. The mothers I spoke to were quite descriptive about the places their children play and the factors that influenced how they negotiated the spaces where their children played, as well as the amount of thought and effort they put into their children's play. Geography was an important factor in this negotiation, as mothers in rural areas described the natural and built environment as a barrier to play and discussed the people around them as protective factors. Urban mothers were more likely to describe neighborhood crime and fear of the people around them as barriers to play. Many of my participants described feeling anxiety around children's play; they felt judged by others for letting their children play unsupervised, or they felt guilty for not taking their children outside to play often enough. Mothers largely knew that play was an important part of childhood but felt anxiety about how to negotiate how and where their children played. Play has increasingly shifted from something that children did on their own to another task that mothers had to coordinate and supervise.

Accordingly, in Chapter 5, I wrote about children's access to sports and structured recreational activities. Participating in sports and organized leisure activities is described as an important way to "combat" childhood obesity (Healthy Kids Panel, 2013; Messner, 2009; Standing Committee on Health, 2008; Wilson, 2002). Participation in sports was described by my participants as expensive, time consuming, and difficult to access in terms of transportation

and coordination requirements, even when there were programs available to help with costs. Mothers with more than one child described these barriers as particularly difficult to navigate and would often refrain from putting children in sports entirely if they could only afford it for one child and not all of them. Still, participating in sports was described as a moral obligation, teaching children skills that would help them throughout their lives such as discipline and teamwork. There is a body of literature on the importance of sports for society, teaching children proper citizenship (Couture, 2015; Maguire, 2008; White et al., 1995). While I thought that free sports or school activities might offer some access to low-income families, that was largely not the case. Many of the free sports programs were not on bus routes and school sports teams held tryouts resulting in more access for children who are already athletically inclined from participating in other sports. While sports were described as a main component of health, they were also seen as difficult or even impossible to access for many of my participants.

Lastly, in Chapter 6, I discussed the role of food and foodwork in relation to childhood obesity discourses. All my participants talked about the importance of food when it comes to being healthy, and all of them described significant barriers to being able to access the types of foods that they consider to be healthy. These barriers included costs, travel to and from stores, finding the time and energy to acquire, prepare, cook, and even to eat the food. One theme that was very clear in this analysis, was that food provisioning was experienced by participants as time consuming, stressful, and necessary work. Several participants described foodwork as one of their most disliked or dreaded tasks involved in maintaining the household. They described in detail many strategies for stretching food to last longer, saving money at the grocery store, or trying to make food as healthy and inexpensive as possible. The links between good mothering

and nutritional foods were captured in every interview, as were feelings of guilt and inadequacy when meals did not measure up to what they felt they should be providing.

Overall Findings

In this research, I tried to avoid using language that aligned with obesity discourses. However, our language is so embedded in discourses of fatness as inherently problematic and unhealthy, that it was hard to escape this language. In this dissertation, I often use the phrases “fat bodies” “fatness” or “bodies categorized as obese” when describing larger bodies. When someone uses the word “fat” to describe other people, it is typically seen as an insult. It is hard to talk about larger bodies in a way that is descriptive and not judgemental, never mind with acceptance. Public health has been moving towards the language person/people *with* obesity (Obesity Action Coalition, n.d.). This is called person-first language and does little to destigmatize fatness. Instead, it positions the person as separate from their fat body. Critical Fat Studies aims to take back the word fat as a descriptor (Rothblum, 2012) but most people are not yet familiar with this usage of the word.

Thus, to address this challenge of using non-stigmatizing language, the recruitment poster positioned the topic as “healthy kids” and mentioned a food excursion. I intentionally avoided words like obesity or bodies, and I avoided connecting health to children’s play and food. In my consent form, I mentioned that I wanted to explore participants’ understanding about the connections between childhood obesity and health in the context of government policies and media articles about obesity. The first question I asked the participants, after obtaining information about the number and age of children, was “What does children’s health mean to

you?” Again, I did not specifically ask about food or physical activities; those connections were made by participants.

All of the participants could point to ways that health problems could cause some bodies to have more fat than others, such as thyroid problems, or how some larger children can be very healthy and active, but many would then go back to referring to fatness as a problem. Even after describing health issues as a cause of the weight they saw as excessive on their own bodies or talking about a child who lives nearby or plays sports with their child who is “obese but healthy and active,” many of my participants would continue to describe individual reasons as the main cause of fatness. I believe this reflects just how embedded these discourses are into people’s ideas about health and fatness.

If fatness is seen as inherently bad, then it is important to prevent fatness. There is a rich body of literature about the connections between neoliberalism and health. For instance, understandings of health have shifted from something that people have (you are healthy or not healthy) to something one does (Campos et al., 2005). We perform health by eating specific foods, getting the *right* amount of physical activity, and avoiding things that are said to be unhealthy like smoking, “junk” foods, or stress.

Mother blame was a common theme in all my chapters. When children's bodies did not conform to standards of thinness or when children appear to be doing things that are not considered to be healthy, mothers are held responsible. For instance, in Chapter 3, I showed that in policy documents and in the words of participants, childhood obesity can be controlled through food and exercise, despite overwhelming evidence that dieting does not work. In Chapter 4 and 5, parents described being worried that their children were missing important life

lessons by not being on a sports team. And in Chapter 6, parents discussed barriers to providing healthy food for their own kids while, at the same time, saying that other parents should be more careful about what children eat. The literature describes how food has become an “equation to be solved: grams of fat, sugar, carbohydrates, plus calories equal the right food” (Koch, 2009, p. 137). They experience these feelings of blame from themselves, from other mothers, teachers, family, and society more generally.

All the mothers I interviewed discussed behaviors they say that they should be doing but are not for a variety of reasons. For instance, several wanted to provide fresh fruit for their children everyday but can't because they only get paid once or twice per month and the amount is not enough to last until the next pay. They clearly understand the nuanced individual and, in many cases, even the structural factors influencing their access to healthy behaviors.

They also describe feeling large amounts of guilt for not being able to follow these health behaviors perfectly, even when there is only a small variation. The literature supports this with many articles describing the anxiety and guilt mothers experience while trying to abide by the nutrition discourse (Beagan et al., 2008; Brenton, 2017; Kinser, 2017; Kinser & Denker, 2016; Koch, 2009; Mitchinson, 2016; Pasche Guignard & Cassidy, 2016; Petersen et al., 2014; Wright et al., 2015). However, it is not possible to always follow the food guide, always get the recommended amount of exercise, and always keep stress levels low enough for optimum health, especially when one lives in poverty. Furthermore, following all of the prescribed behaviors does not guarantee good health outcomes. Still, one of the key characteristics of these health discourses is that they are not attainable; you can always eat healthier.

The experiences described by mothers all connect back to ruling relations, which organize our everyday lives in ways that are often invisible to us. Koch (2009) explains that they do this in ways that meet the needs of the institution, rather than the individual. For instance, grocery stores do not organize and sell foods in ways that are meant to benefit individuals and communities as much as possible, but to maximize their own profits. While this is easiest to see in for-profit corporations, the concept that ruling relations strive to maintain dominant power relations is key to institutional ethnography (Smith, 1987, 2005). Even non-profit organizations and government offices operate in ways that tend to replicate and reinforce the status quo. In the context of what is being called the childhood obesity epidemic, programs and policies intended to improve health replicate harmful discourses by focusing on individual-level solutions, reinforcing individual blame and stigmatizing people with fat bodies. The focus on individual-level solutions happens for a variety of reasons with cost being a primary one. As discussed in Chapter 3, reinforcing neoliberal ideas about individual blame allows for increased privatization and less funding, thus saving the government money through cuts to services. There are estimates that Canadians spent approximately \$10 billion on sporting goods in the year ending June 2015 (CSGA, 2015), and increasing discourses around sports participation as a necessary part of childhood is helping corporations. There are many other reasons for perpetuating these discourses that go beyond the scope of this dissertation, but governments and corporations are benefiting from them.

Even if we were to accept that fatness is harmful to health, a statement which is widely believed but not necessarily supported by research evidence, we need to change the way we talk about children's bodies to end fat stigma. The evidence consistently shows that children and

youth who are bullied about their weight are less healthy than those who are not bullied and gain less weight than peers who are not bullied regardless of the actual weight of the child or youth being bullied. It is quite clear that stress, stigma, and bullying is bad for children's health (Bromfield, 2009; Haines, Neumark-Sztainer, Eisenberg, & Hannan, 2006; Neumark-Sztainer, 2009; Neumark-Sztainer et al., 2002; Neumark-Sztainer, Story, & Faibisch, 1998; Puhl & Brownell, 2006).

Research also consistently finds that many of the health disparities between children of different weights disappear when you control for socioeconomic variables such as family income and education levels (Bacon & Aphramor, 2011). Others have found stronger relationships between poverty, marginalization and health than between health and body size (Brunner & Marmot, 2006; McDermott, 1998; Raphael et al., 2010; Wamala et al., 1999). The research suggests that dealing with childhood poverty may be an effective way to lower the burden of disease that is being attributed to weight.

Limitations

Positivist research methods concern themselves with various types of criteria for judging the quality of research such as objectivity, validity, and reliability (Patton, 2001). Institutional Ethnographic research, like much of qualitative research, uses various other criteria to think about the quality of the data. Some of the criteria that is used in qualitative research include reflexivity, trustworthiness, authenticity, praxis, and contributions to dialogue (Patton, 2001, p. 544).

Reflexivity was important to me in this research. I clarified my position on this research topic from the beginning of my research project. My first reading of the transcripts was a

reflexive reading, where I aimed to look at some of the ways that I influenced participant's responses. I also journaled throughout the research process. I tried to include quotes throughout my work to let the participants voices speak for themselves, providing thick, rich descriptions and checking back with participants about the quotes and themes. I also tried to connect these experiences back to the ruling relations in which they are situated. There are times where I write about how participants' voices upheld dominant discourses around health and children's bodies which was sometimes difficult to write. The women that I spoke to throughout this research were all doing the best they could to give their children everything that they needed and that showed throughout the research process. I hope that they would not be upset by the ways that I contextualized the quotes.

I used interviews and geographic methods to gather data and compared the data I gathered from participants to each other to find common themes and narratives. I met with my supervisors to discuss my findings regularly and in detail, and I checked back with participants if anything that they said was unclear. I presented preliminary findings at conferences with various themes and backgrounds, including critical fat studies, sociology, health research, and nutritionists to obtain feedback from a variety of perspectives.

Praxis is the "merging or bringing together of theory and practice" (Frampton et al., 2006, p. 35). Praxis involves a circular relationship where theory informs practice and practice contributes back to theory. It is not uncommon for research to take place, and the researcher to publish findings and move on to the next project – until fairly recently funding often did not involve requirements for giving back to participants or attempting to use the findings for change. I have tried to encompass the idea of praxis into my everyday life while working on this

dissertation. Some examples of how I did this are listening to people's everyday experiences through my interviews and through podcasts, books, and even social media posts, trying to understand the experiences being described. I read the literature with these experiences in mind, trying to understand how they fit together. I entered my paid work in public health and education with this knowledge in mind, trying to inform the policies and practices of the organizations I worked for that those that students would be entering. And I continue to incorporate these new understandings into my activist work and my relationships with friends, family, and acquaintances, sharing knowledge in small ways when I can. It has even filtered into my parenting and into the ways that I talk to my children about food and bodies. For example, I had a proud mother moment when my daughter refused to do a project for her health class about food and nutrition, as she was protesting the ways that the assignment positioned fat bodies as less healthy than thin bodies, and food as a main component of health and body size.

There may be characteristics common to the women who contacted me, such as an interest in healthy eating, that prompted interest in my study. I tried to control for this by advertising through various means and looking for specific characteristics such as geography and Indigeneity. Some people were excluded from participating in the study, such as people who do not speak English and those who do not live in an area accessible to me by vehicle in Northeastern Ontario. I received several phone calls from married women who wanted to participate but was not able to expand the scope of the study to include them. Since women in heterosexual marriages tend to do most of the childcare and foodwork, future studies could expand this work to see if the experiences of married mothers mirror those described by single mothers.

In interviews, there is a possibility of “distorted responses due to personal bias, anger, anxiety, politics... recall error, reactivity of the interviewee to the interviewer, and self-serving responses” (Patton, 2001, p. 306). I tried to minimize these biases by developing rapport with participants. I used examples (either hypothetical or from my own experiences with my children) to put them more at ease if their responses did not align themselves with the advice from nutrition discourses. I was genuinely interested in their responses and tried to show that in how I responded to them. I also tried to let them direct the conversations to a large extent – I had an interview guide, but if their responses or interests veered from that, I tried to follow their lead in order to create knowledge together. After the interview, I made sure they had my contact information so they could follow up if they thought of anything else. For those who indicated interest, I sent their transcript back and let them know they could make any changes that they wanted to make, but none made any changes.

There were also some temporal limitations to this study. All the interviews were done in the spring and summer. The first interview was done in March, the snow had just really started to melt, and my first participants discussed going outside more now that it was starting to get warm. In the interviews I did towards the end of May, several participants were planting gardens and talked about which seeds they were planting. I think that some of the conversations may have had some different themes had I done the research in the winter. I tried to mediate this by asking participants about how children’s activities are different in the winter, and about things like winter transportation. I discussed this with my committee before I began my research and we decided that it would be safer and more time efficient to travel in the summer. Canada is quite large and geographically diverse. In northeastern Ontario, small communities are spread out by

large isolated distances that can be difficult to travel in the winter months. As such, these interviews are not intended to be representative of experiences in other regions of the province or country. But I do believe they speak to themes identified in the research from other parts of Canada and the United States.

Solutions

According to Karl Marx, “philosophers have only interpreted the world in various ways, the point is to change it” (Marx, 1888, p. 101). While I am sure most researchers would love for their work to make positive contributions to society, the realities of the cost of knowledge translation can make that difficult. I do not have funding for knowledge translation but taking the knowledge that I have developed through this work and trying to apply it to some of the work being done locally is very important to me. I have already presented at the Sudbury & District Health Unit, and to Sudbury’s Healthy Kids Community Challenge Advisory Committee. My short-term goal when I began this research was to get people who work with children to begin to question the everyday assumptions about fat bodies that they might hold. I would like to continue looking for opportunities to discuss this topic and bring some of the ideas from Critical Fat Studies into mainstream health and government policy. I would also like to have the opportunity to work on social policies, beginning to shift the language from individual-level to societal responses. As Koch (2009) notes, “when we start with the experience of people on the ground, policy solutions to social problems are likely to shift from individual-level responses to reorganizing at group levels” (p. 145).

The solutions discussed by the women I interviewed pointed towards some solutions that they felt would help their family in the immediate future. For instance, they suggested low to no

cost sports that were more of a drop-in program so that attendance was not mandatory and provided the opportunity for children to try out new sports without a large commitment. Participants wanted the government to commit to better food policies to control what they described as the increasing cost of fresh foods. They also wanted better maintenance for local parks and playgrounds. Three women I interviewed spoke about sustainable food systems such as local food, farmers markets, and food cooperatives. While these solutions could definitely provide some additional support in people's everyday lives, they do not get to the roots of the discourses surrounding fatness and health. The point of institutional ethnographic research is to begin with the standpoint of individuals and use them to examine broader social relations. As such, I have researched and thought about what kinds of solutions might disrupt these discourses.

In the future, I would like to develop a paper on some possible solutions to interrupting discourses of fatness. Currently, the literature focuses on individual-level solutions such as learning to love your body, interrupting fat-phobia when you see it, or leveraging your thin privilege to work towards ending fat phobia (Afful & Ricciardelli, 2015; Bacon, 2009; Bacon, Stern, Van Loan, & Keim, 2005; Null, 2012; Provencher et al., 2007, 2009). There are some slightly larger-scale solutions, such as changing the curriculums, particularly in medical schools and other health profession curriculums (Cameron & Russell, 2016). Organizational policies and education to interrupt fat phobia in order to ensure fair interviewing, hiring, and promotional practices are also important (Fikkan & Rothblum, 2005; Griffin, 2007; Jasper & Klassen, 1990; Pingitore et al., 1994, 1994; Rothblum, Carol, & Barbara, 1988). We know that individual-level or small-group solutions do little to make societal changes (Smith, 1987), and more structural changes are needed if we are going to change discourses around health and fatness.

Some structural changes can include policies to shift the way that the media portrays fatness. For example, removing common expressions like “combating childhood obesity” or “war on fat” could go a long way towards ending some of the stigma (Boero, 2007; Giovanelli & Ostertag, 2009; Greenberg & Worrell, 2005; Saguy & Gruys, 2010). Also, it would be positive to have characters of varying body shapes and sizes in roles other than the “funny, fat friend” or the “fat bully” particularly seeing people with fat bodies portrayed as happy, healthy, and with complex story arcs that do not revolve around their body size (Gurrieri, 2013; Maor, 2013), while using caution not to further marginalize fat bodies that are not healthy (Meleo-Erwin, 2012). These steps alone will not change the discourses, but they are a starting point for normalizing the idea that fatness is not inherently bad.

On a much larger scale, policies like those described in Chapter 3 must increasingly nuance the discussion, not simplify it. I have cited a lot of evidence in the literature review section of my introduction showing that people whose bodies are categorized as overweight actually live longer than those who are categorized as normal. I also showed that there are stronger correlations between socioeconomic status and health than fatness and health. We need to look at broader social relations, such as the overlap between fat discourses and racialization/colonization (Fee, 2006; Greenwood & de Leeuw, 2012; McPhail, 2017; Willows et al., 2012), poverty (McPhail, 2017; Parsons, 2015; Wright et al., 2015), disability (Aphramor, 2009; Herndon, 2002), gender (Brewis, Hruschka, & Wutich, 2011; Brown, 1985; Dworkin & Wachs, 2009; Griffin, 2007; Hebl & Heatherton, 1998; Parsons, 2015; Seid, 1989), sexuality (Owens, Hughes, & Owens-Nicholson, 2003; Rothblum & Factor, 2001; Share & Mintz, 2002), and other relations that relate to marginalization. More quantitative data analysis can help us

better understand the relationship between these relations and health, which could point to more ways to end fat stigma.

Future Research Directions

During the recruitment phase of this research, I was in touch with an employee from a health services program in a far north region of Ontario known as the James Bay Coast. This area is fly-in only and transportation is quite expensive. This organization was interested in helping me find housing and participants if I was able to visit the far North, but I did not have funding for that travel. Future research could go further north into remote areas. The cost of food is even more prohibitive in this region and employment opportunities are sometimes quite scarce.

In this research, I focused on one specific family-type; low-income single mothers. It would be interesting to see how this work is experienced by two-parent households, LGBTQ families, or single fathers. Focus groups could also be useful; I considered using focus groups in this research because participants can bounce ideas off each other, new themes can emerge, and they could feel a sense of solidarity when other mothers share similar stories. Also, talking to children could help policy makers better understand what children think about things like the school curriculum on health, school activities including lunch and recess policies, after school programming, and how to make sports and other physical activities more fun.

There is a lot of research opportunity in critical fat studies, albeit with somewhat limited funding opportunities. And there is a lot of research on childhood obesity from a perspective that aligns with dominant discourses discussed throughout this article. I have been to Critical Obesity Studies conferences and to Public Health conferences attending sessions on fatness. What I found was that these discourses rarely overlap. Critical health scholars and public health and

government officials need to listen to each other and learn from each other to build scholarship and policies that will have an impact on health.

Conclusion

For this dissertation, I interviewed twenty low-income single mothers living in Northeastern Ontario about their everyday lived experiences parenting children in the context of what is being framed as a childhood obesity epidemic. Despite conflicted evidence about the impact of fatness on health, texts such as government policies, medical advice, and the media present information on fatness as though it were inherently unhealthy and even a threat to society more generally. Using quotes from my participants, I showed that many of them have internalized dominant discourses surrounding fatness and health. Some question and even try to reject this discourse, but it is so prevalent that even these interview conversations were framed by these discourses. Mothers described a great deal of work that goes into trying to follow the advice presented in these discourses, which center largely around food and physical activity guidelines. Every parent I interviewed described many barriers to achieving what they consider to be the healthiest options for their children. Several explicitly said that the standards set for ideal health are impossible for anyone to achieve, let alone people who are trying to live on a fixed income while trying to do all the household labour involved in raising kids on their own, which led to feelings of guilt, shame, and stigma for all my participants in various ways when they failed to meet these criteria.

The literature about the impact of fatness on health is not always clear, but definitely indicates that the relationship between fatness and health is far more complex than public health

discourses suggest. There are relationships between fatness and some health conditions, but the relationship between poverty and health or stress and health outcomes is just as strong, if not stronger. Yet, the texts combine medical discourses with “common-sense” knowledge about bodies to produce discourses that stigmatize people whose bodies are categorized as fat. Neoliberal ideologies impose responsibility for health on individuals, blaming people who are overweight for making unhealthy choices regardless of their actual health or their diets or level of physical activity. When the body is that of a child, it is the mother who is framed as responsible for what they eat, physical activity levels, and their overall health. Stigma has repeatedly been linked to poor health outcomes, and the idea that we can control body size through food intake and energy output has repeatedly been shown to be limited at best. The texts describing bodies and health need to become more nuanced in order to capture the relationship between bodies and health and to begin to end the stigma that is experienced by people whose bodies are categorized as overweight or obese.

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Participants needed for children's health study



I am interested in speaking to low-income single mothers living in Northeastern Ontario about Strengths and barriers to raising healthy children in the north

My name is Laurel O’Gorman and I am a graduate student at Laurentian University in the Northern and Rural health PhD program. I am interested in talking to women to better understand their experiences of raising healthy children on a limited income in northern and rural areas of Ontario.

Your participation would involve;

1. An interview at the location of your choice
2. Taking me on a ‘food excursion’ – showing me where you usually go to get food for your family

The food excursion should last 1-3 hours and the interview will last about an hour. You will receive a \$20 gift card to a grocery store for the food excursion and a \$10 Tim Hortons card for the interview as a token of my appreciation for your time.

Everything you say will remain confidential and your name will not be used in any reports or publications. There is no penalty for not participating and you can withdraw at any time, in which case, I will erase the transcripts and recordings from your interviews. This research has been approved by Laurentian University’s Ethics Review Board.

If you have any questions or wish to participate, please contact me via email at ld_ogorman@laurentian.ca or by telephone at (705) 675-1151 ext. 4280 or 1-800-263-4188 ext. 4280.

Appendix B: List of Initial Contacts

Sudbury

- Sudbury and District Health Unit
- Baby's Breath
- Best Start
- YMCA
- Sudbury Food Bank
- Youth centres
 - Ryan Heights after Four Program
 - Capreol Youth drop-in
 - Dowling Youth Drop-in
 - Levack/Onaping Youth Drop-in

Timmins

- Porcupine Health Unit
- The MotHERS Program
- Ontario Early Years Centres
- Timmins YMCA
- Timmins Food bank
- Costello community care centre
- NEOFACS

Temiskaming Shores

- Temiskaming Health Unit
- Haileybury Food Bank
- Salvation Army (New Liskeard, and Kirkland Lake)
- Temiskaming Shores Public Library
- The MotHERS Program

Espanola

- Sudbury and District Health Unit
- Ontario Early Years Centre
- Espanola Family Resources
- Espanola Helping Hand food bank
- Our Children, Our Future/ Best start

Other

As discussed in the proposal, other contacts will emerge during research preparations, based on the consultations with community groups.

Appendix C: Ethics Approval

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS
 Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL /	New X /	Modifications to project /	Time extension
Name of Principal Investigator and school/department		Laurel O’Gorman, Rural & Northern Health, Diana Coholic and Jennifer Johnson, supervisors	
Title of Project		The Impact of Childhood Obesity Discourses on Foodwork for Single Mothers in Northeastern Ontario: An Institutional Ethnographic Study	
REB file number		2016-01-11	
Date of original approval of project		February 23, 2016	
Date of approval of project modifications or extension (if applicable)			
Final/Interim report due on: (You may request an extension)		February, 2017	
Conditions placed on project			

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.



Rosanna Langer, PHD, Chair, *Laurentian University Research Ethics Board*

Appendix D: Participants

Name	Age	Kids	Community size	Education	Work	Minority / Cultural group
Stacy	42	10, 11, 13	50,000+	College Diploma	Full-time	LGBT
Lyne	40	10, 12	1,000-4,999	College Diploma	Laid off, Employment Insurance	Francophone
Laura	41	11, 15	50,000+	College Diploma	Part-time, Ontario Works	
Rachelle	29	8	50,000+	College Diploma	Disability	Francophone
Kimberly	33	13, 14	50,000+	Bachelor's Degree	Unemployed, disability	Indigenous
Chantal	30	1, 8	1,000-4,999	College Diploma	Maternity leave	
Sara	34	Infant, 7	1,000-4,999	Some College	Maternity Leave	
Karen	35	3, 4, 7	5,000- 9,999	College Diploma	Full-time + part-time	
Natalie	39	8, 10	1,000-4,999	Bachelor's Degree	Disability	Black
Adrienne	35	8, 10	1,000-4,999	College, post-diploma	Full-time	Francophone
Kayla	33	4	1,000-4,999	Bachelor's Degree	Unemployed, Ontario Works	Indigenous
Annie	32	3, 8, 16	50,000+	Bachelor's Degree	Unemployed, Ontario Works	Indigenous
Sylvia	35	8, 10, 16	50,000+	Some College	Disability	
Vanessa	26	4	50,000+	Bachelor's Degree, post graduate diploma	No income	
Sophie	42	9	50,000+	Bachelor's Degree	Ontario Works	Indigenous

Amanda	38	9	50,000+	Master's Student	Full-time	
Emily	28	2, 4, 5, 9	1,000-4,999	Bachelor's Degree	Ontario Works	
Paula	29	2, 6	1,000-4,999	College Diploma, apprenticeship	Disability	
Tanya	22	4	50,000+	University Student	Full-time student, part-time employment	Indigenous
Hetal	40	6, 19	50,000+	Master's Degree	Full-time	Immigrant

Stacy is a 42-year-old single mother with 3 children ages 10, 11, and 13. She left an abusive relationship with the children's father. She lives in an urban area, has a college diploma, and works full time in the developmental services field. She is vegan and tries to make a difference in the community through positive relationships and making sustainable changes.

Lyne is a single mother with two boys, aged 10 and 12. She is 40 years old. After her divorce three years ago, she bought a house in a small rural town with the help of her parents. Her ex husband takes the children a few days a month. She is currently unemployed after being laid off from a stable job. She collects unemployment and does a lot of volunteer work for a local animal rescue organization.

Laura is a single mother living with two children, aged 11 and 15. She is 41 years old. She lives in subsidized housing in an urban area and works part time at a low paid job caring for older adults. Her ex-husband lives nearby and has a good relationship with the kids, but she does most of the caring work. She wants to go back to school to get a diploma in nursing but cannot access funding to do so.

Rachelle is a 29-year-old single mother with an eight-year-old daughter. She resides in an urban area. She went to college for several fields but is unable to find work in them due to both the labor market and her current health. She receives a small disability pension but would like to go back to college to get a diploma in a field that she can work in with her disability. She is Francophone.

Kimberly is an Indigenous single mother with two teenagers. She asked me to give her Anishnaabek noozwin (name) Bidaa-bino Giizhgo Kwe, which means early morning sky woman. She is 33-years-old. She grew up in a first Nations reserve but now resides in an urban area. In her interview, she discussed being a ward of the state, and the impact of colonialism and intergenerational trauma on her own history of addictions. She has a bachelor's degree and works in social services but was unemployed at the time of the interview.

Chantal is 30 years old and has two children, aged 1 and 8. She has a diploma in Early Childhood Education and works in childcare. At the time of the interview, was in her last month of maternity leave. She has lived in various parts of Canada, but currently resides in a small town with her sister, Sara, where she moved after breaking up with her son's father.

Sara is 34-years-old and has two children, aged 6 months and 7 years. She has a third child who died during childbirth. She does administrative work in the nearest city, about 45 minutes away, and is currently on maternity leave. She is active in her church and on a community volunteer committee.

Karen is a single mother with three small boys aged 3-7. She is 35-years-old/ She lives in a small northern town. She recently got divorced and purchased a house for her family with the help of a friend as co-signer. Her children spend every other weekend with their father. She has a college diploma but is underemployed in her field due to a lack of jobs in her community. She works as a waitress on the weekends to earn extra money.

Natalie has two boys, aged 8 and 10. She is 39 years old. She recently moved to a small town in northern Ontario from a large city in Western Canada. She has chronic health conditions that prevent her from working and receives disabilities payments. She is one of the only Black women in her community.

Adrienne is a 35-year-old single mother with two boys aged 8 and 10. She and her ex husband purchased a house in a small community only months before they separated last spring, and she continues to live there with her children. She is Francophone and is active in the community, coaching sports teams and organizing local events. She works in the field of education at an administrative job. She described it as low paid but very flexible.

Kayla is a single mother to a 4-year-old daughter. She is 33 years old. They live in a one-bedroom house in a small First Nations community. She has a university degree but cannot find work in her community. She was in the process of moving to a large urban centre to go back to university at the time of the interview, which would put them in the same city as her daughter's father.

Annie is an Indigenous single mother of three children, aged 3, 8 and 16. She lives in a Small urban centre in the North. She is on social assistance, as she had been unable to work since her husband died unexpectedly about a year before the interview. Her current focus is on culture, spirituality, and being available to her children, who just lost their father. She hopes to go back to work in the upcoming months following the interview but is not sure if the kids are ready for that yet.

Sylvia is a single mother of three children, ages 8, 10 and 16, and is pregnant with her fourth child. She is 35 years old. She lives in a small urban centre. She is unable to work, as she is recovering from issues with addictions and is currently focused on her children, as she had to give them up for a couple years and has only recently regained custody. She is incredibly familiar with the social services in the area and spends a good deal of her time accessing the programs that are available and helping other women with addictions navigate these programs.

Vanessa is a young mother who has recently left the father of her 4-year-old daughter due to relationship violence. She has moved into social housing, finished her bachelor's degree, and was in the process of finishing her post graduate diploma at the time of our interview. She currently has no income, as she is unemployed, does not qualify for social assistance, and is having a great deal of difficulty with the court system where she is fighting to maintain custody and receive child support. She was to begin a minimum wage job in her field of study two weeks after the interview. She described the realities of poverty as shocking in a lot of ways, as she was one of only a few participants who grew up in a middle to upper class family.

Sophie is a single mother who resides with her 9-year-old daughter. She is 42 years old and has Indigenous ancestry. They live in social housing in a small urban centre. While she has a degree in social work, she is currently unemployed because she is recovering from addictions. She is trying to begin a master's program in social work but working on getting the funding and childcare lined up to be able to do so.

Amanda is a 38-year-old master's student at a university in Quebec but is living in a small urban centre in northern Ontario while she writes her dissertation. She lives in a social housing complex that she describes as a great place to live. Her son is 9 years old and has Asperger's. She shares custody with her ex husband. She works in social services for a non-profit organization.

Emily lives in a small town with her four children, ages 2-8. She is 28 years old. Her ex-husband lives an hour away on a neighboring community and has only visited their children twice in the past year. She is on social assistance because paid work is too hard to coordinate with young children in two different schools and separate daycares.

Paula is 29 years old. She was married and had two children in Southern Ontario but moved back north to a small urban centre when she separated with her husband. She has a degree in the social sciences and is certified to work in a skilled trade but is unemployed due to mental illness. She has been writing children's books and is hoping to be published soon.

Tanya grew up in a first Nations community but moved to an urban centre with her two year old daughter to go to university. She had her baby when she was in high school, and described conflicts with the child's father and difficulty navigating the court system. She lives with roommates in order to save money and works in retail while attending school. She said that she is lucky to have roommates who are willing to help with babysitting while she works or goes out with friends occasionally.

Hetal is a recent immigrant to Canada from India. She moved here with her husband and two children, now aged 6 and 19. Her husband died during her son's last year at high school, and they stayed in Canada for him to finish his studies. He is now enrolled in university in a prestigious program. She has two Master's degrees, but is currently working in an administrative job for a small business earning slightly more than minimum wage.

Appendix E: Interview Guide

Read through the consent form

1) Background Information

Purpose: background information on participants

Sample questions:

- Please tell me about your family, starting with how many children you have. What age(s) are they?

2) Health

Purpose: Capture their understanding of 'healthy children' (General)

Sample questions:

- What does the term "healthy child" mean to you?
- Have you heard the term child obesity? W
 - i. What do you think about it?
 - ii. Where have you heard it?

Purpose: More specific understanding of 'healthy children'

- Where do you get information on children's health (i.e. television, magazines, teachers, doctors, internet, newspapers, parents, friends, etc.)? Tell me about the kinds of things they advise.
- What do you think the term "healthy" means to your children, if anything?
- Can you tell me about things that make it difficult to make the healthiest decisions for your children?
- Are there things that make it easier to make healthier decisions for your children?

3) Work (paid and unpaid labour)

Purpose: To find out about the amount of work and different spatial practices that goes into making 'healthy' decisions for their children

Sample questions:

- Tell me about a typical day for you; how much time do you spend;
 - i. Caring for children directly (bathing, feeding, etc.)
 - ii. Doing work related to children (ex. Packing lunches)
 - iii. Unpaid housework
 - iv. Shopping
 - v. Preparing for and cleaning up after meals
 - vi. Caring for others (e.g. elderly relatives)
 - vii. Doing other forms of unpaid work
- Probe about links to kids health
- Ask about whether / how this changes in the winter

4) Neighbourhood questions

Purpose: Spatial understanding of health work, situating the family in the community

Sample questions:

- Tell me about the areas that your children play. Are there safe outdoor spaces for them? (yard, playground, sports fields, etc.)
- Are there grocery stores in your neighbourhood? Do they have fresh fruit and vegetables? Cost of fresh food?
- Do you have an area to grow your own foods, if you wanted to?
- Are there accessible activities for your children (such as affordable sports teams)?
- Do your child's school and/or daycare support healthy behaviors?
- Are there things about your community that help your children stay healthy?
- Does your community have barriers to raising healthy children?

5) Resilience / Negotiation

Sample Questions

- Have you ever drawn attention to the difficulties that you are facing (i.e., offer support or advice to someone in a similar situation, write letters to newspapers or to policy makers, talk to others about problems you've faced, etc.)?
- Is there anything about your community that really helps you raise healthy children?

10. Demographic

Purpose: For making intersectional connections, interested in taking as much information as they are comfortable giving about their racial/ethnic identities and family background, family status (biological mother of child, foster parent, grandparent, etc), sexuality, etc.

- Can you tell me your age?
- What is your highest level of education?
- Can you tell me about your source of income?

Is there anything that I haven't asked that you would like me to know?

Is there anything that you would want to tell policy makers, if you had the chance?

Thank you very much for your time and your contribution to my research.

Appendix F: Emailed List of Questions for Participants

Thank you for your interest in my research. I have prepared a list of potential questions to get you thinking about the topics I may bring up at the interview. You may also talk about anything that you think is relevant to your experiences of trying to raise healthy children, even if it is not on the list of questions. You can choose to read and consider them over the next week, or you can choose to come into the interview without having looked at them.

I look forward to talking to you next week.

Questions

1. What does the term “healthy child” mean to you?
2. What does “childhood obesity” mean to you?
3. What role do you think childhood obesity plays in children’s health?
4. Think of all of the places you receive information about children’s health and childhood obesity. Tell me about some of them. What types of messages are they giving about health?
5. What types of activities do you typically do in order to help your children be healthy? How much time does it take? Think about both what you would ideally like to provide and what you are able to actually do because of time, monetary, or other barriers.
6. Can you tell me about things that make it difficult to make the healthiest decisions for your children?
7. Are there things that make it easier to make healthier decisions for your children?
8. Tell me about the areas that your children play. Are there safe outdoor spaces for them (yard, playground, sports fields, etc.)? Are there organized activities that you can access, such as sports teams?
9. Are there grocery stores in your neighbourhood? Do they have fresh fruit and vegetables? Is it affordable? Where else do you get food? What types of places would you like to be able to go to get food but cannot access?
10. Have you ever drawn attention to the difficulties that you are facing (for instance, have you offered support or advice to someone in a similar situation, wrote letters to newspapers or to policy makers, talk to people about problems you’ve faced, etc.)?

Appendix G: Consent Form

(Laurentian Letterhead)

PARTICIPANT INFORMATION SHEET / CONSENT FORM

Study Title: The impact of Childhood Obesity Discourses on Domestic and Reproductive Labour for Single Mothers in Northeastern Ontario

Investigator: Laurel O’Gorman

Department: Interdisciplinary PhD in Northern and Rural Health, Laurentian University

You are being invited to participate in a research study conducted by Laurel O’Gorman to fulfill the requirements of her PhD in the interdisciplinary Northern and Rural Health program at Laurentian University.

In order to decide whether you want to participate in this research, you should understand what is involved including the risks and benefits. This form contains detailed information about the study. Once the information in this form is explained to you, you will be asked to sign the form if you wish to participate. You may ask questions about your participation and you may withdraw your consent at any time without penalty.

What is the purpose of the research?

Children’s health and childhood obesity has become a hot topic in research, government policies, and the media in the past 10 years. However, little research has been done in northern and rural areas to better understand the implications of this increased attention on childhood obesity. This research project aims to explore;

- Your understanding of children’s health and childhood obesity
- The everyday work and activities that go into raising healthy children
- The strengths and barriers to raising healthy children in the north

Who can participate?

I am interested in speaking to low-income single mothers living in Northeastern Ontario

For the purpose of this research, the term ‘Single Mother’ includes anyone who does parenting work without the support of a partner and identifies as a mother. This could include (but is not limited to) grandmothers, mothers with full, shared or joint custody, with a partner who lives far

away, transgender parents, etc. Similarly, low-income is broadly defined to include anyone who experiences financial barriers to raising healthy children.

What is involved in participating?

Your participation will involve two parts;

1. An interview at the location of your choice
2. Taking me on a 'food excursion' – showing me where you usually go to get food for your family

The interviews will be about an hour in length. We can meet at the location of your choice (your house, library, or other safe and private location). I can assist in finding a location if you do not have a particular place in mind. In some circumstances, the follow up interview could take place over the telephone.

The food excursion will take about 90 minutes to 3 hours, depending on the distance and mode of transportation. I would like you to show me where you usually go to get food for your family, such as a local grocery store, farmer's market, community garden, farm, food bank, etc. You may also choose to show me other locations that are meaningful to your children's health, such as playgrounds, schools, etc; anything that you think will help me understand more about the work involved in raising healthy children.

I will use an audio recorder to record the interview and portions of the food excursion and will track the route and location of the food excursion using GPS. The audio recorders will be transcribed into a written document. This information will be kept confidential (information about your identity will be removed from transcripts and reports) and kept in a secure location.

After the research and transcription is completed, I can send you the transcript of your interview for your feedback, at which point you can make any changes you wish to make.

Are there any risks to participating?

It is unlikely that there will be any harm associated with your participation in this study. You do not need to answer any question that makes you uncomfortable. You may find it stressful to discuss negative experiences, and you can choose to share as much or as little as you wish. You can withdraw your participation at any time.

What are the benefits of participating?

I cannot promise any personal benefits to you as a result of your participation. It is my hope that sharing your experiences can be a positive experience for you and that the information you provide

can help us better understand the strengths and barriers of raising healthy children in northern and rural areas. I hope to share the results of this research with people and organizations involved in providing health care and educational information on children's health in northern and rural areas.

Will my information be kept private?

The information you share will be kept confidential. Any identifying information, such as your name, address, email, workplace, organizations/groups you are part of, the names of children, and possibly even the name of your community will be removed from the transcripts and never used in a report or publication. Information collected by GPS will be presented in such a way as to not reveal your location, such as calculating distance to grocery store. Your contact information will be kept secure in a locked file on a computer in my locked office. The only other people who may have access to these files is my research supervisor, Dr. Jennifer Johnson.

Can participation in the study end early?

Your participation in this study is voluntary. You have the right to withdraw at any time and you may refuse to answer any questions. There are no penalties or consequences if you chose not to participate in this study and you can withdraw at any time, in which case, the audio files, GPS information and transcripts will be erased.

Will I be paid to participate?

You will receive a \$20 gift card to a local grocery store for the food excursion and a \$10 Tim Hortons card for the interview as a token of my appreciation for your time.

Will there be any costs?

Your participation in this study will not involve any costs to you. If you will incur any costs by participating in this research, such as parking fees, gas, or bus fare, let me know (try to let me know ahead of time, if possible) and I will be sure to reimburse you for the expense.

How will my information be used?

In order to maintain confidentiality, no identifying information will be collected other than which you volunteer to provide. Audio-tapes will be kept in a locked filing cabinet. Electronic versions of the transcripts will be kept in a password protected document on the researcher's personal computer. All personal identifying information will be removed at the transcription stage.

The files collected from all of the research participants (20 to 25 people) will be compiled and analysed for similarities and differences. These will be used primarily for a dissertation and academic publications. Direct quotes will be used, but an anonymous ID or alias, that you can come up with yourself, will be used to protect your identity.

Although confidentiality is of the utmost importance, information will be disclosed to the proper authorities if I have reason to believe that you intend to harm yourself or another person, or if you disclose information about child abuse or neglect.

Who can I call if I have questions, concerns, or problems?

The research has been reviewed by and received ethics approval from the Research Ethics Board at Laurentian University. If you have any questions or concerns about the study, you can contact me at ld_ogorman@laurentian.ca or 1-800-461-4030, ext. 4280. You may also contact my supervisor, Dr. Jennifer Johnson, at 705-673-1730 ext. 601 or jljohnson@laurentian.ca.

If you have any questions pertaining to ethics, you may contact Dr. Robin Craig, Laurentian University Research Office, telephone: 705-675-1151 ext 3213, 2436 or toll free at 1-800-461-4030 or email ethics@laurentian.ca.

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- | | |
|--|--|
| I agree to have notes taken during the research. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| I agree to have the location of the research tracked using GPS | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| I agree to have the research audio-taped. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| I agree to have the research transcribed (typed). | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please include an email address if you would like the transcripts to be emailed to you at (email) _____ in order to provide you with an opportunity to review prior to them being used for analysis.

If you would prefer receiving a paper copy in the mail, please include your mailing address below. I can provide you with a return envelope.

I have read the consent form and agree to participate in this research.

Participant's Signature

Date

Appendix H: Policy Summary Table

Policy document	Level of government	Definition	Observations
Obesity: Preventing and managing the global epidemic (2000)	World Health Organization Global	“a condition of abnormal or excessive fat accumulation in adipose tissue, to the extent that health may be impaired” (p.6).	Health <i>may</i> be impaired – possibility of fat and healthy Normal weights vary by individual and culture BMI problematic, especially in children Individual, cultural, and societal causes
Healthy Weights, Healthy Lives (2004)	Ontario’s Chief Medical Officer of Health Provincial	Energy in, energy out equation BMI Waist Circumference	Linked underweight and overweight to poor health outcomes using research BMI may not be accurate for children during growth spurts Individual and societal causes
Healthy Weights for Healthy Kids (2008)	Standing Committee on Health Federal	No definition Used BMI	Noted that poor health outcomes are well documented (no citations) BMI may not be accurate for Aboriginal children many causes, including individual and societal stressed the need for surveillance
Ontario’s Action Plan for Health Care: Better Patient Care through Better Value for our Health Care Dollars 2012	Ontario Government Provincial	No definition	Alarmist language (this generation of children could live shorter lives than their parents), no citations Stated obesity rate with no definition or measure No explicit mention of causality, but stresses “healthy habits and behaviors”
No Time to Wait: The Healthy Kids Strategy	Healthy Kids Panel Provincial		language stressed urgency, fatness as a threat to the future of the province Uses BMI uncritically as a measure of fatness

2013			acknowledges societal causes, stresses individual causes and solution phrase “healthy kids” means child who is not overweight
Patients First: Action Plan for Health Care	Ministry of Health and Long Term Care Provincial	NA	words “weight” or “obesity” do not appear promotes “healthy behaviors” individual causes