Exploring the Acceptability of Sugar-Sweetened Beverage Taxes Amongst Residents of River Heights, Winnipeg: A Critical Discourse Analysis

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A Thesis Submitted to the Faculty of Graduate Studies of

The University of Manitoba

In Partial Fulfillment of the requirements of the degree of

MASTER OF SCIENCE

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Winnipeg

Abstract

Introduction: In response to public health focus on "obesity", health organizations and governments have proposed a sugar-sweetened beverages (SSB) tax to reduce sugar intake, given their association with weight gain. However, "obesity" is already associated with social stigma, which intersects with other marginalized identities. Thus, a SSB tax may have unintended consequences because of the potential for exacerbating existing intersecting stigmas.

Objectives: Our research objectives were: 1) To explore the discourses informing SSB taxation, and their underlying ideologies, amongst white residents of River Heights, Winnipeg, and 2) To determine the acceptability of SSB taxation to white residents of River Heights, Winnipeg.

Methods: Qualitative interviews were performed with participants from River Heights, an upper-middle class neighbourhood in Winnipeg. Recruitment occurred based on: residence in River Heights, English-speaking, and being over 18 years old. We purposively recruited young adults, mothers, and regular consumers of SSB. The interviews were semi-structured, audio recorded and transcribed verbatim. Critical discourse analysis methods were used for analysis. Critical weight studies was used to inform analysis for objective 1, as well as theories of healthism and tax psychology for objective 2.

Results: Eighteen participants were recruited; all were white, food secure, with high self-reported health, and spoke about (grand)parenting when discussing SSB. Fifteen participants were female. *Objective 1*: Discussion of SSB was framed by personal responsibility, which dictated the acceptability of SSB behaviours. Responsibilization of SSB behaviours were discussed in relation to weight and health, such that regular, or irresponsible, consumption, were largely discussed with negative emotions and judgement. Parental responsibility for SSB and juice intake of children was prominent throughout the interviews, and elicited judgement towards others and particularly among mothers, themselves. *Objective 2*: When discussing SSB taxation specifically, support for taxation mostly utilized healthism discourse, whereas criticism and concern was framed using concepts of fairness, and to a lesser extent, trust.

Conclusions: SSB have complex social meanings, particularly in the context of taxation. The pervasiveness of moralisation with regard to SSB intake in participant discourse, and its priority

over fairness concerns suggests that SSB taxation will have consequences for stigma and health equity.

Acknowledgements

Writing a thesis in a pandemic was an exercise in patience, determination and at some points, absurdity. I am truly grateful to everyone who supported me on this journey, as I could not have done it without you. Many thanks are in order;

First, to my participants, without whom there would be no study, for their time, willingness and participation.

Second, I need to thank my research team and lab group, for their positivity, encouragement and inspiration. I especially need to thank Maria Kisselgoff and Mae Santos, my comrades, for their chats, reassurance and shared experiences. As well, Kelsey Mann, your expertise, willingness to help and kindness were vital to anything I did, so thank you! I am so lucky to be surrounded by a team of strong, passionate academic women!

In addition, my many thanks to my advisory committee Dr. Patricia Thille and Dr. Kerstin Roger, for your time, commitment, valuable input, and seeing through a pandemic thesis. As well, to Dr. Andrea Bombak, for your advice and assistance with theory.

I was also very grateful for the of the financial support I received, in the form of the University of Manitoba Faculty of Graduate Studies Graduate Enhancement of Tri-Council Funds (GETS), the Canada Graduate Scholarships-Master's Canadian Institutes of Health Research (CIHR), as well project funding through a CIHR Project Scheme.

I also need to thank my supervisor, Dr. Natalie Riediger, for providing me this opportunity, always asking the right questions, challenging the status quo and approaching everything with understanding and encouragement. I can only hope that when I grow up, I'll be as radical as you.

Finally, I also need to thank my family and friends;

To Garrett and Braydn, for always reminding me about real life,

To David, Liz and Sheeba, for holding so many writers retreats, taking care of me, and your infectious energy,

To my brother Colin, for your fabulous sense of humour, and great recommendations for television,

To my parents, Kristin and Keith, for your support, care packages, offers to proofread, keeping me on track, and for teaching me how to think for myself,

To my partner, Zev, for the joy you bring to all things, your never-ending patience and always encouraging me to challenge myself.

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List of Abbreviations

CCHS	Canadian Community Health Survey
CDA	Critical Discourse Analysis
CDC	Centres for Disease Control and Prevention (USA Government Agency)
NCD	Non-Communicable Chronic Disease
SSB	Sugar-Sweetened Beverages
PHAC	Public Health Agency of Canada
WHO	World Health Organization
WRHA	Winnipeg Regional Health Authority

Chapter 1

Introduction

Overview

"Obesity"[1] is becoming a major focus of public health around the globe (World Health Organization (WHO), 2018), and so too is its stigmatization (Puhl & Heuer, 2010). Stigma can be defined as when "labeling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them" (Link & Phelan, 2001). Weight stigma is associated with adverse health outcomes including negative health behaviours, such as the avoidance of healthcare, all of which are of concern for health policy interventions (Green & Senker, 2017; Goldberg, 2014; Rail, Holmes, Murray, 2010; Puhl & Heuer, 2010). As a result of concerns around the so-called "obesity epidemic"[2], sugar-sweetened beverages (SSB) have been singled out as a possible intervention target.

The consumption of SSB has been strongly associated with weight gain and incident type 2 diabetes (Malik et al., 2013; WHO, 2018). As a result, major health organizations have recommended the implementation of a tax on SSB to reduce SSB, and thus sugar, consumption (Dietitians of Canada, 2016; Heart and Stroke, 2017; WHO, 2017). SSB are defined as beverages that are sweetened with added sugars, which includes pop, fruit drinks, sports drinks and other pre-prepared beverages, as well as mixed alcoholic drinks or sweetened coffees (Dietitians of Canada, 2016; USDA, 2015; Centres for Disease Control and Prevention (CDC), 2017). There are some sugary drinks that do not contain added sugar, for example 100% fruit juice, and as such are not included within the SSB category. However, these sugary beverages without *added*

[1] "Obesity" will be referred to using quotation marks to acknowledge the normativity and stigmatization inherent with the use of term (Meadows & Daníelsdóttir, 2016)
[2] "Obesity epidemic" will also be referred to with quotation marks, as this phrase stems from biomedical and public health constructions of bodily fatness

sugar remain an important beverage in the discussion regarding SSB as all sugary drinks are often also positioned as a health risk (e.g. Jones, Veerman & Hammond, 2017).

An excise SSB tax has been proposed, which in contrast to a sales tax that, in our setting of Manitoba, does already exist. A sales tax is applied at the point-of sale, whereas an excise tax would be applied to the distributor/manufacturer and passed on to the consumer; therefore the price increase appears on the price tag. Another difference between an excise and sales tax is that there is variation with how the taxation amount is determined, such as a percentage of the cost, amount of sugar in the beverage, or the volume of the beverage (Backholer, Blake & Vandevijvere, 2016; Backholer, Blake & Vandevijvere, 2018). However, both sales and excise taxes are flat taxes, and thus are regressive which means lower income individuals pay a higher *proportion* of their income on these taxes (Roach, 2010). For this reason, excise taxes contribute to income inequality.

The implementation of a SSB tax may have unintended consequences due to pre-existing weight stigmatization and socioeconomic and racial health disparities rooted in established power relationships (Backholer & Martin, 2017; Lupton, 1995; Moosa-Mitha, 2015; Frohlich, Poland & Sharek, 2017; Strings, 2019; United Nations, 2007). In fact, health policies tend to disproportionately benefit the 'worried, white, wealthy, and well' (Kerner, 2008), which are informed by, and contribute to, a culture and discourse of white dominance in health policy. Additionally, taxation creates negative social value when items are taxed, which makes it particularly associated with stigma (Lupton, 1995; Frohlich, Poland & Sharek, 2017). Weight stigma is also relevant in the discussion of SSB taxes because, the policy is proposed to address "obesity", which is already associated with considerable social stigma (Green & Senker, 2017; Goldberg, 2014; Rail, Holmes & Murray, 2010; Puhl & Heuer, 2010). With the first SSB tax on

track to be implemented in Canada in 2022 (Government of Newfoundland and Labrador, 2021), there is added urgency to explore SSB taxes from a health equity lens and in particular the discourses underpinning support for the policy.

Research Objectives

1. To explore the discourses informing SSB taxation, and their underlying ideologies amongst white residents of River Heights, Winnipeg.
2. To determine the acceptability of SSB taxation to white residents of River Heights, Winnipeg.

Research Questions

1. What are key discourses around SSB and their consumption and purchasing amongst white residents of River Heights, Winnipeg?
2. What are key discourses around SSB taxation amongst white residents of River Heights, Winnipeg?
3. Is SSB taxation acceptable to the residents of River Heights? Why or why not?
4. What informs the acceptability of SSB consumption and purchasing?
5. Which beverages do residents of River Heights identify as potential tax targets? Which are not?

Significance of Research

Firstly, my project is significant as SSB taxation is becoming a reality in Canada, with Newfoundland and Labrador implementing the first Canadian SSB tax in 2022. There is an urgent need to explore the discourses, and thus ideologies, informing this tax, to provide insight and predict the potential consequences of taxation, before SSB taxes are implemented elsewhere

in Canada. Additionally, as the tax is regressive in nature, the likelihood of greater financial impacts on populations already experiencing stigma, such as low income and racialized populations, is high. Therefore, a focus on the effects of SSB taxation on health equity is both urgent and necessary. Also, to meet national and global calls to address weight stigma in health policies, this project will inform ongoing efforts to understand how policies may enact stigma (Rubino et al., 2020). Finally, as my project is a small part of a larger project looking at perspectives on SSB taxation in Manitoba, with an Indigenous health focus, my research is providing an important perspective within this project, as it represents the dominant social group as well as serving as a comparison for the other locations. Therefore, my project is offering a timely and equity-informed exploration of SSB taxation among Canadians, and to inform any future discussion of wider implementation.

Chapter Summary

This thesis is presented as a manuscript-based, or "sandwich", thesis, and includes the following chapters:

Chapter 1 offers an introduction to this project.

Chapter 2 is a review of the literature around "obesity" discourse, SSB consumption patterns as well as potential details of their taxation, and finally equity in health policy.

Chapter 3 is an outline of the methods used for this project, including the design, data collection and data analysis.

Chapter 4 is a manuscript titled: **"If you're serious about losing weight, why are you drinking all those cokes?": A critical discourse analysis of interviews on sugar-sweetened beverages amongst residents of a middle to upper class neighbourhood in Winnipeg, Manitoba**

Chapter 5 provides a connecting text for the two manuscripts (Chapters 3 and 5), highlighting the threads of moralisation and equity that flow throughout the results.

Chapter 6 is a manuscript titled: **"Coke's not a food": A critical examination of discourses informing sugar-sweetened beverage taxes utilized by white residents from an upper-middle class neighbourhood in Winnipeg, Manitoba**

Chapter 7 is a discussion for the entirety of the thesis, outlining strengths, limitations, implications, knowledge translation, conclusions, and future research.

Contribution of Authors

Inclusion and order of authorship for manuscripts will be determined at the time of submission to a journal for publications. AW will be first author. To date, the following individuals have contributed to the work included in the manuscripts:

AW- Writing, transcription, analysis, drafting manuscripts

KM- Interviewer, research/ project Coordinator,

NR- Interviewer, assisted with analysis, writing, developed concept for the study

PT- Methods, assisted with analysis, advisory committee member

KR- Advisory committee member

Chapter 2

Literature Review

In this literature review I will summarize some of the background regarding SSB, and SSB taxation, particularly regarding the links between SSB and "obesity", as well as recommendations for, or previous iterations of, SSB taxes. Additionally, I will outline relevant concepts from the psychology of taxation that inform taxation discourse. Then I will examine biomedical perspectives of the "obesity epidemic" as it informs SSB taxation. Next, I will introduce alternative approaches or critical perspectives of biomedical "obesity" discourses, which inform my thesis research. This critical orientation continues into the following section, focused on stigma, to set up our focus on weight stigma in the analysis for objective 1. Health moralisation is described in the next section, which again will serve to introduce my theoretical orientation for objective 2 analysis, and continuing to build on our critical orientation. Finally, this literature review will summarize the relevance of these theoretical perspectives to health equity within health policy, and how these perspectives complement each other to explore SSB taxation.

Sugar-Sweetened Beverages and Consumption Patterns

SSB can be defined as any beverage that is sweetened with added sugars (Dietitians of Canada, 2016; CDC, 2017; USDA, 2015). Therefore, beverages such as soft drinks, fruit drinks (not 100% juice), sports drinks, and other types of pre-prepared beverages would be considered SSB. There are beverages that are contentious in terms of their inclusion in the definition of SSB, such as sweetened milk drinks, artificially sweetened pop, sweetened alcoholic beverages (sometimes referred to as alco-pop), sweetened coffee or tea prepared at the point purchase, and fountain drinks, all of which fall outside of most SSB taxation legal frameworks (Riediger et al., in preparation), and are usually not included in recommendations for SSB taxation (Dietitians of Canada, 2016; CDC, 2017; US Department of Human Health and Human Services & US Department of Agriculture, 2015). Attitudes towards various SSB may differ, which has not been fully explored, and consequently different social understandings or attitudes toward various SSB may correspond to which beverages are identified for taxation.

From the 2015 Canadian Community Health Survey (CCHS), we know that SSB are not consumed equally in Canada. In fact, SSB consumption patterns differ based on socio-demographic factors such as age, gender and race/ethnicity (Jones, Kirkpatrick & Hammond, 2019). In Canada, ages 9-18 (children and adolescents) were found to be the highest consumers of SSB, and amongst adults, ages 19-30 were the highest consumers, although still less than 9-18 year olds (Jones, Kirkpatrick & Hammond, 2019). In terms of gender, Canadian men consumed more SSB (Jones, Kirkpatrick & Hammond, 2019). In a different study with Canadian youth, boys were also found to be higher SSB consumers than girls (Vanderlee et al., 2014). Race and ethnicity were also significantly associated with SSB consumption in Canada, such that off reserve Indigenous[3] populations were the highest consumers, by volume (Jones, Kirkpatrick & Hammond, 2019). White populations however were the highest consumers of alcohol (Jones, Kirkpatrick & Hammond, 2019). There was no comparison available between consumption patterns and income with Canadian data, however in the USA, income and SSB consumption were found to be related. Zagorsky & Smith (2020) reported that for adults in the USA, higher income individuals were found to have the lowest SSB consumption from 2008-2016. It is likely that a similar pattern would exist in Canada. However, the most interesting result from the 2015 CCHS, despite the lack of income comparison, was that compared to the previous CCHS (2004) there was a significant decrease in SSB or high-calorie beverage consumption (Jones, Kirkpatrick & Hammond, 2019; Tugault-Lafleur & Black, 2019). It remains unclear as to which groups were most changed between the two data sets, or time periods.

Taxation of Sugar-Sweetened Beverages

The taxation of SSB has been a popularized intervention to address the increasing global prevalence of non-communicable chronic diseases, which some argue also includes "obesity" (See Table 1 for proposed or implemented Canadian SSB taxation examples). SSB are the target for this intervention because of their sugar content, which is the link between SSB consumption and negative health outcomes. SSB taxation was reported by Backholer & Martin (2017) to not only reduce the consumption of SSB, but have three additional potential outcomes such as; generating tax revenue, to shaping health messaging on SSB and stimulating demand (and

[3] Indigenous People in Canada are comprised of First Nations, Métis and Inuit, as defined in Section 35 of the Canadian Constitution of 1982.

supply) for lower-sugar products (Backholer & Martin, 2017). These wide-ranging policy objectives suggest that SSB taxation may impact individuals, government, media, discourse, and/or industry, but also suggests a lack of policy focus and includes obvious (though unacknowledged) tensions between reducing intake but generating revenue simultaneously.

Table 1: Recommendations and Existing SSB Taxes in the Canadian Context

Organization	Recommendation	Reasoning	Year	Citation
Dietitians of Canada	At least 10-20%	Excess weight, "obesity", chronic disease	2016	Dietitians of Canada, 2016
Heart and Stroke Foundation	No specific value, Recommendation, aligns with WHO	Chronic disease, "obesity", childhood "obesity"	2017	Heart and Stroke, 2017
World Health Organization (WHO)	20% is the start of efficacy	NCD reduction, "obesity", childhood "obesity"	2017	World Health Organization, 2017
Government of Northwest Territories	5 cents per 100mL for prepackaged drinks; Fountain drinks on sliding scale	"Obesity", Type 2 Diabetes, Tooth Decay	2019	Government of Northwest Territories, 2019
Manitoba Green Party	At least 20%	Cancer, "Obesity", Diabetes	2019	Manitoba Green Party, 2019
Government of Newfoundland and Labrador	20 cents per litre	Chronic disease, "Healthier Choices", and social determinants of health	2021	Government of Newfoundland and Labrador, 2021

Proposed and implemented SSB taxes takes the form of an excise (or *ad valorum*) tax. An excise tax is first imposed on a distributor or retailer of SSB, who is purchasing beverages to sell to consumers. The distributor can then choose to "pass-on" the cost of the tax to their consumer or not. An excise tax, if applied, would appear on a price tag, which is in contrast to a sales tax that are applied only at the point-of-sale. The decision of the distributor to "pass-on" the cost of the tax to the consumer, or not, is another potential complication of the tax, which has been shown to vary across type of store as well as type of beverage (Silver et al., 2017). Each

distributor may have a different approach, although the size of each organization is a likely determinant, where the smaller the business, the more likely the consumer would be "passed on" the cost of the tax (McLure & Häuser, 2007). SSB taxes can take on different forms, as demonstrated by some of the examples in Table 1, such as a percentage of the cost, or can be based on the volume or sugar content of the beverage (Backholer, Blake & Vandevijvere, 2016; Backholer, Blake & Vandevijvere, 2018). However, all forms of SSB taxes are flat taxes, which makes them regressive taxes. Regressive taxes are the same amount for all members of a population regardless of income, and could have potential effects on equity; for example for individuals with lower incomes, the taxation value will take up a larger percent of a lower income.

SSB taxes have been implemented in many nations and smaller jurisdictions around the world, including Mexico, Portugal and the UK, along with the American counties of Philadelphia, PA and Berkaley, CA (Backholer, Blake & Vandevijvere, 2016; Backholer, Blake & Vandevijvere, 2018; City of Berkeley, 2014). The earliest of these taxes was implemented in January of 2014 in Mexico, and after two years a reduction of in-store purchasing of SSB was reported, with un-taxed beverages sales increasing slightly (Colchero et al., 2017). Interestingly, the same study also reported that low income household had the highest reduction in purchasing, from 9.0% in the first year of the tax, to 14.3% in the second, more than double that of high-income households (Colchero et al., 2017). However, other researchers have highlighted that the research done by the government of Mexico was highly involved with industry stakeholders (i.e. Coca-cola) so, that data could not be trusted (Backholer, Blake & Vandevijvere, 2018).

Different models have been used to predict the possible revenue of an SSB tax, and in Canada, with at 20% tax on SSB, up to $1.2 billion could be generated as revenue (Jones, Veerman & Hammond, 2017). As a result of this substantial potential revenue source, many authors describe a SSB tax as an "untapped resource" for governments around the globe (Kane & Malik, 2019; Baker, Jones & Thow, 2018). However, and perhaps arguably more important than the revenue potential of a SSB tax is the allocation of these funds. The use of tax revenues is a major area of concern for the implementation of a SSB tax, where the framing of the tax becomes very important.

In Philadelphia, a SSB tax was implemented with a very clear plan for the tax revenues outside of a health framing, aimed towards community development, including earmarking for funding universal pre-kindergarten (Kane & Malik, 2019). A SSB tax was implemented with these terms, with a modest "success" reducing SSB consumption (Kane & Malik, 2019). Significantly this instance of a SSB tax was without a health-focused framing, which has been identified as one of the reasons it was successfully implemented (Kane & Malik, 2019). Conversely, potential or modelled tax revenues have been found, in an American context, to be on the lower side of reported numbers, and that market losses would amount to greater than the revenue generated (Dharmasena, Davis & Capps, 2014). The same study concluded that the ultimate effectiveness of a SSB tax would be questionable, especially in regard to reducing SSB consumption or calories (Dharmasena, Davis & Capps, 2014). Therefore, many questions still remain on the effects of SSB taxation on population health.

"Obesity Epidemic": Public Health Rhetoric in the Construction of Fatness

"Obesity" is described by the World Health Organization (WHO) as "abnormal or excessive fat accumulation that may impair health" and is considered to be an epidemic (WHO, n.d.). "Obesity" is associated with adverse health outcomes, most notably non-communicable chronic diseases (NCDs), including cardiovascular disease, type 2 diabetes, muscoskeletal disorders and some cancers (Bray, Kim & Wilding, 2017; WHO, n.d.). However, much of "obesity" research does not consider whether, or to what extent, weight stigma may be contributing to the association between "obesity" and adverse health outcomes. "Obesity", and its associated stigma, has documented impacts on other aspects of health, such as mental health including depression, anxiety, and stress (Wu & Berry, 2018) which can have additional detrimental effects to the physical health of an individual (Reynolds et al., 2018). Furthermore, weight stigma may lead to healthcare avoidance, which can have additional consequences (Amy et al., 2006), as well as perceived sub-standard care from health care providers (Brown et al., 2006).

In Canada, 9.9 million adults are considered overweight, and 7.3 million are considered "obese" (Statistics Canada, 2019). In 2016, 64% of Canadian adults were overweight or "obese", compared to the global prevalence of 39% (WHO, n.d). However, "obesity" is not experienced equally in Canada. For example, Indigenous populations in Canada have a higher prevalence of

"obesity' compared to the non-Indigneous Canadian population (Garriguet, 2008). Previous research has also established that self-identifying as Indigenous is a significant predictor of overweight or "obesity" (Garriguet, 2008; Statistics Canada, 2020). Indigenous populations also experience inequities in terms of access to perishable and nutritious foods, particularly in Northern Communities (Galloway, 2017), one of many factors that may contribute to these unequal experiences.

The epidemic construction of "obesity" incorporates pre-existing, stigmatizing stereotypes associated with fatness. Stereotypes, a part of Link & Phelan's (2001) definition, are also a part of the process of stigmatization. Examples of these stereotypes include that fat people are lazy, stupid and worthless, and can be implicit and un-conscious judgements or explicit and consciously enacted (Teachman et al., 2003). These stereotypes have been well documented in a variety of environments, such as employment, health care, and education, and anti-fat stereotypes in public spaces have been less so (Puhl & Brownell, 2001; Puhl & Heuer, 2009). In an employment setting, for example, anti-fat stereotypes have been found to result in measurable disadvantages such as lower wages or reduced chances of promotion for overweight or "obese" employees (Puhl & Heuer, 2009). Additionally, in previous research with an education setting, children in Spain as young as primary (elementary) school have been found to exhibit implicit anti-fat stereotypes and weight bias (Pereda-Pereda, Echeburúa & Cruz-Sáez, 2019).

Anti-fat attitudes and stereotypes have also been found to be directed more towards adults than children, and this then results in parents being blamed for their children's weight status (Holub, Tan & Patel, 2011). In particular, it is mothers who are held responsible for their children's "obesity" (Holub, Tan & Patel, 2011; Kokkonen, 2009; De Brún et al., 2013; Jackson, Wilkes, & McDonald, 2007). Mothers reported to have felt guilt, blame, judgement and stigma, from themselves and others, if their children are overweight or "obese" (Jackson, Wilkes, & McDonald, 2007). In this way, parents of "obese" children are then associated with anti-fatness stereotypes (lazy, irresponsible, poor character) along with being perceived as bad parents (Kokkonen, 2009). Additionally, mothers are held to be responsible for the health of their children (De Brún et al., 2013; Ioannoni, 2017). Anti-fatness stereotypes are prevalent in many aspects of the social world, for all ages, and are a compelling element of the biomedical approach to "obesity" and the corresponding discourse.

Critical Weight Studies and Alternative Constructions of "Obesity"

"Obesity" can also be understood outside of the biomedical or disease model, as the medicalized, self-responsibilized, and stigmatized understanding of fatness. As well, the origins of "obesity" discourse cannot be understood without recognizing the racialization and gendering inherent in the epidemic approach to "obesity", as described by Sabrina Strings in Fearing the Black Body: The racial origins of fat phobia (Strings, 2019). The medicalization of "obesity" has a considerable history, but the current stage of this progression can be well illustrated by the Body mass index (BMI), a measure of weight for height. Firstly, the BMI measure was intended to be used to measure weight-related health at a population level but has been continually used to rank individual health status (Lupton, 2018). The boundaries for BMI categories also changed in 1998 and 2004, which then included more individuals in the overweight or "obese" categories, contributing to the epidemic status (Lupton, 2018; Statistics Canada, 2019). More recently, the overweight category of the BMI has also been found to have *protective* effects on health, as opposed to higher risk of disease, especially in older adults (Flegal et al., 2007; Fransoo et al., 2011). Finally, BMI is based on white European population data, and thus cannot be considered an accurate measure of weight-related health for all, particularly if applied to racialized populations (Norman et al., 2015). The use of BMI, and the current developments associated with it serve to illustrate the positivist and universalist paradigms that "obesity" discourse is informed by.

Scholars of critical weight studies also draw attention to the discourse of self-responsibility for body size such that an individual becomes entirely responsible for their weight status (Thille, 2018; Bombak, 2014). With the common, scientifically inaccurate construction of weight as merely a reflection of diet and exercise, higher weight bodies are perceived as a failure of the individual (Thille, Friedman & Setchell, 2017). Also within this construction of weight, it is the individual's responsibility to self-regulate, and therefore control their weight, even leading some to the extreme of bariatric surgery as a solution to "obesity" (Bombak, Monaghan & Rich, 2019). Finally, "obesity" is constructed as a burden to others, to the health care system, and to the global population (Kirkland, 2011; De Vogli et al., 2014). This further emphasizes the personal failure frame associated with "obesity". The self-responsibilization for weight is critical for understanding how the stigmatization of "obesity" occurs.

Stigma and Weight

As defined in Chapter 1 by Link & Phelan (2001), stigma occurs when "labeling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them". Importantly, stigma can also be described more explicitly in terms of identity, to do with moral character (Turan et al., 2019), social identity (Reutter et al., 2009) or even spoiled identity (Burris, 2008). Stigma and stigmatization can be related to many aspects of status, including health status or social status, which can be determined by race, socio-economic status, and appearance, among others. Stigma has everything to do with power, status and norms.

Stigma operates by the devaluing of a specific trait, which could be related to identity (eg. Race), behaviours (eg. Smoking), health conditions (eg. HIV), or appearance (eg. "obesity"). This devaluing can come from macro-level forces, such as colonialism, micro-level interactions, between individuals, or structural-level interventions (creating structural stigma) (Reutter et al., 2009). Additionally, stigmatization can occur within the self, by the internalization of stigmas, and self-responsibility for the stigmatized trait or behaviour (Bombak, 2014; Cook et al., 2014; Public Health Agency of Canada (PHAC), 2019). Self-stigmatization can also occur through anticipated stigma, when an individual is expecting to be judged (stigmatized) due to their outward identity or behaviours (PHAC, 2019). Stigma also has an emotional component, eliciting emotions such as shame and guilt (Burris, 2008), as well as anxiety in the case of anticipated stigma (PHAC, 2019).

Stigma affects health, for example, weight stigma can have negative impacts on both the psychological and physical health of an individual, as well as changing health care interactions (Puhl & Heuer, 2010; Rubino et al., 2020; Amy et al., 2006; Wu & Berry, 2018). However, identities are complicated, and stigmatized individuals may also experience the effects of multiple stigmas, which can have additive or complicating effects (Turan et al., 2019). For example, Logie et al. (2016), in their study with Black Women living with HIV in Canada, found that HIV stigma, racism, mental health, poverty, access to social services, and self-related health all interacted. In fact, they were able to associate racial discrimination and HIV related stigma with depression and lower social support, for example (Logie et al., 2016) Therefore, stigma has tangible effects on health, but it is not always simple to identify, and often affects those who are already marginalized (Logie et al., 2016).

In the context of SSB taxation, stigma is relevant as it can be perpetuated through policies, such as health policies put in place to change behaviours, creating structural stigma (Reutter et al., 2009). Policy can also legitimize pre-existing stigmas (Reutter et al., 2009). The presence of stigma as a behaviour change mechanism in policy has led some to conclude that these policies are unethical due to the de-valuing of groups of people, and as they typically have the greatest adverse effects of populations already oppressed (Burris, 2008; Brewis & Wutich, 2019). However, health organizations and health research are starting to recognize the harms of stigma, and take action. Stigma was identified by the Public Health Agency of Canada (PHAC) as a major influence on the health of Canadians in 2019, and a public health priority to address (PHAC, 2019). Additionally, the PHAC recognized that stigma contributes to both social and health inequities (Stangl et al., 2019; PHAC, 2019). Finally, there are also multiple global initiatives focused exclusively on ending weight stigma in policy, such as: The Joint International Consensus Statement for the Ending of Stigma of Obesity, which was assembled by multiple international experts as well as organizations (Rubino et al., 2020). Therefore, exploring stigma within SSB taxation is both timely and important.

Moralisation and Health

Moralism can be defined as "a social process, by which activities come to acquire moral status within a particular social/cultural context, at a particular time" (Brown, 2018). For example, the changing perceptions of weight I have outlined above could be considered the moralisation of weight, the moving of weight into the moral domain. Brown describes the differences between applying morals to an already moralised context, which is less problematic, versus a new context, where the morals applied are "contentious", i.e. that they are not universal (Brown, 2018). Moralisation can also be related to personal responsibility, particularly within health and health policies. In addition to the exclusionary effects outlined above, moralisation can result in stigmatization (Brown, 2018).

The specific moralisation of health has been termed Healthism (Crawford, 1980). This concept was intended to capture the evolution of growing "health consciousness" of the 1970s (Crawford, 2016). Brown defines healthism as the medicalization of new domains of life, and the elevation of health to a new "super-value" (Brown, 2018). Thus, health-valuing cultures and their citizens measure themselves by how well they ascribe to accepted ideas of health, and by the

characteristics that indicate health-forward behaviours (Crawford, 2016). Culture is also defined, in these cases, by the pursuit of health as it is a requirement for a good life (Crawford, 2016). Individuals that "super-value" their health are thus good citizens (Crawford, 2016), or as Lupton puts it "'Healthiness' has replaced 'Godliness' as a yardstick of accomplishment and proper living" (Lupton, 1995). Healthism can also have consequences, which Crawford (2016) terms "victim-blaming", or the stigmatization of behaviours. Although we will be exploring healthist discourses, and their application to weight, alternative frames such as cultural framings of weight do also exist (Lupton, 2018).

Taxation, Policy and Fairness

Taxation is certainly a contentious topic, and it has been reported that many individuals will first respond to taxation with a general dislike (Kirchler, 2007). Kirchler (2007) highlights three fundamental components of taxation psychology relevant to our analysis: (dis)trust, norms and justice. The first, (dis)trust, typically is aimed at the creator of taxes, the government; however distrust can also result from poor understanding of tax systems (Kirchler, 2007). The opposite is also true, a good understanding of tax can encourage governmental trust (Kirchler, 2007). Generally, satisfaction with public/social services such as education, health, security/justice, etc. contribute to higher government trust (Murtin et al., 2018). Additionally, trust in others has also been found to be related to neighbourhood connectedness, such that more connection typically results in more trust (Murtin et al., 2018). Trust can be fostered in many different ways, and is a relevant narrative in terms of taxation acceptability. In this way, exploring SSB tax acceptability within neighbourhoods may be an appropriate approach.

Social norms are the second component of taxation psychology that contributes to tax discourses. Taxation, as a form of governmental regulation, establishes social norms within instruments of the state and vice versa (Dagan, 2016). In this way taxation can establish what is perceived to be "normal", and create a "normative taxpayer" (Dagan, 2016). Additionally, Kirchler (2007) identifies Christian values as an influence on tax discourses, which contribute to tax behaviours. SSB taxes are considered by many to fall into the category of "sin taxes", which are seeking to tax supposedly harmful consumptive products, a classic example of which is tobacco. The word "sin" is derived from Christian understandings of moral failing, and neoliberalism (Reubi, 2016). Therefore, taxation is a covert avenue by which values or morals

can be established and normalized within economic systems and the societies they belong to. With respect to SSB taxation, social norms regarding "obesity", SSB, and health are relevant.

The final component of tax psychology relevant to our exploration of tax discourses is justice. Kirchler (2007) emphasizes the role of justice as another influence on tax behaviour and a point of concern for taxpayers. Wenzel describes three different levels that justice operates on, and three types of justice (Wenzel, 2003). The three different levels are the individual, the group (could be social group, occupational, ethnic group, etc), and the societal level (such as Canada-wide) (Wenzel, 2003). The first type of justice is *distributive justice*, which is concerned with the exchanging of resources, as well as the balance between contributions and benefits (Wenzel, 2003). Thus, distributive fairness is reached when the taxpayers perceive that their contributions are matched by the rewards or benefits they could receive, as well as how their contributions/benefits are fair in relation with others (Kirchler, 2007). The second type is *procedural justice,* which is focused on the fairness of the *process* of the distribution of resources (Wenzel, 2003). Procedural fairness is reached when tax implementation is perceived to be executed with respect, consultation, justification, and efficiency (Wenzel, 2003). Finally there is *retributive justice*, which is concerned with the perceived fairness of punishment for any rule-breaking (Wenzel, 2003). All three types of justice and levels are relevant to explore regarding SSB taxation, particularly given existing socioeconomic disparities in SSB consumption.

Health Equity and Public Health Policy

In Canada, policy makers (and thus their policies) have been described as the "worried, white, wealthy and well", or the 4 "w"s (Kerner, 2008). The 4 "w"s also characterize the dominant social group in Canadian culture, and as a result are representative of both the context and target for public health policies in Canada (Lupton, 1995). According to Lupton (1995), policies are also vital in establishing norms and therefore the standards for health. In our case, health and normal are represented by the 4 "w"s, and those who do not fit these norms are then vital to the maintenance of power. Therefore, the 4 "w"s and their policies that Kerner (2008) is describing are therefore both creating and maintaining the dominant culture.

Looking deeper at the process of creating values and norms through policy, it is inherently moralistic, as a specific set of values are being imposed on a diverse population through policy implementation (Lupton, 1995). In this way public policy becomes a method of

social control, and another way to maintain power relationships (Burris, 2008). In a similar critique, Preda and Voight (2015) highlight that the consequence of normalizing policies is that individual experiences are not represented nor are their social contexts reflected in policy. Instead, the context and experience that is represented is that of the policy makers, or the socially dominant group. In this way, policies can lead to, or exacerbate, health inequities (WHO, health inequities; Frohlich & Potvin, 2008).

Health inequities are defined by the WHO as a "difference in health status or in distribution of health resources between different population groups because of social conditions" (WHO, 2018). Health inequities differ from inequalities as they are modifiable, unfair and unjust; and thus, health status can be shaped by political, social and other factors, not just biological ones (WHO, Health Inequities; Government of Canada). Health inequities are faced disproportionately by lower income and marginalized populations (Carroll, 2017; WHO, 2008).

Another issue that can arise from moralistic public health policy is the concept of individual responsibility for health (Frohlich & Potvin, 2008). As previously mentioned, responsibilization of health, such as for "obesity" can lead to stigmatization. Lupton describes the effects of moralistic health policies as creating self-regulation or self-policing (Lupton, 1995), which can also lead to the responsibilization of health. Indeed, implementing policies that are driven by implicit social values result in individuals themselves regulating their own status in regard to the norms of health (Lupton, 1995). These types of policies serve to create and enforce norms and standards for health, which have been modelled on the norms of 4 "w"s (Kerner, 2008). As a result, these policies can lead to individual responsibilization for health, as well as stigmatization, particularly among populations already oppressed by multiple identities.

I am interested in exploring discourses used by members of a dominant social class in discussing SSB taxation. The theories just described (weight stigma, tax psychology and healthism) inform my exploration of discourse, as they establish the beliefs, values, assumptions and thus identifiable elements of discourse. The discourses identified can then be used in the analysis process to describe the ideology of the dominant social group, to address my first objective. For my second objective, these three theories were specifically selected to address what is found to be acceptable in dominant society, and their discourse, and what is not.

Therefore, these three theories will inform my analysis of acceptability in terms of SSB and its taxation, as well as provide insight into the ideology of the dominant social group, represented by my participants, to better comprehend their power and its effects on policy, discourse, and other groups.

Chapter 3

Methods

Paradigmatic Framework

My study design and analysis were informed by a critical paradigm (Cresswell, 2013; Moosa-Mitha, 2015), which was complimented by my use of critical theoretical frameworks. Throughout this study, I have been inspired by ideas from both anti-oppressive and transformative approaches. For the reasons that follow, I was not able to completely subscribe to these paradigms, but concepts from them were included as much as possible. These reasons include logistical limitations, limitations as a student, and that I am performing a secondary data analysis, along with the unique nature of this study. Additionally, this thesis project is part of a larger Indigenous health study, but all participants with my project self-identified as white and non-Indigenous. Additionally, the larger study is community-based, but my individual project is not, although it is 'community informed' by the Indigenous partners who are the community foundation for the larger study. Therefore, my study cannot truly be defined as anti-oppressive or transformative, although it is informed by these approaches (Moosa-Mitha, 2015; Potts & Brown, 2005; Creswell, 2013).

A critical orientation directed my focus on exploring power, inequities, and social change (Creswell, 2013). Ontologically, it is difference-centred, versus universal or positivist paradigms, and is focused on the validity of individual perspectives (Moosa-Mitha, 2015). The epistemology of this paradigm is that knowledge is subjective, based on experiences and has a context (Moosa-Mitha, 2015). My epistemology was also inspired by what Potts and Brown describe as a pillar of anti-oppressive research: knowledge as socially constructed and political (Potts & Brown, 2005). These epistemological considerations are important when addressing my research questions, and aligns with my methodology of Critical discourse analysis, which is intended to address "pressing social issues" (Van Dijk, 1993). Similarly, another important paradigmatic consideration that I borrowed from anti-oppressive and transformative approaches is the idea of social justice, injustice, and resistance (Moosa-Mitha, 2015; Potts & Brown, 2005). With this in mind, I hope that my research will contribute to health equity in two ways, the first is by critically reflecting on the dominant group, behind the proposed policy (SSB taxation), and secondly by exploring discourses pertaining to "obesity", healthism, justice, norms and trust in relation to SSB and taxation, and how they inform ideology, as well as policy.

Methodological Framework

Critical discourse analysis (CDA) is the qualitative methodology or framework that I used for my analysis. In particular, my methods were guided by Fairclough's Critical Language Awareness (which quite soon after was renamed to CDA) (Clark et al., 1991), with some inspiration from Van Dijk's (1993) socio-political CDA. Socio-political CDA is primarily concerned with the "role of discourse in the (re)productions of and challenges of dominance" (Van Dijk, 1993), which I found to be quite complimentary to my research questions, and participants, although was intended for media-specific analysis. As such, the methods outlined by Fairclough and colleagues (Clark et al., 1991) were combined with the focus on power, and dominance that van Dijk (1993) emphasized.

Discourse can be defined in many ways, but Fairclough and colleagues (Clark et al., 1991) described it as "verbal interaction as social practice". Discourse in action, or discursive practices, is both the production and consumption of texts, through language, for example: interviews, institutional texts, or advertisements (Jørgenson & Phillips, 2002). These discursive practices are also important in the creation of the social world, including social relationships (such as power relationships) as well as social identities (Jørgenson & Phillips, 2002; Vaara & Tienari, 2010, Clark et al., 1991). Discourse, and therefore also CDA, is centred around a cycle: people are both the products of discourse and the producers of discourse (Edley & Wetherell, 1997; Jørgenson & Phillips, 2002). As a result of this relationship, discourse can function on an ideological level (Jørgenson & Phillips, 2002), and the critical part of CDA engages with the "ideological presuppositions of a text and understanding how it constructs a particular version of reality" (Cameron & Panović, 2014).

CDA is complimentary to my research objectives as it allows for searching for hidden, or underlying forces in the interview texts, as opposed to purely focusing on the surface level or content of the text (Cameron & Panović, 2014). This is what Cameron & Panović refer to as "covert" data, and it was essential to identify and construct the dominant discourses used by my participants in discussing SSB, using the theoretical lenses of *weight stigma*, *healthism* and *tax psychology*. The nature of my research questions and goals, which are seeking to understand the perspective of the dominant group, make direct questioning difficult. As a result, my analysis will rely on what is unsaid, or the forces and assumptions that are dictating what is being said by participants. Using a methodology that will allow for a deeper level analysis of the interview

text, and the inclusion of theory at the point of coding is crucial to meeting my objectives. Additionally, another inspiration from van Dijk is the "top-down" approach, which directs the research focus on "elites and their discursive strategies for maintenance of inequality" (van Dijk, 1993). Taking this approach suits both my research questions and my participants, who represent the dominant societal group.

Design

My thesis project followed a qualitative research design, using CDA (Clark et al., 1991). The project was the secondary analysis of 18 semi-structured interviews, which were completed prior to the start of my (AW) graduate degree. My project is a part of a larger mixed-methods study titled, "Sticky Money": Exploring the acceptability of a sugar-sweetened beverage tax among Canadian Indigenous populations". "Sticky Money" includes qualitative data collection from four locations in Manitoba, including River Heights. My project is the location representing the dominant social group, for comparison with the other locations of the North End (another neighborhood in Winnipeg), Flin Flon (a rural location) and Island Lake First Nations, and all three including only Indigenous participants.

Setting

The location of my project was River Heights, a neighborhood in Winnipeg, the capital city in Manitoba. It was selected because of its demographic characteristics, which make it ideal to compare to the other locations in the larger study. River Heights is ideal for comparison as it is exemplary of a dominant social group, which is made up by the "4 ws" (Kerner, 2008). River Heights is an upper-middle class neighborhood whose residents are primarily white, highly educated, healthy, and food secure (Winnipeg Regional Health Authority (WRHA), 2015). In the 2019 Winnipeg Health Region Community Health Assessment, River Heights was reported to have a similar median household income to both municipal and provincial averages of $56,848 (Cui et al., 2019). River Heights had a prevalence of 14% low-income residents, which was also quite similar to municipal and provincial numbers (Cui et al., 2019). The population of River Heights included 8.7% Indigenous people, and 14.9% visible minorities (Cui et al., 2019). Additionally, 64% of the River Heights population had a post-secondary certificate, degree or diploma, which is much higher than the municipal and provincial averages (Cui et al., 2019). Therefore, to examine the discourse around SSB and its taxation, the residents of River Heights will provide a valuable perspective as the dominant social group.

Participants and Recruitment

Participants were recruited based on the inclusion criteria of residing in the neighborhood of River Heights, being over the age of 18 and English speaking. Additionally, we used purposive sampling to recruit parents, young adults, consumers of SSBs and people who self-identified as "obese", to ensure that these perspectives would be included in our sample. Interestingly, only white residents volunteered, although we had no inclusion criteria stipulating as much. Additionally, 15 participants were female, 3 male, and every participant self identified in the interviews (or spoke about) parenting or grandparenting. Recruitment occurred through posters in community spaces, social media, and through snowball sampling.

Data Collection

Interviews were completed in the summer of 2019 (between May 5th and June 28th) with a total of 18 participants. The interview process included a demographic form, which the interviewer completed with the participants prior to the start of the interview. The demographic data collected was: gender identity, age, education level, employment status, race/ethnicity, self-rated health, food security, and SSB consumption level, to characterize the sample (See Appendix A: Demographic Form). The interviews were semi-structured and based on an interview guide, with additional prompts used by the interviewer (See Appendix B: Interview Guide). Interviews were performed in person, and primarily one-on-one. Field notes were written after the completion of each interview, to include any information that may be missing from the audio as well as providing context for later analysis. Initially we intended to recruit 20 participants, but after 18 interviews were completed, interest had decreased, previous interviews had been rich, and little new information was being shared. Therefore, instead of re-starting recruitment, we ended data collection at 18 participants. We considered the River Heights interviews to be rich as they averaged 24.6 minutes in length, and generated 240 pages of text. Interviews were completed by the PI (NR) and research study coordinator (KM), both of whom identify as white, cis-gender, thin women. Furthermore, both are also affiliated with the Department of Food and Human Nutritional Sciences.

Data Analysis

My role (AW) in the data analysis process started with transcription, and I transcribed 17 of the 18 interviews verbatim, while working in NR's lab as a summer undergraduate student (Summer 2019). Once this project became my thesis study (Fall 2019), and my project planning had commenced, I began using CDA methodology.

My data analysis process was centred on coding the interview transcripts using NVivo Pro software version 12 (Johnston, 2019). I started data analysis by re-engaging with the data, which included re-reading the transcriptions, field notes, and writing a brief summary of each interview (Braun & Clarke, 2006; Morse, 1994). Next, I began coding, starting with initial coding in NVivo, with copies of the transcripts. Once I had completed this step, I started a closer coding process of coding line- by-line through each transcript (Johnston, 2019). While coding I made sure to return to the initial transcripts, at the end of each stage, to ensure that there was continuity within the coding process and that any new or emerging ideas would be included in the first transcripts. The coding process for CDA, unlike other coding styles, is not as prescribed and instead there is a focus on asking questions of the data, or heuristic devices (Johnston, 2019; Eakin & Gladstone, 2020). My coding was guided by three areas of focus: language, interaction, and discourse, which are outlined below.

Language

When analyzing the language of a text using CDA, there is a focus on "linguistic choices (Cameron & Panović, 2014). These "choices" include the vocabulary, metaphor, grammar and framing of the text-creator (Cameron & Panović, 2014). I looked at the language used by both the participant and the interviewer, focusing on instances where "covert" data is being shared. As previously mentioned, "covert" data refers to the underlying assumptions and forces that are explicitly unsaid but are dictating what is being said or shared in the text (Cameron & Panović, 2014). Thus, language choices made by the participants in the interviews assisted in identifying discourses, and their underlying ideologies. Some sample questions could be: *Why have they chosen this word? Does the use of this word, or similar words repeat? What bigger ideas and beliefs are behind these words? What is this person really saying?*

Interaction

The analysis of interaction was less focused on the content of the interview, and more on the interview itself. Therefore, I looked at how both the participant and interviewer position

themselves, within the interview and with their opinions. Additionally, I explored the flow of power and control in the interview, and moments of domination. As well, I examined emotions and emotional responses, which was also an opportunity to bring in the field notes, for observed emotions or similar. Sample questions include*: How is this person positioning themselves relative to another group? How are they creating an identity? What is their identity within this discourse? Who has control over the conversation? How are they asserting control? What discursive practices are used to take/retake control? What is their emotional state? What creates an emotional reaction? What is behind this emotional reaction?*

Discourse

The third focus of my coding process was analyzing the discourses that are present in the interviews, to intentionally engage with them. Although my research questions are focused on dominant discourses, this part of my analysis also included looking for counter-discourses or resistance to the dominant discourse. This step was also the most direct way to bring in the theory that is informing my analysis. Some sample questions include: *What broader ideas are behind this? What discourses are being used? Are these dominant discourses? Are these weight stigmatizing discourse? Do they repeatedly discuss these beliefs or position themselves in the same way? Are they positioning certain behaviours as normal? Are they positioning certain behaviours as abnormal or unacceptable?*

Once I had completed coding, and answered the questions posed by my heuristic devices, I arranged the codes into webs, and started looking at how they could relate to discourses. Also at this point I sought both advice and refinement from my supervisor and advisory committee, to ensure I had correctly identified discourses and had enough examples, which I then began to write about. The final stage in data analysis was producing the final report, my thesis. My final report will be prepared as a sandwich thesis, meaning that the results of my analysis will be reported as two papers. These two papers correspond with each of my research questions. To ensure continuity and clarity, an additional discussion chapter and final conclusion will also be included to bring both sets of results together, and to highlight their significance and contribution to the research area. There will also be a short section between each of the papers, to provide cohesion and reinforce the flow of theories and results between the two papers.

Rigour

Lack of rigour is a frequent critique of qualitative research, and yet, rigour can be an important marker of the quality applied to conducting qualitative research (Tracy, 2010). Tracy describes both "due diligence" and appropriate methodology to be essential for rigourous methods (Tracy, 2010). "Due diligence" includes ensuring that enough time, care and effort to be comprehensive, is taken at each step (Tracy, 2010). Although my project is a secondary data analysis, the decision to stop interviewing, for example, would have had to comply with specific directions associated with rigour or quality of conducting qualitative research. To make this decision, the interviewers and myself (as the transcriber at this point) discussed the final interviews content in detail to determine that no new information had been raised that contributed to our decision to finish data collection. Diligence was also important for transcription, and I made sure to listen back to the audio recordings to ensure the accuracy of my transcription at various points. Another important way to demonstrate diligence is ensuring that the context for the study is valid. In the case of my study the context is the setting, River Heights, which is appropriate. I have described the reasons that it was selected for, namely that its demographics represent the population and perspective that we were seeking to explore (that of dominance), as well as being ideal for later comparison. River Heights may not have been the only neighborhood that we could have selected to represent our population of interest, however it was a good compliment to the other Winnipeg neighborhood being studied, the North End. These neighborhoods share a health care, political and tax system, along with having similar beverage availability and are part of the same school division (Winnipeg School Division, 2020).

I have ensured that my project is rigorous also by choosing and following an appropriate methodology (Tracy, 2010; Braun & Clarke, 2006). It is important to choose a methodology that is compatible for the project itself, starting with the research questions, frameworks, and continuing to the data analysis plan (Tracy, 2010). True to the iterative nature of qualitative research, there is always a chance that methods or even research questions can change within the research process (O'Rielly, 2005). However, rigour can be maintained as long as the changes are making the project more appropriate and realistic, and documenting these changes (O'Rielly, 2005). Documentation itself is another important part of rigour, and recording research decisions, as well as logging what has been done are ways to achieve this (O'Rielly, 2005). Memo writing served a dual purpose of facilitating analytical writing at different points in the analysis process,

as well recording methodological decisions, or changes to my data analysis plan (Richardson, 1998; Potts & Brown, 2005). Maintaining rigour, and overall producing a quality qualitative project is as important as without quality the results will not be actionable.

Ethics

The larger project, "Sticky Money" was approved by the Health Research Ethics Board (HREB) at the University of Manitoba (HS21878 (H2018:234)). I also gained ethics approval from the Joint-Faculty Research Ethics Board at the University of Manitoba for secondary data analysis for my thesis research specifically (HS24335 (J2020:068)).

Additionally, at the stage of data collection, each participant provided their individual informed consent to participate in the study and the use of their data for analysis. The participants also had the option to leave at any time, and restrict the use of their information, or use of direct quotations, one of whom did. I also completed both PHIA (Personal Health Information Act) and TCPS-2 CORE (Tri-Council policy statement: ethical conduct for research involving humans course on research ethics) training in ethics, to ensure all data from participants were and will be used in an ethical way (See Appendices C and D for certificates of completion for the respective courses). Finally, I also signed a confidentiality pledge, to guarantee my ethical conduct with the interview and participant data (See Appendix E).

Ethics are an important part of anti-oppressive research, and for reasons I have outlined I was not able to take a transformative, or participatory approach (and thus have not been relationship focused on this project as anti-oppressive tenets dictate), I am committed to respecting my participants and their perspectives (Potts & Brown, 2005). As a part of the larger study, the National Indigenous Diabetes Association (NIDA) and their executive director were involved in the development of the study, including the selection of data collection locations, and the value of exploring this perspective. As well as sharing the data with our community partners, I am intending to use the results of my study to address health inequities between the dominant and non-dominant groups, inspired by anti-oppressive theories (Potts & Brown, 2005). I plan to prepare an article summarizing my findings for Conversation Canada, with the guidance of my supervisor, Dr. Riediger, particularly exploring weight stigma and the potential harms of SSB taxation.

Reflexivity

Throughout my research project, I have had to reflect on many topics that I was conflicted about. These are chiefly those that surround my new role as a researcher, including my relationship to the setting, my identity, and my discipline. Using the ideas of Pillow (2003) from their article "Confession, catharsis or cure? Rethinking the uses of reflexivity as methodological power in qualitative research", I sought to reflect on where I felt the most comfortable, uncomfortable, and why I felt that way.

The first place of reflection was on the setting, River Heights. My study is located in the neighborhood where I grew up, and my immediate family still lives there. It is a context in which I am familiar and feel comfortable. As a researcher, I am an insider in many ways due to my familiarity with the culture and norms associated with a white middle class neighborhood, and that made me uncomfortable. To explore that feeling more, I realized I am also an insider because of my membership within the dominant group, and which the participants also belong to. I am a white, thin and cis-gendered female, meaning that I too am a part of the four "w"s (Kerner's "worried, white, wealthy and well" (2008)), and come from a degree of privilege. As mentioned earlier, both of the interviewers also identify this way, and therefore the interview environment is shaped, from all sides, by the dominant group. This suggests that certain social norms and values we all hold around health, diet, food and life in general may be intrinsic to how I read the interviews, or understand the data. The three of us also work in the disciplines of nutrition, and academia in general. This further contributes to our insider status due to our pre-existing membership in the academic community and background knowledge that is the context for this project. Finally, the role of being a researcher, no matter the discipline is automatically associated with power, and creates a power relationship with participants. But why does this make me uncomfortable?

Doing critical research demands a focus on power, dominance and equity in society, but it is also important to be critical of yourself as the researcher, including your own identity, privilege, and power. Once you begin on this journey of critical research, it becomes uncomfortable to realize that your identity, ideology and life have been shaped by the same norms, social forces, discourses etc. that you are analyzing, and how much they are going to be present in your research. I realized that my inherent complicity was why I felt uncomfortable being an insider. However, to ensure that I am actively reflecting, challenging my perspective

and the status quo is one of the reasons why I chose to take a critical perspective in my research. By situating myself this way, I am intentionally exploring the dominant group, their power and how it is exercised and maintained, with the context of SSB taxation. To uphold this perspective I am guided by Pillow (2003), in that I am also acknowledging my own assumptions, based on my identity, about both dominant and non-dominant groups (Pillow, 2003). As Pillow cautions, it is important to be comfortable that unfamiliar experiences or perspectives will remain unfamiliar (Pillow, 2003). In addition to this idea, it is also crucial to get comfortable with being uncomfortable, especially when reflecting on my identity, the groups I am privileged to belong to, and that I am co-creating knowledge throughout this project, which will be reflective of who I am.

A final element of my identity that I have reflected upon is my academic background in nutrition. As a result, I am bringing to this project previous knowledge about diet, food patterns, food guides as well as an understanding of the social aspects of food. Nutrition is a unique area of study as it can combine on one hand, the biological and physiological aspects of food intake, and the socio-cultural and spiritual importance of food. This will help me take a more holistic and diverse perspective into my project, but I also need to be mindful of the cultural aspects of the discipline of nutrition in which I have been socialized in. Traditionally, nutrition has been rooted in biomedicine, and to maintain ontological and epistemological consistency with the design of my study, I will need to work and reflect on how I am thinking about food, people, and health related policy. I understand that other cultural norms may be unfamiliar to me, other ideas about health and weight, diet and stigma may vary from my own. To ensure rigour, I can perform my analysis according to my data analysis plan and ground it in my data. However, the value of my study is not lessened by my subjectivity, as long as I can remain aware of my influence and the implications of it (Pillow, 2003).

Chapter 4

Manuscript 1:

"If you're serious about losing weight, why are you drinking all those cokes?": A critical discourse analysis of interviews on sugar-sweetened beverages amongst residents of a middle to upper class neighbourhood in Winnipeg, Manitoba

Abstract

Background: Global concern about what some call an "obesity epidemic" has led to the development of policy directed at prevention and treatment. Sugar-sweetened beverages (SSB) have been identified as a policy target, due to their sugar content, and associations with weight gain. However, "obesity" is also associated with social stigma. Therefore, policies directed at "obesity" should be evaluated for their potential to exacerbate existing stigmas or create new ones. The purpose of this study was to explore the key discourses used when discussing SSB, and their consumption and purchasing, amongst residents of a middle-upper class neighbourhood in Winnipeg, Manitoba, Canada.

Methods: Critical discourse analysis methods were used to analyze qualitative interviews, collected as part of a province-wide study on SSB. English-speaking, adult participants were recruited from a middle-upper class neighborhood of Winnipeg using a purposive sampling approach. Weight stigma was used as our theoretical framework.

Results: Eighteen participants were recruited, 15 of whom were women, and all self-identified as white, and parents or grandparents. The major discourse utilized by participants discussing SSB was *personal responsibility*, which determined the acceptability of SSB purchasing and consumption in varying contexts. Responsibilization of SSB behaviours were discussed in relation to weight and health, such that regular, or irresponsible, consumption, were largely discussed with negative emotions and judgement. Acceptability of SSB was context and person dependent such that any consumption perceived as regular was less acceptable, and consumption by higher weight individuals and children were less acceptable. In this regard, parental responsibility for SSB intake of children was prominent throughout the interviews, and elicited judgement towards others and themselves, particularly among mothers. Participants also utilized some alternative discourses such as body positivity or empathy for individuals struggling with food insecurity.

Conclusions: The weight stigmatizing discourse of personal responsibility was prominent among participants whilst discussing SSB. Results suggest stigma is directed at parents, more so mothers, individuals of higher weight, and lower income populations. Public health organizations and policy makers should strongly consider the impacts of policies directed at SSB, such as public health messaging or taxation, on stigma, as key discourses utilized by the dominant social group are stigmatizing.

Introduction

Sugar-sweetened beverages (SSB) have been identified as a public health concern amidst the so-called "obesity epidemic" (Dietitians of Canada, 2016; Heart and Stroke, 2017; WHO, 2017). SSB can be defined as any beverage that is sweetened with added sugars, and includes soft drinks, fruit drinks (although not 100% juice), sports drinks, and other types of pre-prepared beverages (Dietitians of Canada, 2016; USDA, 2015; CDC, 2017). SSB have been identified as a potential intervention point to prevent and treat "obesity" (WHO, 2018), due to their sugar content. SSB, and added sugars, are associated with weight gain (Malik et al., 2013). In addition, SSB are also associated with dental caries and type 2 diabetes (Malik et al., 2010; Moss et al., 2021)

"Obesity" Discourses

"Obesity" discourse[4] is founded on the concept of medicalization of fatness as a biomedical health condition (Lupton, 2018). Medicalization is "described [as] a process by which human problems come to be defined and treated as medical problems" (Sadler et al., 2009). Common perceptions of "obesity" include that it is a serious medical condition, evidence of a failure to self-regulate, and, as such, worthy of disgust (Lupton, 2018). Another core element of anti-"obesity" discourse is the concept of personal responsibility for weight, as within the medicalized framing of "obesity" an individual has failed to be responsible for their dietary consumption or compensatory activities (i.e. exercise)(Lupton, 2018; Bombak, 2014; Kirkland, 2011).

"Obesity" stereotypes are an example of enacted anti-"obesity" discourse. Some stereotypes include laziness, stupidity, or worthlessness (Teachman et al., 2003). When children are perceived as "obese", stereotypes are often directed towards their parents instead, and mothers in particular (Kokkonen, 2009; Jackson, Wilkes, & McDonald, 2007). These parental stereotypes build on anti-"obesity" stereotypes with parents being held responsible for their

[4] Discourse, as defined by Fairclough and colleagues (Clark et al., 1991) is "Verbal interaction as social practice"

children's weight, contributing to stereotypes of being permissive or bad parents (Kokkonen, 2009; De Brún et al. 2013; Ioannoni, 2017)

Alternative discourses to anti-"obesity" discourses recognize that health can exist at different body sizes, or body types, such as the Body Positivity movement or Health at Every Size™ (HAES™) (Bacon et. al, 2005). Additionally, these discourses embrace that different bodies are an example of natural variation among people and recognize the importance of intersectionality, such as gender, race (Strings, 2019), and other aspects of identity and social circumstances that can exacerbate stigma and discrimination in multiplicative ways.

Stigma and Weight

Stigma, as defined by Link & Phelan (2001), is when "labeling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them". Thus, stigma is created by power imbalances, and as such can occur within an individual, through interpersonal interaction, or at a structural level (e.g. intervention or policies) (Link & Phelan, 2001; Reutter et al., 2009). Stigma devalues a specific trait, which can be related to identity, behaviors, health conditions or appearance and is associated with negative emotions such as shame, guilt (Burris, 2008) or anxiety, in the case of anticipated stigma of oneself (PHAC, 2019). Self-stigma can also occur through the internalizing of stigma and stigmatizing discourse (Bombak, 2014; Cook et al, 2014; PHAC, 2019).

Weight stigma is an essential element of "obesity epidemic" discourse, where an individual is stigmatized based on their weight. The personal reponsibilization of weight is a foundational assumption underpinning weight stigma, which ignores any external factors, social forces and the like, that may be contributing to lifestyle-related behaviours, weight, and health of an individual. In biomedical and public health discourse, "obesity" is seen as a failure of an individual to self-regulate and be a "good citizen" (Lupton, 1995), in this way centering the responsibility for "obesity" on an individual also contributes to weight stigma.

Beverage consumption patterns

In Canada, where the most recent dietary data is provided by the 2015 Canadian Community Health Survey (CCHS), SSB are not consumed uniformly among the population. Consumption patterns of SSB in Canada differed based on socio-demographic factors (Jones,

Kirkpatrick & Hammond, 2019). Canadian men consumed more than women (Jones, Kirkpatrick & Hammond, 2019). Additionally, children and adolescents aged 9-18 were the highest consumers of SSB, and when looking solely at adults, the youngest group of adults were the highest consumers (Jones, Kirkpatrick & Hammond, 2019). Potentially the most important result from the 2015 CCHS was that, when compared to the previous survey (2004), daily consumption of SSB or high-calorie beverages had decreased significantly (Jones, Kirkpatrick & Hammond, 2019; Tugault-Lafleur & Black, 2019). Though it remains unclear among which population groups intake decreased the most. From a different study exploring the consumption patterns of youth, boys were also found to be higher consumers than girls, like adults, and in general, youth were found to be high consumers (Vanderlee et al., 2014).

Race/ethnicity was also a relevant socio-demographic factor when considering SSB intake. In Canada, off-reserve Indigenous[5] populations reported the highest volume consumption of SSB compared to all other ethnicities in 2015, while white populations consumed the most alcohol (Jones, Kirkpatrick & Hammond, 2019). Race/ethnicity is particularly relevant in the chosen context of the "obesity epidemic", as Indigenous and other racialized populations are also disproportionately categorized as "obese" (WHO, 2018; Carroll, 2017).

While Canadian data is lacking, income has also been found to be associated with SSB consumption among other populations. In the USA from 2008-2016, higher income individuals were found to have the lowest SSB consumption (Zagorsky & Smith, 2020). Put another way, those with higher income had a lower likelihood of drinking SSB, or a lower number of SSB consumed weekly (Zagorsky & Smith, 2020). Therefore, the highest consumers of SSB in Canada may already be encountering stigma and discrimination due to race, income, weight, and/or other socioeconomic factors, which is relevant to our exploration of stigma.

Policies targeting Sugar-Sweetened Beverages

Reducing the intake of SSB, in the context of the "obesity epidemic", has been an increasingly attractive intervention for public health organizations and governments. Many different policies have been proposed that seek to use SSB (and SSB consumption) as an

[5] Indigenous People in Canada are comprised of First Nations, Métis and Inuit, as defined in Section 35 of the Canadian Constitution of 1982.

intervention point for “obesity” reduction policies. Krieger and colleagues (2021) identified that these proposed policies can be categorized as: financial, informational, default, and availability. Financial policies would include SSB taxation. Informational policies would include changes to labelling or advertising, such as the front-of-package labelling that has been proposed in Canada (Health Canada, 2021). Policies that create defaults would be those that seek to make other beverages, such as water or milk, the default at restaurants or schools; for example, in meal combinations or programs. In the American context, a policy had been previously implemented in New York City to limit the size of SSB that could be purchased, which has since been overturned (Roberto & Pomeranz, 2015). Changing availability of SSB was also explored in a pilot project that explored the influence of the placement of SSB in the grocery store on SSB purchasing (Minovi, Munch & Synder, 2021). Finally, in the context of our study, Manitoba has previous implemented policies that effect the availability of SSB in schools, such as in vending machines or cafeterias (Manitoba Health, 2014).

SSB taxes, specifically, have been proposed in the Canadian context, both at the federal and provincial levels. The province of Newfoundland and Labrador is set to be the first province to introduce a SSB tax in April of 2022 (Government of Newfoundland and Labrador, 2021). Additionally, they have garnered support from major health organizations, globally in the WHO (WHO, 2017), and nationally with the Dietitians of Canada (Dietitians of Canada, 2016), Heart and Stroke Foundation (Heart and Stroke, 2017), and the Canadian Centre for Policy Alternatives (CCPA) (CCPA, 2020). All these organizations describe SSB taxes as policies to address “obesity”.

Stigma and Policy

Stigma in general has been reported to contribute to both social and health inequities (Stangl, 2019; PHAC, 2019). The intersection of multiple stigmas, or other marginalized social identities, is also linked with adverse health outcomes and behaviours (Reutter et al., 2009; Turan et al., 2019). In fact, recognizing and ending weight stigma in public policies is gaining increasing recognition, due to the negative effects on health. There are global calls to end weight stigma (Aarora et al., 2019; Rubino et al., 2020). In the Canadian context, the Public Health Agency of Canada released their annual report in 2019 which was titled “Addressing Stigma: Towards a More Inclusive Health System” (PHAC, 2019); given the increasing implementation

of taxation of SSB globally, and now in Canada, exploring SSB, weight stigma and "obesity" discourses is urgently needed.

The purpose of this study is to explore the discourse around SSB amongst residents of River Heights, a middle-upper class neighborhood, in Winnipeg, Manitoba, Canada, using critical discourse analysis methods. Specifically, our research question, using weight stigma as a theoretical lens, was: *What are key discourses around SSB and their consumption and purchasing amongst white residents of River Heights, Winnipeg?*

Material and Methods

Design and Framework

This study is situated in a critical paradigm, focused on exploring power, inequities and social change (Creswell, 2013). We used Fairclough's critical discourse analysis (CDA) (Clark et al., 1991) to explore the "role of discourse in the (re)productions and challenges of dominance" (van Dijk, 1993). Discourse itself can be defined as verbal interaction as social practice (Clark et al., 1991).

Given that the policy of SSB taxation is geared at impacting bodily fatness, we explored how both common and resistant discourses are taken up by our participants, the criteria for which were selected to represent the dominant social group. Respectively, the theoretical framework chosen for this study was critical weight studies. Our theoretical framework was applied throughout the research study when developing the interview and research questions, engaging with the data, coding, and interpretive analysis.

Setting

The study was conducted with residents of the neighborhood of River Heights situated in Winnipeg, Manitoba, Canada. River Heights is a middle to upper class neighborhood and was selected to be the setting for this study as the residents well represent the dominant social group in Canadian society (WRHA, 2015). Nearly 75% of River Heights residents are white, and 64% have a post-secondary certificate, degree or diploma (Cui et al., 2019). River Heights residents also prioritize public health; for example River Heights is one of the three neighborhoods in Winnipeg with the highest COVID-19 vaccine uptake (Government of Manitoba, 2022). River

Heights also has a history of supporting liberal politics. Both current representatives for the area are Liberals, in at least their second term, and coincidentally are both men 70 years or older: Jon Gerrard (Provincial) and Jim Carr (Federal) ("Winnipeg South Centre", 2022; "River Heights (electoral district)", 2021). River Heights has been a liberal riding since the late 1980s. Finally, the neighborhood has a long history of prestige and being the home, historically, for Winnipeg's wealthiest residents (C. Mann, 2017).

Participants

The participants for this study were recruited based on the following criteria: self-identified residence in River Heights, English speaking, and ≥18 years old. We also purposively selected mothers, young adults, high SSB consumers, and people who self-identify as "obese". Recruitment occurred with posters in community spaces, social media, and to a lesser extent snowball sampling, where participants were asked to recommend future participants. Participants were also provided a gift card honorarium for participation. While not a part of our inclusion criteria, only white adults participated.

Ethics

This study protocol was approved by the Joint Faculty Research Ethics Board, Protocol HS24335 (J2020:068), and the Health Research Ethics Board HS21878 (H2018:234) at the University of Manitoba. In addition, each participant provided their informed, written consent prior to their interview. To maintain confidentiality, we utilized pseudonyms when quoting participants here, with the exception of one participant who did not consent to be quoted.

Data Collection

Qualitative semi-structured interviews were mostly conducted one-on-one by the principal investigator (NR) or the study research coordinator (KM), with some assistance from lead author (AW). Interviews took place in a variety of public settings as well as in participants' homes, at the request of the participant, between May and June 2019, and were audio recorded. Participants completed a demographic questionnaire, which collected information to characterize our sample including: gender identity, age, education level, employment status, race/ethnicity, self-rated health, food security, and SSB consumption level, (See Appendix A: Demographic

Form). Field notes were written after each interview to document interview location, and any relevant information and observations.

The interview guide had approximately 10 main questions, with follow-up questions/prompts, and sought to stimulate discussion about consumption patterns of SSB among participants themselves as well as family or community members, reactions associated with purchasing or consuming SSB, and any health implications of consuming SSB (See Appendix B: Interview Guide). Data collection concluded once 18 interviews had been completed, as recruitment at this point had slowed considerably, and we had reached saturation.

Data Analysis

All interviews were transcribed verbatim by the lead author, and what followed was immersion/ familiarization step with the completed transcriptions. For the next phase of analysis, CDA methods were employed, following Fairclough's (1991) methodology (Clark et al., 1991), and inspired by Van Dijk 's (1993) critical examination of power, through coding and analytic writing. Coding was primarily done using NVIVO 12 Pro software, with some additional hand coding.

As described by Fairclough (Clark et al., 1991), coding first began on a descriptive level, seeking to gain familiarity with the data, and de-contextualize it (Morse, 1994). Next, analysis moved to the interpretive level (Clark et al., 1991) which sought to generalize the data and contextualize it (Morse, 1994). The second stage of coding was guided by asking questions of the data, such as: *Is weight stigma, anti-fatness, pro-thinness discourse used by participants? Are alternative discourses or discourses that challenge weight stigma, anti-fatness, pro-thinness discourse used by participants? How is the "use" (consumption, purchasing) of SSB treated or considered?* Analytic writing such as memoing was also used to move to broader and more abstract concepts, and as a tool to explore ideas and examine connections.

Rigour was enhanced through memo writing as both a form of documentation and analytical tool, as well to document any decisions, or changes in the methods. Finally, "due diligence" from the researcher was also performed to maintain rigour. This included applying appropriate time, care, and effort to be comprehensive at each step of the research study (Tracy, 2010), most notably during transcription (including periodic comparison of the transcript with audio), coding,

analytic writing, and writing of results, such as ongoing memoing and heuristic devices, in the form of questions directed at the data to focus analysis, particularly to engage with theory (Eakin and Gladstone, 2020)

Reflexivity

This research study began with the supposition that policies targeting SSB, may exacerbate weight stigma, and have the potential to inequitably effect people who already are experiencing stigma, due to the intersection of many factors (Riediger & Bombak, 2018). Reflexivity was an active part of this study, and was a crucial part of the study design, data collection and analysis aspects. This study is part of a larger study on Indigenous health, and health equity in the context of SSB taxes, led by the Principal Investigator (NR). The inclusion of a comparison, non-Indigenous population provides a different perspective for the larger study. The importance of examining the dominant social group, to explore the origins, context, and ideology behind this policy merited the inclusion of perspectives from a liberal, middle to upper class neighbourhood. Additionally, I (AW) am a white, thin and cisgender woman, the same can be said for how both interviewers identify (KM and NR), and therefore the interview discourse is shaped, from all sides, by the dominant group. The three of us all also work in the disciplines of nutrition, and academia in general. This further contributes to our membership in the dominant social group due to our pre-existing membership in the academic community and background knowledge that is the context for this project. Because of this, most participants assumed that the interviewers would all be in support of a SSB tax, which likely influenced many participants discussion of SSB, their acceptability of any proposed taxation, and the relationship building that occurred.

Results

A total of 18 participants volunteered, including 3 men and 15 women, with an average age of 44 years old. (**Table 2: Demographic characteristics**). Every participant identified as white, food secure, and described their health as good, very good, or excellent. Almost every participant had completed a post-secondary program or degree. Each participant also discussed being a parent, and/or grandparent during the interviews, though we did not ask participants directly. The interviews averaged 25 minutes, and generated approximately 240 pages of transcribed text. More than half of participants supported SSB taxation, although most

participants assumed that the interviewers would all be in support of a SSB tax, which likely influenced many participants discussion of SSB, their acceptability of any proposed taxation, and the relationship building that occurred.

Table 2: Demographic Characteristics of Study Participants

Characteristics (n=18)	n (%)
Gender	18
Female	15 (83)
Male	3 (17)
Age Ranges	17*
51-90	4 (23.5)
41-50	5 (29.4)
21-40	8 (51.1)
Average Age	44
Highest Level of Education	18
Completed University Degree	14 (77.8)
Completed trade/technical school or college diploma, or primary school	4 (22.3)
Current Employment Status	18
Not working in the labour force	3 (16.7)
Working full in time in the labour force	11 (61.1)
Retired or Semi-retired, or working part time in labour force	4 (22.3)
Self-Rated SSB Consumption	18
Never, or Less than once per week	7 (38.)
1-3 times per week	5 (27.8)
4-6 times per week	2 (11.1)
At least once per day	3 (16.7)

*Not every participant provided their birth year.

We found that participants were primarily drawing on the discourse of *personal responsibility* in their discussion of SSB. In fact, perceived *personal responsibility* was found to be a determining factor for the acceptability of SSB consumption and purchasing (from this point on, known as SSB behaviors). Acceptable SSB behaviours were those that appeared to be responsible, and unacceptable SSB behaviours were those that were perceived to be irresponsible. Parental responsibility was also a facet of personal responsibility that ran through the interviews and was highly valued for participants.

The Process of Responsibilization

Personal responsibility discourse was the primary discourse identified in the discussion of participants on SSB. Personal responsibility as a discourse was drawn upon both indirectly and directly by participants when talking about weight and or health and SSB. Despite an absence of interview questions about weight, participants often answered questions about health with answers of weight. There were some instances of health discussed outside of framing with weight and responsibility (such as diabetes or general health complaints), although with the focus on SSB, weight was central to participant discourse. This indicates the conflation of health with weight, as well as some familiarity with the associations of sugar and weight. Personal responsibility was identified through the negative associations of SSB and weight in participant discussion. Many participants when discussing weight, used negative language, emotions and reactions, which were both directed inwards as well as outwards. A participant who was asked about their drink preferences said:

> *"I got to find a new drink to drink because I am, and I've just noticed, even just because of my age, I've never, I've always, but the weight I'm putting on, disgusting"* (Emily)

Disgust of body fat was an emotion shared by another participant, who was asked about their reaction to someone overweight purchasing a sugary drink replied with "*I'd be a little, disgusted"* (Sheila). Through the negative language, emotions and judgement, weight was set up as a failure of responsibility, and thus a state that needed to be fixed.

SSB, particularly pop, was also talked about with negative emotions, including shame and guilt. For example, one participant said

> *"I actually feel, like if someone sees me drinking a pop like I actually feel embarrassed. Especially with certain groups of people"* (Kristen)

Negative emotions associated with SSB were somewhat dependent on the context. Specifically, Emily felt "guilty" about consuming SSB at work. Also a factor when purchasing SSB, the negative emotions continued;

> *"I would probably feel most comfortable buying them at Superstore and using the self checkout"* (Grace)

In contrast to the participants own experiences with SSB consumption or purchasing, perceived judgement from others related to SSB behaviors was minimal; most participants did not perceive any judgement from external sources. There was an exception to this, one participant who identified as "bigger" said:

> *"Maybe because I'm a bigger woman and maybe I shouldn't be drinking those kinds of drinks"* (Grace)

However, participant discussion of weight was not all negative, such as Colleen who acknowledged:

> *"Sometimes I think there is a bit of stigma, like you know, overweight, you know like, heavier people set, heavy set*,"

Other participants drew on discourses like body positivity, in contrast to negative and responsibilization approaches to weight. Similarly, there also was often an initial moment of hesitancy to engage with negativity associated with weight. Almost every interview included a variation of:

> "*Interviewer: Um, how do you react to people buying sugary drinks? Or drinking them? Respondent: I-usua- don't react-*" (Roxanne),

However, most participants did eventually engage in or share experiences of judgement. Therefore, not all participants were utilizing weight stigmatizing discourse, and instead offered some understanding, or alternatives to negativity.

Similarly to how weight was responsibilized through the negative associations, the same process occurred with SSB. Some participants also described negative emotions, including judgement and guilt, when discussing the expectations of them as parents and how to feed their child(ren). One participant said, "*as a parent, you feel guilty all the time, right?"* (Nikki). In addition, "*I feel a little bit judge-judge-judged in even groups of moms too"* (Paige). The language and emotions utilized by participants about their parental responsibilities suggests internalized (or self) judgement. Participant discussion had high expectations for parents, where to be a good parent, they need to be responsible for their family's health. Furthermore, as health was continually conflated with weight, parental responsibility discourse was extended to

child(rens) weight. The responsibilization of weight, health, and parenting (although alternative stances were also taken in terms of weight), occurred within participant discussion, contributing to personal responsibility discourse, and thus the dominance of responsibility in participant understanding and discussion of SSB.

Explicit Responsibilities

Personal responsibility was also utilized more explicitly by participants. Building on the negativity of weight was the responsibility for weight. One such way this appeared in participant discussion was in talk of losing weight or managing weight, such as

> *"Well my wife used to say to me, if you're serious about losing weight, why are you drinking all those cokes?"* (James)

This quote also illustrates the negativity associated with weight, in the need to lose it, as well as a strong link to SSB. Another example of participants talking about taking responsibility for weight was the following:

> "*Respondent: After having a baby, like I gained a lot of weight so, I'm trying to lose it and yeah, so, maybe it's gotten worse after having a baby"* (Paige)

Building on the negativity associated with weight, through the personal responsibility discourse of participants, weight was discussed as an individual's responsibility, both of which contribute to the overall framing of responsibility in these results and the link between SSB and weight.

For many participants however, the idea of weight and health were inseparable. For example, when a participant was asked about how they might react if they saw an overweight person purchasing SSB:

> *"Participant: they don't necessarily need that-*
>
> *Interviewer: And what kind of reaction?*
>
> *Participant: They cou-should consider their health more"* (Jennifer)

In this quote, Jennifer is utilizing personal responsibility discourse in reference to health (and weight), and the moral imperative is quite clear with their switch from "could" to "should".

Another example of the responsibilization of weight and health was from Louise, when asked about her reaction to an overweight person purchasing SSB,

> *"I would think, and I do think they they, uh, if they made just a few changes in their lives they would be happier"* (Louise)

Again, the simplicity of making a "few changes" implying that would make a big difference suggests that weight is easily reduced. This reinforces both weight stigmatizing stereotypes, and the narrative that individuals with bigger bodies are failing to take action. Additionally, this quotation has an underlying meaning that people who are perceived to be unhealthy must also be unhappy. The conflation of health and weight fits into weight stigmatizing discourse, as well as reinforcing the link to the biomedical framing of fatness.

Another way that health and responsibility were linked was through the discussion of the 'burden of obesity' on the health care system, such as:

> "*And people need to take more initiative towards their, their health and [quietly] just taxes our health care system more*" (Jennifer)

This participant's use of a quieter voice suggests that this participant is aware of their judgement, and the potential harm of what they are saying. With this 'burden of obesity' discussion, it brings together the negative associations with weight and its responsibilization, and suggests that 'obese' individuals are undeserving of health care, as they have failed to control their weight (and thus, health).

Explicit responsibility also was identified when participants were talking about their parental roles, and their obligation to establish healthy eating habits for their children. Perceived transgression of this ideal, elicited judgement, as described by James:

> "*I cringe when I see grocery carts with soft drinks in them and kids. 'Cause it's, it's, they're building a life long habit that is unhealthy"* (James)

Additionally also in this quote from James, he makes the assumption that SSB are for the kids in question. Judgement, although identified by both fathers and mothers, was primarily experienced and internalized by mothers, which was also suggested through the *Process of responsibilization*

narrative. Parental responsibilities in regard to health were also a major topic for participants, and this responsibility extended to SSB:

> *"We strive to be healthy as a family, but um you know, um there's pitfalls and sugary drinks had been one of ours, like our personal family ones"* (Dorothy)

Parental responsibilities included encouraging and facilitating healthy habits for their children. Direct use of personal responsibility discourse, in terms of weight, health and parenting further shows how linked SSB and responsibility are for participants, and how pervasive this understanding is. Also, it is an interesting finding in itself that parental responsibility discourse was utilized by parents when discussing SSB.

Unacceptable SSB Behaviours

As personal responsibility discourse was vital to how participants engaged with the discussion topic of SSB, we found that perceived personal responsibility determined the acceptability of SSB behaviours. Unacceptable SSB behavior was primarily what was perceived as regular consumption. For many participants, regular SSB behaviors were indicated by an "obese" individual, consuming or buying SSB. Regular SSB consumption was also signaled by consumption at work, making it also unacceptable, for example a participant when asked about comfort and SSB consumption;

> "*Interviewer: Where do you feel least comfortable?*
>
> *Respondent: [Still laughing] Work."* (Emily)

Another participant, who did not consume SSB themselves at work but had a colleague who did, spoke about it at length:

> *"-Like she always has a bottle of pop in her hand. And I-I feel bad, I feel bad even saying this, but I find it like really off-putting, like, I'm just like How can you drink that all the time? Like it just, it doesn't sit well with me [Laugh], Yeah."* (Kristen)

For the majority of participants, it was unacceptable for children to consume any SSB, which made any parent/adult involved with children and SSB complicit and irresponsible. One example of this was a participant describing their experiences purchasing SSB;

> *"Um, but if I've, if I'm there on my own, it's perceived a little bit better if I'm there with my kids and then buying lots of sugary drinks. I think people, kind of, you look at it and think like, hmm, like, and you are automatically sort of being judged a bit, cause you've got little kids in there and you've got things that are, (Mumbles) everyone knows are unhealthy"* (Grace)

Some of the participants experienced the negative consequences of sending their child to school (or daycare) with juice boxes, which were sent home by the school (or daycare). They quickly learned that juice consumption was unacceptable in these settings:

> *"Um, there was maybe a couple of times where I put a juice box in her lunch, just because you know, you're running out of time, and [laughs] you know how it is, like you're, so I would just like, here's a filler [high voice] and I know sometimes she likes juice, just the odd time, it always comes back, and they've never made a rule, and they've never said anything in the newsletters like, don't bring juice, but I'm wondering if they just don't accept it there"* (Nikki)

As a culmination of responsibility discourse, both personal and parental responsibilities, participants found SSB behaviours to be primarily unacceptable.

Acceptable SSB Behaviours

Due to the pervasiveness of personal responsibility discourse, acceptability of SSB behaviours was quite limited. As such, the acceptability of SSB behavior was determined by the perceived responsibility of the consumption or purchasing. Primarily, that meant that SSB behaviors that were seen as non-regular were more responsible as a result. Non-regular SSB behaviors included consumption at special occasions like a community BBQ:

> *"Like, last night at a bar-community barbeque I had pop. Like so in the summer, it's probably more like once a week. But in the winter, not at-hardly ever."* (Kristen)

Acceptable SSB behavior also included consumption for the sake of wellness, such as drinking ginger ale for gastro-intestinal issues. Multiple participants also described that they had never experienced judgement, or feelings of unacceptability when consuming SSB. Finally, acceptable consumption also included drinking SSB as an alternative to other options that could be

perceived as irresponsible. For participants, an example of this was drinking SSB when pregnant, which was the responsible option compared to drinking an alcoholic beverage. Choosing SSB over alcoholic beverages was also perceived as responsible in other contexts:

> *"so with my brother, it's a-it's a, he doesn't drink alcohol, so, he sort of substitutes pop for alcohol*" (Kristen)

Conversely, SSB mixed with alcohol was discussed as an acceptable beverage, when consumed in moderation on weekends or social celebrations; again signaling infrequency of consumption. SSB and alcohol proved to have a complex relationship, as both types of beverages have diverse social meanings depending on the context and individual.

Acceptable, or responsible, consumption of SSB for children was described as more restricted and yet still resulted in heightened feelings of judgement and guilt. Perceptions of children's SSB behaviors seemed to be less influenced by context, compared to adult SSB behaviors. In fact, the discussion around SSB consumption for children limited the acceptability to only special occasions, such as a rare "treat", or social celebrations (like birthday parties), and often the only sugary beverage considered acceptable in these situations was juice. Notably, juice does not fall under the definition of a SSB. Juice was also considered acceptable in an emergency situation when packing a child's lunch, and the parents had not had time to grocery shop (such as Nikki, from above), or if the juice was diluted, which was the more acceptable of the two, which many participants described.

> *"And my toddler would have, maybe, every couple of days, would have a juice, like a diluted juice in the morning"* (Grace).

The very limited acceptability of children's SSB or juice consumption frames parents as responsible for their children's intake, and that good parents invariably pack "healthy" lunches. This also positions schools or daycares as protection for children from their parent's poor choices. The limited acceptability for all SSB behaviours, but particularly for children, highlights how ingrained personal responsibility discourses are for participants, and their understanding of SSB.

Discussion

Our results suggest that weight stigma is deeply linked with SSB discourse, and thus, likely the ideology of a dominant, white, educated, liberal culture in Canada. Our participants were more likely to make judgements on SSB behaviour towards higher weight individuals. We also found that participant discussion of SSB was framed by personal responsibility, which is a discourse highlighted by critical weight studies scholars. Personal responsibility figured prominently in participant's perceived acceptability of SSB behaviours, such that seemingly responsible SSB behaviours were considered acceptable, but behaviours that implied regular consumption, were not acceptable. This lens of responsibility, which is reproduced in weight stigma, was an essential part of how participants conceptualized SSB acceptability, and how weight was the primary connection to health. However, alternative discourses to weight stigma were also present, such that some participants exhibited empathy to other contexts of SSB consumption. Finally, there was also limited discussion of SSB and health outside of the framing of weight; some participants did mention associations of sugar and oral health or diabetes.

There is limited research exploring attitudes and ideologies pertaining to SSB, particularly in a Canadian context. Research to date does however support strong discursive links between negative emotions, responsibility for weight, and SSB. A previous study set in rural Michigan (USA), also found a similar judgement of higher weight individuals when consuming SSB, as well as a judgement of parents when their children were SSB consumers (Bombak et al., 2021). In this regard, Bombak et al. (2021) cautioned against policies directed at SSB, due to the potential for weight stigmatization. In another study (Riediger et al., 2021), responsibility for weight was a theme identified in qualitative interviews in Dharwad, India, within a university context; though, personal responsibility for weight was held secondary to food safety and security concerns. Given that the highest SSB consumers in Canada are Indigenous, have lower levels of education, and report food insecurity (Jones, Kirkpatrick & Hammond, 2019; Warren et al., 2022), weight stigma is likely to be magnified for individuals experiencing multiple intersecting, marginalized identities. Therefore, there is potential for weight stigma to be reinforced by SSB targeting policies, through the ideology informing the policy and its effects on discourse. When stigma becomes structural, it can serve to legitimize those existing stigmas. In this case, the policy of SSB taxation, if implemented, could serve to legitimize weight stigma.

In the present study, we found that parental responsibility was a strong motivator, and present discourse for our participants, which led to judgement of self and others. Looking back to the definition of stigma from Link & Phelan (2001) (See Introduction, *Stigma and Weight*), there needs to be some sort of (perceived and labelled) moral failing, such as stereotyping, or discrimination, and a power dynamic for stigma to occur. It is likely that this parental responsibility discourse contributed to the judgement of parents. In terms of talk about responsibility as parents, there were many examples of moral failings. Participants expressed their own individual failings as a parent (on an interpersonal level), for example Dorothy who described sugary drinks as her family "pitfall", or on an interpersonal level, like James who "cringed" at families buying SSB together. Most notably, one participant also described their feelings pertaining to being a parent as "guilty all the time" (Nikki). In particular, the participants who were mothers, such as Nikki and Dorothy, spoke of internalized judgement, whereas James, a father, described the judgement of parents, but it was directed at other parents, not internally. This suggests a pattern of mothers feeling the weight of unattainable caregiving expectations, which parental responsibility discourse contributes to, of which feeding their child(ren) is one essential aspect. These results suggest links between SSB and intensive mothering ideology, which was first described by Sharon Hays (Hays, 1996), and refers to the gendered idealization of resource and labour intensive child rearing.

Intensive mothering is also linked to the context of the "obesity epidemic", where to be a "good mother", there is a responsibility to feed your child(ren) healthy meals, to thus prevent your child(ren) from becoming "obese" (Woolhouse, Day & Rickett, 2019; Wright, Maher & Tanner, 2015). Intensive mothering has also been documented to have varied effects within different social classes, although the pressure to be a "good mother" effects mothers of all classes (Villabos, 2014). Intensive mothering has been well documented for middle class mothers, and has led to self-surveillance, guilt, and anxiety for mothers around their child(ren)'s eating habits (Wright, Maher & Tanner, 2015), which could explain our participants experience, in their struggle and negative emotions surrounding their child(ren)'s consumption of SSB, juice, and school/daycare lunches.

Parental responsibility, especially maternal, when it manifests as intensive mothering, also creates the potential for stigma, including self-stigma, which may intersect with other

marginalized identities and social locations. As Elliot, Powell and Brenton (2015) outlined in their research with low-income, black mothers, there is a similar pressure to be a "good mother" as with middle class mothers, but individuals do not have the same resources to do so, and similarly blame themselves for not living up to societal expectations. Lower class mothers may also experience judgement from others for their perceived lack of "good mothering" in the context of intensive mothering. Surprisingly, Morel et al., (2019), found that in their research with low income mothers and health practitioners with children under 2 years old, messaging highlighting negative consequences of SSB consumption was the most effective. Despite effectiveness in reducing SSB consumption of children, there may be negative, unintended effects, particularly related to stigma. This ideology, and its links to SSB, may have far-reaching implications for marginalized mothers in Canada. For example, off-reserve Indigenous populations report the highest SSB consumption in Canada (Jones, Kirkpatrick & Jones, 2019), and historical and current colonial policies (e.g. residential schools, child welfare systems, etc) have been informed by negative misrepresentations of Indigenous parenting (Baskin, Strike & McPherson, 2015). Particularly to the context of Northern Indigenous communities, the limited accessibility of perishable foods, and inequitable solutions to food insecurity (Galloway, 2017), also increasing the cost of SSB may have compounding effects. Future research should examine complementary discourses related to parenting and SSB among marginalized populations.

The acceptability and responsibility of SSB behaviours were also linked with alcohol. Participant discussion of SSB and alcohol followed a pattern, and they frequently consumed the two together, which was a surprisingly acceptable form of SSB consumption. Interestingly, SSB also seemed to be an acceptable alternative to alcohol. Many participants shared experiences of choosing SSB over alcohol, such as while pregnant, or for regular consumption. In social/health policy, alcohol is viewed as a substance and falls under different regulations as compared to SSB, which falls under food-related policies, in terms of regulation, food safety, etc. In most SSB focused research, alcohol is not considered as a substitute or alternative to SSB. Looking at the beverage consumption patterns, white populations are the highest consumers of alcoholic beverages, compared to other populations (Jones, Kirkpatrick & Hammond, 2019). Therefore, white consumption of alcohol seems to be more acceptable, or perhaps is discursively associated with responsibility compared to others consuming alcohol.

Drawing on our inspiration from Van Dijk's (1993) focus on power and dominance, discourse analysis can serve as a way that groups can create or maintain their power. These discourses (and ideology) maintain the dominance of this group over those who are not members, and also provides insight into how power dynamics remain entrenched in society. Therefore, this policy also serves as an avenue to maintain the existing power dynamics, which gives us further understanding about how this could continue to happen, and perpetuate power inequity. This process of dominance, and maintenance, ensures that a single perspective is captured, and thus the cycle continues. Therefore, SSB taxation could maintain dominance of an educated, white group, and potentially widen health and social inequities.

This study has some limitations, including the sample. Our participants included few men when compared to women, and thus transferability is limited, but greater for white, educated, and liberal populations. Additionally, participants reported heterosexual relationships, which are not representative of all relationships, and all parenting circumstances. Finally, these interviews took place in a pre-COVID-19 world, and parenting, public health, as well as the societal relationship to public health may have transformed with the COVID-19 pandemic.

In conclusion, white River Heights residents utilized personal responsibility discourses on occasion in their discussion of SSB, which contributed to the stigmatization of weight, as well as judgement of parenting. Acceptability of SSB consumption or purchasing was also tied to perceived responsibility of any consumption. As members of a dominant societal group, the utilization of these discourses, and thus biases towards weight as elements of how SSB is understood suggests that policies targeting SSB would be similarly partisan. Therefore, to answer global calls to end weight stigma and address health inequities, policies directed at SSB should be considered a potential structural driver of stigma.

Chapter 5

Connection between Manuscripts

The two manuscripts included (Chapters 4 and 6) were divided intentionally, as both the data and theory lent itself to examining SSB-specific discourse first, and then SSB taxation. In fact, the interview guide was mostly divided among these subjects, with the first half focusing more on SSB and general beverage questions (See Appendix B), and the second half asking specific questions about the implementation of an SSB tax. The theories that primarily informed analysis also supported this divide, allowing the analysis to grow in scope, starting with Weight stigma (i.e. critical weight studies) and finishing with Healthism. The theories I utilized for tax-specific analysis also fit into a wider-scope analysis, as tax discourses include elements of tax policy reflecting social norms, of which, healthism can be viewed as a current cultural/social norm.

Between the two analyses, there are some threads that run through both papers, moralisation and equity. Moralisation was present in Chapter 4 in personal responsibility discourse, which is a foundational element of critical weight studies. Moralisation was attributed with both weight and health, as well as parental responsibility for health and weight of children. This moralisation extends to the participant discussion of taxation (explored in Chapter 6, Manuscript 2), as the moral imperative to health, which extended to SSB behaviours, is the key motivator of SSB tax acceptability. In this way, taxes are an acceptable mechanism to sanction immoral SSB behaviours.

The moralisation present throughout participant discussion and my analysis, also raises concerns related to equity and SSB taxation. Using a tax psychology theoretical lens, encompassing elements of trust, social norms, and justice, it is clear how moralisation pertaining to SSB, as a social norm, informs participant acceptability of SSB taxation. The analysis demonstrates how enforcing social norms related to healthism and SSB generally supersedes any participant concerns about government trust or justice. However, concerns regarding justice and equity were discussed by participants, particularly when prompted; though participants did not readily identify themselves as being part of community particularly advantaged or disadvantaged by SSB taxation. Health moralisation (i.e. healthism) and equity were also relevant in interpreting participant discussion regarding which beverages to tax. Utilizing current

epidemiology of beverage intake patterns according to social and economic factors, and race/ethnicity, suggests perceived tax targets (i.e. pop) and exemptions (i.e. sweetened coffee) map onto existing disparities.

Chapter 6

Manuscript 2:

"Coke's not a food": A critical examination of discourses informing sugar-sweetened beverage taxes utilized by white residents from an upper-middle class neighbourhood in Winnipeg, Manitoba

Abstract

Objectives: Increasing concerns about the health impacts of sugar consumption has led to the proposition of a sugar-sweetened beverage (SSB) tax in Canada. However, competing concerns related to stigma and equity remain, and have yet to be explored in a Canadian context. Therefore, we sought to examine how residents of an upper-middle class neighborhood conceptualize SSB tax acceptability, and the discourses that inform their discussion.

Methods: We conducted and analyzed qualitative, semi-structured interviews, with residents of a middle-upper class neighborhood in Winnipeg, Manitoba, Canada. Participants were recruited based on their residence, ages 18 and over, and English speaking. Fairclough's critical discourse analysis methodology was used, and the theoretical frameworks of Healthism and Tax psychology informed analysis.

Results: Eighteen participants were recruited, 15 female and 3 male, all identified as white, and spoke about parenting or grandparenting. Healthist discourse was utilized by participants when discussing their support for SSB taxation. With the mobilization of this discourse, ideal citizens and parents were described as "health concious", and would reduce SSB intake as a result of taxation. Healthism also contributed to identifying which beverages would be targeted by a tax, and which had redeeming healthy qualities. Limits to SSB tax support were expressed as fairness concerns, with a focus on the procedural justice of the tax, directed at the individual and societal levels. Therefore, social norms related to healthism and SSB generally superseded participant concerns about government trust or justice.

Conclusions: Participants supported SSB taxation, as it was perceived as contributing to individuals acting as ideal, health-valuing citizens and parents. However, participants were also concerned about the fairness of implementation, although this did not outweigh the prioritization of good health.

Background

Newfoundland and Labrador, a province in Atlantic Canada, is the first in Canada to plan to implement a Sugar-Sweetened Beverage (SSB) tax as a part of their 2022 budget (Government of Newfoundland and Labrador, 2021). SSB Taxes have been endorsed by global health organizations, such as the World Health Organization (WHO, 2017), and national groups like Dietitians of Canada (Dietitians of Canada, 2016), and Heart and Stroke (Heart and Stroke, 2017) amidst growing global concern about sugar consumption and its associations with weight gain and incident diabetes (Malik et al., 2013). SSB are any beverages that are sweetened with added sugars, which includes beverages such as pop, sports drinks, fruit drinks (but not 100% fruit juices), and other pre-packaged drinks.

SSB taxes have been implemented elsewhere including Mexico, Denmark, the UK and various US jurisdictions, such as Philadelphia, PA or Cook County, IL, (Colchero et al., 2016; Kane & Malik, 2019; Backholer, Blake & Vandeijvere, 2018; Schmacker & Smed, 2020). Most SSB taxes take the form of an excise tax, which is a flat tax and thus a regressive tax, meaning lower income populations would contribute a high proportion of their income as compared to higher income populations (Roach, 2010). In this regard, some jurisdictions have repealed their SSB tax, including Denmark and Cook County, IL (U.S.) (Schmacker & Smed, 2020; Chriqui, Sansone & Powell, 2020). Given these existing controversies pertaining to equity internationally, it is important to examine Canadian perspectives regarding SSB taxation. To understand these better we will be exploring relevant discourses that contribute to acceptability of SSB taxation, and highlight the implications of these discourses to health equity.

Public Health Policy and Moralisation

Public health policy influences population health and is critical in mitigating health inequities. However, public health policies are often reflective of the policy makers and their experiences and contexts (Lupton, 1995). This group, in an American context, has been described as the "worried, white, wealthy and well", or the four "w"s (Kerner, 2008). Public health policies function in establishing norms including how health is defined, and its societal value (Lupton, 1995). In the Canadian context, social norms with respect to health could also be

represented by the four "w"s and thus excludes populations that are higher weight, "obese[6]", lower income, or racialized populations. The policies that Kerner (2008) describes are therefore both creating and maintaining the dominant culture of the 4 "w"s.

Furthermore, the creation of values and norms through policy is inherently moralistic, in that a specific set of values are being imposed on a diverse population through policy implementation (Lupton, 1995). Preda and Voight (2015) highlight the consequence of normalizing policies is that individual experiences and their social contexts are not necessarily represented. Lupton describes the effects of moralistic policies as creating an environment of self-policing where individuals are regulating their own status in regard to the norms of health (Lupton, 1995). Thus moralisation in health policies creates and enforces self-responsibility for health, which could then potentially result in stigma for individuals not adhering to social norms, as well as inequitable effects of policies.

Healthism

Healthism was described by Crawford as a shift to "health consciousness", which occurred in the 1970s, and continued with the moralisation of health by middle class Americans in the 1980s (Crawford, 1980; Crawford, 2006). Crawford (2006) particularly emphasized the role of individual responsibility in health discourse to be a driving mechanism behind this shift. Brown expanded on this idea and described healthism as two narratives, the medicalization of new domains of life (such as behaviours, or lifestyle), and the elevation of health to a new "super value" (Brown, 2018). As a consequence of this, the failure to adhere to the "super valu"-ing of health, is viewed negatively and thus compromises one's social identity (Brown, 2018), which creates the potential for stigma. Stigma can be defined as "labeling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them" Link & Phelan, 2001). Crawford also highlights that victim blaming is a direct consequence of healthism discourse, leading to stigma (Crawford, 2006). As mentioned above, moralisation in health policies is a major concern for health equity, thus we are looking to explore the participants' use

[6] "Obesity" will be referred to using quotation marks to acknowledge the normativity and stigmatization inherent with the use of term (Meadows & Daníelsdóttir, 2016)

of healthism discourse in discussing SSB taxation, building on our analysis of attitudes toward SSB (Waugh et al., In preparation).

Tax Discourse

Tax discourses are shaped by the psychology of taxation, and initially, anti-tax opinions and discourse are extremely common (Kirchler, 2007). Outside of the initial and general dislike of taxes, tax psychology has three major elements that are relevant to our analysis: distrust, norms, and justice. Distrust in tax discourse is typically directed at the tax creator, specifically the government. Kirchler (2007) described understanding of taxation to be vital for government trust, and conversely, poor understanding of taxation will result in distrust. Norms and morals are another aspect of taxation discourses and intersects with the previous section on healthism as a societal norm. Taxation, as with other policies, can impact identity and inform what is considered "normal", creating a "normative taxpayer" (Dagan, 2016). Kirchler (2007) also emphasizes the importance of Christian values to tax discourse and thus also tax behaviour. In fact, taxes on perceived harmful consumptive products, such as tobacco or soda, are often referred to as sin taxes (derived from Christian understandings of moral failings) (Reubi, 2016). Taxation is an important way that societal values can be transferred and normalized within economic systems. In addition, norms are important for discourse analysis, as internalized norms (social) and behaviours are indicative of societal norms, which contribute to our understandings about dominant society. Finally, norms, when violated, can result in feelings of shame, guilt and blame, which links this to stigma.

Justice is another aspect of taxation discourse, and according to Kirchler (2007), often the major point of concern for taxpayers when discussing taxation. Perceptions of justice can influence tax related behaviours of individuals (Kirchler, 2007). There are three types of justice (Wenzel, 2003), as well as three levels at which justice is relevant.

The first type of justice is *distributive justice*, which is concerned with the exchanging of resources, as well as the balance between contributions and benefits (Wenzel, 2003). Thus, distributive fairness is reached when the taxpayers perceive that their contributions are matched by the rewards or benefits they could receive, as well as how their contributions/benefits are fair in relation with others (Kirchler, 2007). The second type is *procedural justice*, which is focused on the distribution of resources, and the fairness of that process (Wenzel, 2003). Procedural

fairness is reached when tax implementation is perceived to be executed with respect, consultation, justification, and efficiency (Wenzel, 2003). Finally there is *retributive justice*, which is concerned with the perceived fairness of punishment for any rule-breaking (Wenzel, 2003). Each of these avenues of justice can also be reflected within three different levels, the individual, the group (could be social group, occupational, minority group), and the societal level (such at Canada-wide) (Wenzel, 2003). Issues associated with justice are also linked to identifying with your group or social category, such that an increased identifying with your group results in increased tax compliance (Kirchler, 2007).

As a result of SSB taxation becoming a reality in Canada, it is important to critically examine this policy from a health equity perspective. Thus, through this study we were looking to explore the discourses utilized in discussing SSB taxation, and to answer the following questions: Which discourses contribute to the acceptability of SSB taxation? How are trust, justice, and equity considered in its acceptability?

Materials and Methods

Design

We utilized a critical qualitative study design, for which we performed and analyzed 18 semi-structured interviews. Critical discourse analysis inspired by Fairclough (Clark et al., 1991) was utilized, and Van Dijk's (1993) approach to power was vital to our analysis. Both healthism and theories regarding taxation informed our analysis.

Setting

River Heights is a neighborhood in Winnipeg, the capital city of the province of Manitoba, Canada. River Heights was selected as it is a middle-upper class neighborhood. In 2019 River Heights was reported to have a similar median income to both the municipal and provincial averages of $56,848, (Cui et al., 2019). The population of River Heights included 8.7% Indigenous people, and 14.9% Visible Minorities (Cui et al., 2019). Additionally, 64% of the River Heights population has a post-secondary certificate, degree or diploma, which is much higher than the municipal and provincial averages (Cui et al., 2019). Politically, River Heights has been a Liberal stronghold for almost 40 consecutive years and is currently represented at both the provincial and federal level by Liberal politicians, both of whom are also white, male

and 70 years of age or older ("Winnipeg South Centre", 2022; "River Heights (electoral district)", 2021). River Heights residents also share a health mindedness; for example, the neighbourhood reports one of the highest COVID-19 vaccination rates in Winnipeg (Government of Manitoba, 2022). Discursively, River Heights has always had a reputation for housing Winnipeg's most wealthy, which continues to this day (C Mann, 2017).

More broadly, Manitoba has among the highest prevalence of food insecurity in Canada (Statistics Canada, 2020). In fact, the 2017-2018 Canadian Community Health Survey (CCHS) found that rate of household food security in Manitoba was 10.2% of households, which is higher than the national average. Additionally, 28% of children in Manitoba are experiencing poverty, who are disproportionately Indigenous, the second highest prevalence among the provinces and territories (Frankel et al., 2021). In Manitoba as well, there are currently three boil water advisories reported by the federal government, of 29 nationally (Government of Canada, 2022).

Participants

Participants for this study were recruited based on the following criteria: Residence in River Heights, English speaking, and aged 18 or older. We used purposive sampling to target mothers of young children, young adults, high SSB consumers, and people who self-identify as "obese". Participants were recruited with posters in community spaces, social media, and snowball sampling. Participants were provided an honorarium, as a gift card, for their participation. Only white participants volunteered.

Data Collection

Two types of data were collected as a part of this study, interview data and demographic data. The interviews were semi-structured, audio recorded, and transcribed verbatim. The interviews were based on an interview guide that sought to explore community health concerns of participants, SSB consumption, reactions associated with SSB, SSB taxes, SSB tax effects, and SSB tax revenue. The interviews were conducted primarily one-on-one, by either NR (Principal Investigator) or KM (Research Coordinator for this study), between May and June 2019. Interviews took place in a variety of public spaces, or in participant's homes, at the request of the participants. The demographic questionnaire collected gender identity, age, education

level, employment status, race/ethnicity, self-rated health, food security, and SSB consumption level of participants, to characterize the sample. Detailed field notes were completed by the interviewer following each interview. Data collection concluded once 18 interviews had taken place, and data saturation was reached.

Analysis

The first phase of analysis was the transcription process, which were then imported into NVivo 12 Pro software, for the second phase of analysis. This phase used Critical discourse analysis methods, based on Fairclough (Clark et al., 1991) with inspiration from Van Dijk (1993). Each transcript was summarized initially to re-familiarize and immerse with the data. Coding began first with a descriptive level of coding which looked at the interview text content, context and directly engaged with the text itself. Next came the interpretive phase of coding, which was dictated by critical questions and our theoretical approach, and further validated through discussion amongst the research team. Analysis continued through the use of "heuristic devices", the development of questions to directly engage with data (Eakin & Gladstone, 2020), as well as through analytic writing, including memos and draft preparation.

Results

Eighteen participants completed interviews, 15 of whom identified as female and three as male, with an average age of 44. As expected from the chosen setting, almost 80% of the participants had a university education, all participants were food secure and ranked their health as good, very good or excellent (Waugh et al., In preparation). Interviews averaged 25 minutes (range 10:52-43:44), and transcription generated approximately 240 pages of text. Most participants were in support of the SSB Tax. When discussing SSB taxes, participants constructed an ideal citizen based on perceived societal norms. Additional concerns about SSB taxes were centred on the concept of fairness, at the individual and societal levels. In general, over half of our participants were in support of SSB taxation, which was rationalized through the "super valuing" of health, and despite concerns about tax fairness.

Ideal citizens and parents are "health conscious"

We identified healthism discourse throughout participant discussion of SSB taxes. In fact, there was repeated use of the phrase "health conscious" or some variation used by participants.

“Health conscious” people are those who value health, would be most impacted by SSB taxes through behaviour change, and in favour of SSB taxes. For example, in response to a question about who would be impacted by a SSB tax, James said: "-The ones who are thinking about it already. So people who are, already have a health consciousness would use that an opportunity to leverage some more, uh, reflection on their practice" (James). Another description of “health consciousness” was the following; “Another one that's going to be conscientious too is parents. Parents, right? Parents with children, because then I think, I'd think they probably won't buy it at all." (Roxanne).

Healthism continued to come up, describing how the ideal citizen could be or would show their “health consciousness”. One instance was “I think it would be the wakeup call that I need to stop buying those beverages and then look at healthy alternatives” (Roxanne). This participant is utilizing healthist discourse about themselves, embodying the “need” to prioritize health and change their behaviour, as well as to support SSB taxation. Another example of the usage of healthism discourse to describe the effects of SSB taxes on others: “They’ll probably, sorry, they’ll probably want to, if the sugary drink have the tax, try to go for the, maybe healthier option, or I should hope” (Paige). Again, the focus in this quotation is on health, and moralisation is very evident with the “I should hope”.

Healthism was also a relevant discourse when participants were discussing their parental responsibility to protect their children from SSB, and their parental “health consciousness”. One participant described their approach;

> We really try not to give her access to pop right now, and sugary drinks, just because we know, like, it can become so addictive and just the amount of sugar in juice, for kids is, you know, so you can just see that kids, you know, already struggling with weight at a certain age and you can pinpoint it’s probably related to sugar intake (Nikki).

This participant, by eliminating SSB in their child’s diet is seeking to protect them from many dangers to their health, including sugar, addiction, and “obesity”. Another participant, Roxanne, speaks about how they need to worry, when asked about the effects of drinks with sugar on an individual’s health: “They’re bad. They’re bad on a child for their bain-brain growth and their development, is what I’ve learned from studies. I mean, you can worry yourself sick about all these different things”. (Roxanne). In this quotation there is also a direct link to “worry”, from

the four "w"'s (Kerner, 2008). Another participant also speaks to their success as a "health-conscious parent", "I think like, as a parent, um, I-I always I sort of joke but it's kind of true, that one of things I'm proudest of, as, for my kids, is that they don't really drink, they basically don't drink any juice or pop, anything like that." (Kristin). To be a good parent, and meet the expectation of responsibility, protecting children from SSB consumption is a must

Healthist discourse was also used when addressing directly one of the interview questions, which was *Which drinks should be included in the tax? And why?*. This line of questioning addressed some complexity to the implementation of a SSB tax, as well as exploring the social meaning of different beverages. This also includes which beverages are considered healthy or essential, food, and which are not, and thus eligible for taxation. Pop was the most common beverage suggested as a tax target, and thus was not valued as a food. James said it succinctly: "Coke's not a food". Other participants as well identified soft drinks as the primary tax target, with energy drinks also frequently mentioned.

While most participants agreed that pop and energy drinks were prime targets for taxation, perceptions related to sugar-sweetened coffee were only provided when prompted. Several participants remarked how difficult it would be to determine eligibility for taxation and as such, the complicacy rendered sweetened coffee (aside from Ready-to-drink types) not feasible for taxation. The fairness of sweetened coffee tax (in)eligibility was not discussed. One participant also noted that individuals drinking sweetened coffee would not change their behaviour anyway, as they likely could afford the increase in price, suggesting consumers of sweetened coffee are perceived as higher income, and in this way taxation would not be effective. This line of thinking was notably absent when it came to the pop-drinking population, which could imply that pop drinkers are lower income, and thus the SSB tax is also targeting that same population. Furthermore, this also suggests that sweetened coffee consumption does not violate a social norm. Participants did not largely factor sweetened coffee into their (un)acceptability of the tax. Notably, most participants described consuming coffee regularly, unlike SSB.

Juice was a much more controversial beverage. Some participants had no issues with juice. However, some strong voices felt quite the opposite:

> I think our government would conveniently tax soft drinks, because that's a natural target. But they should also tax juice, because juice is the, is actually the hidden one. Because people naively believe that juice is healthy and the sugar is healthy because it's natural sugar. And that's just crap. Uh, so I hope governments are careful on how they assign the tax, and that it would be all sugared, all, all sugary drinks, not just those with additives (James).

This quote from James first makes the connection between sugar, and unhealthiness. However, he puts the danger of sugar on the sometimes "hidden" nature of it. He also highlights the potential health consequences of "additives" in beverages, although sugar is held in higher disregard compared to additives. This could also have been a result of the focus of the interviews on sugar and SSB, and thus some co-construction of data. Other participants framed juice with the same discursive resource, such as Dorothy:

> 'Cause, yeah, like juices, that's yeah, juice is so bad for you, and I know it's bad for you, but it's, it's from fruit, so a lot of people are like fruit is healthy so juice must be healthy. And it's like no, it's the worst part of the fruit (Dorothy).

Similarly to James, Dorothy also highlights the dangerous nature of fruit juice, with "hidden" unhealthiness and shares the feeling of the necessity to take responsibility against juice, as well as the unacceptability of juice as a "healthy" beverage.

An additional narrative within the participant discussion of beverages to be tax targets was the nutritional value:

> I would like those [energy drinks] to be included [laugh]. I feel like those have a lot, have like no redeeming qualities, and it even more negative aspect to it, like red bull and stuff. It's like, all these weird additives I don't know. " (Kristen)

The nutritional value or "redeeming qualities", in addition to the sugar content, could also be used to determine the acceptability of sugar-sweetened beverages. In some cases, adequate nutritional value could supersede the negatives of sugar; "Um, I guess chocolate milk I guess is sugar sweetened, but that's a more nutritious beverage in my opinion" (Phoebe). The idea of "redeeming qualities" also aligns with health consciousness, as it implies a hierarchy of 'healthiness', as well as the priority to choose based on that hierarchy. This narrative also

includes a perceived ability to discern the ‘healthiness’ of a beverage, thus further positioning the participant as ‘health conscious’.

When participants were discussing which SSB should be included in the tax, there was also a change in interview dynamics. They asserted dominance over the interviewer and the interview discourse, which was categorized as instances of animation, high emotions and assertiveness. Some instances were as simple as “that’s a more nutritious beverage in my opinion” (Pheobe), suggesting she had expert knowledge. Two other great examples are James’ and Dorothy’s quotes from above. James embodies this dominance and assertive control, with his use of “crap” and “naïve”, and Dorothy with her declaration that juice is the “worst part of the fruit”.

Few participants briefly discussed enjoying SSB, feeling addicted to SSB, or that SSB could be a vice for some people. Hedonism was an idea brought up by only one participant, who discussed their desire to be allowed their “vices”, which was Pepsi (Katherina). However, overwhelmingly participants utilized healthism in support of, or discussing, SSB as tax targets.

Finally, in discussing potential uses for tax revenue, participants relied on healthist discourses to propose ideas for revenue allocation. Some examples of acceptable uses included school lunch programs and subsidies for “healthy” foods in northern communities. For example, “I don't think it's fair that, the more nutritious foods are more expensive. I think that's completely wrong, it should be the opposite" (Phoebe). This quotation in particular came after a series of questions about taxation implications for specific communities, including those without drinking water, and Northern communities (See Appendix B: Interview Guide).

Concerns about taxation fairness

Participants expressed an initial dislike to taxation generally, not necessarily specific to the context of SSB taxation. For example: “I think we’re taxed to the maximum.” (Sheila) and “Well, I’m not happy with any of the taxes that are being placed on us lately” (Colleen). Interestingly, Elizabeth noted “There’s a *group of people* [our emphasis] who get angry at every new tax in life”, though it was not clear who she was referring to, but nevertheless suggests a distancing from individuals who are critical of taxation.

Once participants overcame their lack of enthusiasm for taxation, the discourses about fairness and justice were consistently and universally utilized. Participants were extremely concerned about a potential SSB tax being fair and mostly engaged in narratives pertaining to procedural justice to describe their concerns. Concerns were described at the individual and societal levels, as most participants did not identify themselves as a member of a group particularly advantaged or disadvantaged by a SSB tax.

Concerns of fairness at the individual level were focused on how the specifics of SSB tax implementation would affect individuals. Within the interview guide there was no explicit questioning about the perceived fairness of the tax, but there was a line of inquiry that was exploring the impact on populations other than that of River Heights, such as communities with high costs of food, without drinking water, and Northern communities. Participants utilizing equality discourses on the topic of SSB tax implementation did not consider justice in terms of susceptibility to SSB intake or access to alternative sources of food or water. For example, one participant said "Um I think, it think if we're gonna do it, it should be done throughout the whole province not just targeted communities" (Thomas). Equality as an approach was echoed by another participant, answering the same question: “I guess that's not really fair. I guess, whether you live remotely or not, everybody should be treated the same, in Canada or Manitoba" (Emily). There was some initial hesitancy to ignore differing contexts, however many participants overcame it.

On the other hand, some participants did consider equity and discussed an inherent injustice that related to SSB intake for some communities, but only when prompted. Some raised concerns about the equity of SSB taxation, and how it might be impacting other individuals or communities, given as answers to the same line of questioning.

> I would, I would like people, I would think it probably be better for uh, communities as a whole, to probably not drink as many, but we also have to consider justice. (Pheobe)

This quote from Phoebe is one of the few mentions of justice within the set of interviews. A similar idea was raised by Roxanne:

> Respondent: So it depends what their choices are. Yeah, that's a very good question, but it depends what their choices and variety is up there. So if all they have is sugar drinks up there, -
>
> Interviewer: -yeah-
>
> Respondent: -That's not really being fair to them. (Roxanne)

This line of questioning with Roxanne above, was intended to prompt discussion of potential tax implications for Indigenous communities, although very few participants mentioned Indigenous communities specifically.

Fairness was also a concern for participants at the societal level, which in term of procedural justice, included discussion of the fairness on the administration, logistics, transparency, or media presentation of the tax policy. For participants in the interviews this came through as a focus on how the tax was being portrayed, such as one participant who said:

> I don't know how effective educational campaigns would be, just as a reminder to people why this is happening, like why are we having this additional tax, so, um you can bring more people on board, um, that might be thinking ugh, we're getting tax (Nikki).

This quotation highlights the concern about the intent of the taxation, how fair it is as a society to be taxed and the importance it bore to their acceptance or perception of the tax efficacy. Another example of procedural fairness discussion is the following;

> I think it's a really interesting idea, um, I think it all depends on how it's actually rolled out and the, I think the key part of it is the messaging around it, because if it's just a cash grab, then I don't think it's going to go down very well. But if they use it as like a way to actually educate people, I think it would be really powerful (Dorothy).

Dorothy emphasizes the messaging of the tax policy, and how important it is to the perceived fairness of the tax to the taxpayer, although she also utilizes healthism as the better option when compared to financial motives. Finally, from Louise;

> I don't mind paying a tax if there's a, if the money does actually benefit the population but if it doesn't, and the government or whoever's taxing doesn't have a clear plan that's believable, I feel like I'm being penalized and not receiving any benefit. (Louise)

Louise also speaks with concern over the potential fairness of tax, at a societal level, and with possibly even some distrust of the government to use the revenue to "actually benefit" anybody, which is another element of tax discourse.

Distrust of the government was not a major discourse, but it did come up for a few participants as cynicism or sarcasm, in response to an interview question *where do you think the tax revenue will go?* Louise said that the revenue generated would be "wasted by government in bureaucracy". Another participant suggested the money might go towards "roads" or even "Jets parties. Whiteout parties" (Elizabeth), referring to Winnipeg's professional hockey team. A final example was: "Oh, I'm so cynical, I think everything comes down to making more money, for somebody, um, the government" (Pheobe). Notably though, most participants did not utilize narratives regarding government (dis)trust in their discussion of their acceptability SSB taxation, suggesting, on the whole, participants were largely trusting of government.

Discussion

We identified two key discourses that informed participant discussion of SSB taxation. The first was healthism, through which participants framed their support for SSB taxation, and constructed an "ideal citizen and parent", who was going to change their behavior for the better with the implementation of a SSB tax. The second, fairness, informed by tax psychology, was vital to our interpretation of participant discussion on taxation. In particular, fairness concerns were most prominent on the level of procedural justice, the fairness of the *process* of the distribution of resources (Wenzel, 2003), and including a focus on equality or equity. Concerns regarding governmental distrust were less prominent. Additionally, both tax psychology and healthism theories reinforced how critical moralisation and social norms are to SSB taxation support.

Interestingly, healthism discourse was particularly prominent in participant discussion regarding which beverages should be targets of taxation. Similarly, Bombak et al. (2021) found in their study in rural Michigan, USA, that pop and energy drinks were also identified as tax targets, but not juice, which in contrast, was a strong health concern for many participants in the present study. Among a highly educated sample in India, participants lauded the health benefits and naturalness of juice (Riediger et al., 2021). Importantly, 100% juice does not fit within the definition of a SSB. It is likely that our sample has been influenced by current *Canadian*

discourse, as juice was recently removed as an eligible fruit/vegetable serving from the 2019 Canadian Food Guide, whereby water is recommended as the beverage of choice (Government of Canada, 2019). In Canada, adult 100% juice consumption patterns were determined based on the 2015 Canadian Community Health Survey, and there was no relationship between socio-economic position and 100% juice consumption (Warren et al., 2022). However, American data indicates children are the highest consumers of juice (Drewnowski & Rehm, 2015), and therefore the inclusion of juice as a potential tax target is likely, at least partially, reflective of the opinions participants had regarding parental responsibilities for feeding children (Waugh et al., in preparation). In their study with parents of children under 6 in Singapore, Chan et al (2021) reported that parents were interested in reducing their children's SSB intake, but expressed that they were not always able to control their child(rens) intake, due to different approaches between parents, a caregiver or school/daycare. This may also suggest the role culture plays in terms of parental responsibilities and the diet of their child(ren). Additionally, through the regulation of children's juice consumption via inclusion in proposed SSB taxation schemes, parents may be seeking to demonstrate their adherence to the "ideal citizen and parent are health conscious".

During the discussion of juice in the context of taxation, when participants were talking about juice they also had strong emotional reactions, in some cases to the point where there was a change in interview dynamics, with dominance over the interviewer. Dominance (assertiveness, and strong emotions) in participant discussion, was also associated with the hierarchy of healthiness, which was an answer to questions about *which beverages*. Many participants positioned themselves as having expert knowledge about health, and consequently had the ability to discern which beverages were healthier than others. Van Dijk (1993) described CDA applied to dominant groups as a way to tell the story of "elites and their discursive strategies for maintenance of equality". In this case, the question of *which beverages* was an opportunity for the participants, as members of the dominant group, to re-assert and thus maintain their dominant status, through the frame of healthism. Crawford (2006) also described health, in general, as a "language of class", which is structured in domination. Thus, the use of healthism when discussing the beverages targeted by taxation, illustrates how entrenched these ideas are, and how the language of health can be used by the dominant group to maintain their status, and in particular, related to parenting. Van Dijk's (1993) use of "equality" is important, as

it also highlights the singularity in terms of perspective, and in our case, the singular meaning of health.

Any explicit lack of support for SSB taxation was generally framed as a concern regarding fairness or justice, which manifested as a conflict between equity and equality. These two discourses were utilized mostly within the line of questioning seeking to explore participant perspectives on communities outside of their own, including Indigenous communities in Manitoba (See Appendix B for Interview Guide). No participants seemed to be surprised by this line of questioning, and all had something to say on this subject, but few participants mentioned Indigenous people specifically, as the question intentionally did not include the term 'Indigenous'. Ostensibly, participants were familiar with the issues (the question highlighted high costs of food, or lack of drinking water, for example), but there was a lack of engagement on a deeper level, and a tension as to how fairness should be conceptualized. Health inequities related to SSB intake, such as type 2 diabetes, are particularly pronounced amongst Indigenous populations (Blanchet & Rochette, 2008; Kolahdooz et al., 2017), and as outlined in the Truth and Reconciliation Commission (TRC) (2015) are attributed to colonialism. Notably, the province of Manitoba is only second to Ontario in both the total on-reserve and total First Nations populations in Canada, with almost 165,000 First Nations people in Manitoba (Government of Canada, 2021) which makes these inequities close to home for our participants

Within the equality discourses mobilized by participants when discussing SSB tax implementation, there was a prioritization of sameness or equality in the application of a SSB tax; in this way, SSB intake was not considered as a consequence of lack of or limited access to food or water. When equity discourses were used, justice was prioritized, although typically not before prompting. A lack of deeper discussion and reflection without prompting by most participants could therefore be indicative of the deeply entrenched racism and colonialism that continues to impact Indigenous Peoples in Canada (TRC, 2015), as well as a lack of fluency in equity, as fairness, discourses.

Trust, an aspect of tax psychology, was another thread that ran through participant discussions of tax fairness. The instances of distrust were principally a response to an interview question about the allocation of potential revenue of SSB taxation and included some skeptical or sarcastic remarks about governments. Generally though, distrust was remarkably absent from

participant discussion of SSB acceptability, indicating that although participants may have some misgivings in terms of the use of tax revenues, there was considerable ideological alignment with SSB taxation, and likely as a result of reasonable trust in the government. This is unsurprisingly given the current federal government is a Liberal minority government and participants were residents in a liberal riding, With their similar political orientation, our participants are within the same context as policy makers, and more likely to trust people who look like them, like their neighbours (Murtin et al., 2018). In contrast, Bombak et al. (2021) identified resistance to taxation as a theme among participants from rural Michigan, which generally holds more politically conservative views. Interestingly, among some Michigan participants, SSB taxes were specifically viewed as a liberal policy and not aligned with values in rural Michigan (Bombak et al., 2021).

Tax psychology (Kirchler, 2007) identifies that justice acts on three levels; however within the interviews in the present study there was a focus on only two: individual and societal level discussion. Group level was minimally addressed, with the exception of other groups that were introduced by the interviewer, such as northern communities and food insecure populations. As River Heights residents were chosen as participants to represent the dominant group in Canadian society, this could be a reflection of the perceived, or internalized dominance of this group, or even the shared ideology of this group. Additionally, the lack of group level discussion may also indicate a lack of recognition that the participants belong to a group (for example the 4 'w's (Kerner, 2008)). It has been previously documented that white people experience a "denial of having any identification with whites as a collective reality" (Lewis, 2004). Thus, this lack of awareness of belonging to a racial group may contribute to blind spots as to the racial under currents informing beverage (in)eligible for SSB taxation (Riediger & Bombak, 2018). An example of this is sweetened coffee, which was consumed by many of our participants, but not considered as an SSB or target for taxation. Although sweetened coffees certainly fit the definition of an SSB, the social meaning of coffee is very different compared to that of pop despite a similar sugar content, and race likely contributes to this difference in social meaning. In the USA, Park, McGuire and Galuska (2015) in their study exploring SSB and geography, found that the consumption of sweetened coffees or teas was highest in regions with higher socio-economic status and identified as white. Furthermore, sweetened coffee intake in Canada increased more than any other SSB type between 2004 and 2015 (Jones, Veerman & Hammond,

2017), but is generally not regarded as a public health concern. In addition, the lack of group awareness may have further consequences in that this lens assumes that there is only a single perspective, or experience. If this approach is applied to policy, there is the possibility that policies would only capture a single experience, which would continue the cycle of dominance and maintenance of Kerner's (2008) four "w"s.

In contrast to healthism, hedonism was mobilized by one participant (Katherina), who wanted to be permitted her "vice" of SSB. This discourse did not carry through the interviews, and as such it was not a dominant discourse, however this comment identified an important counter-discourse to healthism. Hedonism comes from the idea that good health is a result of "good pleasure" and takes a position contrary to modern public health (Klein, 2010). Academic literature is largely silent on consuming and deriving pleasure from SSB consumption, and the associated health benefits from SSB consumption. Future research in this area, particularly among diverse communities, would likely be valuable in better understanding motivations to consume SSB, as well as continuing to add to the body of critical research on SSB.

Although this study had many strengths, it was limited by the smaller sample, which included few men compared to women. The study has limited transferability, particularly outside of white, educated, middle class, Canadian adults and parents in this time period. Interviews with different demographic groups, particularly single mothers, individuals with lower education, racialized communities, or neighbourhoods with more conservative political viewpoints, could elicit different perspectives. Additionally, discourses are deeply tied to a specific context, so transferability is also limited in this regard. However, this does not limit the value of this study, as it traces the discourses utilized in framing Canadian health policies, through analysing a neighborhood representative of this dominant social group.

In conclusion, we identified two major discourses in participants' discussion on SSB taxation. The first was healthism, which built upon our previous analysis of personal responsibility (Waugh et al., In preparation), and was utilized by participants in support of SSB taxation. This lens provides insight into how the dominant social group creates and maintains dominance; through the language and "super-valuing" of health. The second discourse was derived from tax psychology (Kirchler, 2007), which described participant concerns with the fairness of taxation, at the individual and societal levels. This tax discourse was typically utilized

against SSB taxation, in contrast to healthism. Therefore, the residents of River Heights were accepting of an SSB tax when it was for health, and a way to demonstrate their valuing of health, as an ideal citizen and parent, but had concerns when it came down to how, and whom it would be affecting the most, despite most not considering themselves particularly targeted.

Chapter 7

Discussion and Conclusion

General Discussion

The overall objectives of this study were to,

1. To explore the discourses informing SSB taxation, and their underlying ideologies amongst white residents of River Heights, Winnipeg.
2. To determine the acceptability of SSB taxation to white residents of River Heights, Winnipeg.

To meet these objectives, a critical, qualitative approach was used, to analyze 18 interviews, with our participants from River Heights, Winnipeg. The results of this study have been organized into two self-contained research papers. Each paper addressed both discourse and acceptability, however, the first paper (Chapter 4) focused on SSB specific discourse, and acceptability, whereas the second paper (Chapter 6) examined SSB taxation, as a separate concept.

In our findings, we identified personal responsibility discourse, as an instance of weight stigma, within SSB-specific discussion. Additionally, in our analysis of SSB taxation, healthism, and procedural justice were both discourses informing participant talk, and thus awareness of SSB taxation. SSB taxation was constructed positively when framed as a step required for 'health consciousness' and good parenting. There were limits to acceptability, notably through concerns about fairness of taxation, as well as sensitivity to individual/community contexts.

Strengths

The first strength of this project is that is contributes to the body of literature around SSB and the social meanings of beverages using CDA, which, to our knowledge, as only been used to examine commercial determinants of health (i.e. food industry opposition to SSB taxation). An additional strength of this project was the sample population, as we had all white participants volunteer which was unexpected. This allowed for a very consistent perspective to come through, and the analysis to become very focused. Similarly, saturation was reached, as this sample was very similar in their perspectives and discourses utilized, so 18 interviews was

sufficient. In terms of analysis, it was a strength of this study that I (AW) was able to transcribe the interviews, and be a member of the research team during the interview process, so that I was involved, and immersed in the project, starting with the data collection. Finally, as both myself (AW) and other members of the research team (NR and KM) belong to the dominant social group, we informally served to member-check our results in discussions.

Limitations

Although the sample population could be considered a strength, there may also be limitations in terms of transferability, particularly as the sample included few men. As such, the findings of this study may be more representative of River Heights women, than all residents of River Heights. This is particularly relevant to SSB, as men tend to be higher consumers. This also prevented us from doing any analysis comparing female versus male perspectives, which could have yielded additional insight. The sample also included mainly married individuals in heterosexual relationships, who had kids. Therefore these results pertain to a very specific demographic, which again may limit transferability. Another potential limitation of this research study was that no interview questions specifically asked about political orientation, which could have provided a clearer picture of the ideology of participants. In particular, this line of questioning could have also solidified attitudes towards taxation, due to their link with political ideology.

Implications of Findings

As a part of the larger study "Sticky Money", my findings contribute an important piece of a much larger picture; one location in Manitoba, to add to multiple locations representing a variety of populations and perspectives. The results of my study, because of the chosen setting of River Heights, contribute to this study as the dominant social group, and thus a comparison for the other locations studied in "Sticky Money". In particular, my findings serve to identify dominant discourses, while the other locations studied showcase the effects of those discourses for Indigenous communities marginalized by food insecurity, colonialism, and lack of clean drinking water. This larger diverse sample will provide differing perspectives regarding SSB and a potential tax, particularly from a Manitoba perspective.

Looking more specifically at my findings, they include an identification of key discourses utilized by the dominant social group, about SSB and taxation: personal responsibility, healthism and fairness - through procedural justice. Through the nature of discourse, and the process of their identification, we can predict something about the ideologies held by the dominant group, and how they can inform policy support, as the policymakers are typically a part of this dominant group. Therefore, the ideologies and discourses mobilized by this group may also find themselves in policies, which can maintain the existing power dynamic for this group, as well as negatively effecting equity, such as through the impact of ongoing stigmatization.

The findings of my research could also have implications for policy, as SSB taxation is now an implemented policy in Newfoundland and Labrador, and likely to be proposed in other jurisdictions. Before an SSB tax is implemented elsewhere in Canada, it is most important to understand the potential implications on equity. From our findings, we anticipate that an SSB tax would have inequitable effects, through stigma. The use of personal responsibility discourse by participants when discussing SSB, particularly directed at higher weight individuals, positions an SSB tax as a policy reinforcing weight stigma. In addition, from the findings it seems as though an extension of personal responsibility, parental responsibility will also evolve into judgement of parents, based on both the negativity and judgement associated with what is perceived as 'poor' parenting (which also includes having children who are of a higher weight), and the power dynamic in those scenarios including gender, class, and race. In addition, participant discussion of SSB taxation also included discourses of "super-valuing" of health, or healthism. Healthism is founded in a cultural view that good citizens are those who are seeking health above all else. Healthist discourse was drawn upon by participants when voicing their support for SSB taxation, and thus demonstrates that support for SSB taxation can inform harmful ideals of good and bad citizens, despite some participants also acknowledging some communities as having access to fewer alternatives to SSB. Participant discussion of SSB taxation was also extremely concerned with fairness, and any resistance to taxation was based in discourses of procedural justice; whether or not tax cost and benefit would be balanced. Participants were divided in their perspective of favouring equity or equality as a perceived balance.

Knowledge Translation

As this was a community-informed research project, as well as one that was striving to be anti-oppressive, knowledge translation was a priority. For participants, once the interviews had concluded, some preliminary results, as well as some demographic information were shared through a bookmark (Appendix I). Additionally, the dissemination of my findings occurred through my presentation of study findings in the Food and Human Nutritional Sciences Graduate Seminar, the Canadian Nutrition Society Annual Conference (2021), Canada Student Health Research Symposium (2020), and International Critical Dietetics Conference (2020).

Once this thesis is completed, with the involvement of my advisory committee and other co-authors, we plan to submit the prepared manuscripts, the first (Chapter 4) in and the second (Chapter 6) for peer-reviewed publication. Additionally, we plan to share our results with the broader public, we are planning on writing an article for the Conversation Canada, in light of the first Canadian SSB tax soon to be implemented. Finally, we will also share the findings with the broader 'Sticky Money' team at an upcoming large team meeting, which will inform discussion and interpretation of data from other study sites.

Conclusions

The results of this study highlight the discourses, and thus ideologies, that are relevant to how these participants, as members of the dominant group, understand SSB and SSB taxation. The discourses circulating in this group are weight stigmatizing, moralizing, and emphasizing procedural justice, all of which have consequences for health equity. Therefore, the implementation of a SSB tax may have harmful consequences, through the validation and reproduction of these discourses, the continued stigmatization of "obesity", and the judgement of parents, and particularly mothers who are also marginalized via income, class, and race. We urge that before SSB taxation is considered for implementation in Manitoba, and across Canada, the potential effects on stigma and health equity are considered, as stigma is a known driver of health inequities.

Future Research

Additional research on SSB, acceptability, and experiences of diverse populations could help provide a clearer picture of the social meaning of SSB, and the potential policy

implications. This research could include recruitment of more diverse populations than this project, such as a sample that included more men or same-sex couples, which would also allow for a potential qualitative exploration of the role fatherhood, perceived responsibility, and judgement of parents among individuals in same-sex couples who may hold differing views on parenting-related gender roles. Other qualitative research on SSB taxation could also explore the discourses utilized by racially diverse populations (i.e. not all white participants) which then might provide insights into dominance, tension, as well as group-level discourse. Additionally, research with different age cohorts, or more intention to capture different ages or generations could serve to explore how the social meaning of beverages have changed over time, or the different priorities within each generation.

Another avenue of potential research could include utilizing different settings, with a different political alignment (compared to River Heights). This could facilitate an analysis of the role of politics or community within discourse and ideology, or even within the meanings of health and nutrition. As River Heights is a neighborhood that is historically Liberal in its politics, choosing a neighborhood that has been historically conservative, for example, could offer such a comparison, such as Kildonan St. Paul. As mentioned above, including a more diverse sample (more men, for example), within one sample population could also offer more opportunities for internal comparisons which could provide more insights within a single study.

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Appendices

Appendix A: Demographic Questionnaire

Demographic Questionnaire

Please take a moment to complete this short questionnaire. Your answers will remain confidential.

Participant ID#:_____

Date:_____

1. With which gender do you identify?
   ❑1 Male ❑2 Female ❑3 Other

2. In what year were you born? _____[YYYY]

3. What is the highest level of education you have completed?

   ❑1 Primary school

   ❑2 Some secondary school

   ❑3 Completed secondary school

   ❑4 Completed trade/technical school or college diploma

   ❑5 Completed university degree

4. What is your current employment status?
   ❑1 Retired

   ❑2 Semi-retired or working part-time in the labour force

   ❑3 Working full-time in the labour force

   ❑4 Not working in the labour force (a caregiver who doesn't work by preference/on leave/ unemployed)

5. With what race/ethnicity do you identify?
   ❑0 White

   ❑1 First Nations

   ❑2 Metis

   ❑3 Inuk (Inuit)

❑4 Black

❑5 South Asian

❑6 Southeast Asian

❑7 Arab

❑8 Chinese

❑9 Multiple ethnicities/races

❑10 Other: _____

6. In general, how would you rate your health?

❑5 Excellent

❑4 Very Good

❑3 Good

❑2 Fair

❑1 Poor

7. Do you and other household members always have enough of the kinds of foods you want to eat?

❑2 No

❑1 Yes

8. How often do you consume sugar-sweetened beverages (such as soda/pop (regular or diet), sports drinks, sweetened tea, sweetened coffee)?

❑5 Never

❑4 Less than once per week

❑3 1-3 times per week

❑2 4-6 times per week

❑1 At least once per day

Thank you for your participation!

Appendix B: Interview Guide

Date:_____

Participant ID:_____

Interviewer:_____

Interview Guide:

1. What health concerns, if any, do you have for yourself, your family, and/or the community?
2. What beverages do you consume most frequently?
    a. How often do you have drinks with sugar?
        i. Pop
        ii. Diet drinks
        iii. Sport drinks
        iv. Coffee or tea
    b. How often do people in your family have drinks with sugar?
        i. What types of drinks?
        ii. Has this changed over time?
    c. How often do your friends have drinks with sugar?
        i. What types of drinks?
        ii. Has this changed over time?
3. How do you think drinks with sugar affect (or do not affect) individuals' health?
    a. Where have you heard about drinks with sugar and health?
4. What are people's reactions (if any) to your drinking sugary drinks?
    a. How does that make you feel? How do you cope with these experiences? What do you think are the causes of these experiences?
    b. Where do you drink sugary drinks? Where do you feel most and least comfortable drinking sugary drinks? How has this changed (or not changed) over time? Why do you think there are (or are not) differences?
    c. How is the experience of drinking sugary drinks different or the same in public or private?
    d. If someone reacts to you drinking sugary drinks, who is reacting to you?
    e. How are these reactions the same or different than they were in the past?
    f. How are these reactions the same or different compared to when you drink other types of drinks? Certain types of sugary drinks?
5. What are people's reactions (if any) to you buying sugary drinks?
    a. How does that make you feel? How do you cope with these experiences? What do you think are the causes of these experiences?

    b. Where do you buy sugary drinks? Where do you feel most and least comfortable buying sugary drinks? How has this changed (or not changed) over time? Why do you think there are (or are not) differences?
    c. If someone reacts to you buying sugary drinks, who is reacting to you?
    d. How are these reactions the same or different than they were in the past?
    e. How these reactions are the same or different compared to when you buy other types of drinks? Certain types of sugary drinks?
6. How do you react to others drinking or buying sugary drinks? Your family? Friends? Strangers? Children? Adults?
    a. Why do you react (or not react) that way?
7. What have you heard about the sugar-sweetened beverage tax?
    a. What sources did you hear that from?
8. How do you think the tax will affect people?
    a. What drinks do you think are the focus of the tax? Why?
    b. What specific people will be affected?
    c. What about people who cannot afford food?
9. How would you feel about the tax being introduced in Manitoba or Canada?
    a. What about in northern, remote communities?
    b. In communities where the cost of food is much greater than Winnipeg?
    c. In communities without drinking water?
10. Where do you think the money generated from the tax would go? Where would you want it to go?

Thank you for your time and participation. Is there anything you want like to add or ask me?

Appendix C: PHIA

UNIVERSITY OF MANITOBA

PERSONAL HEALTH INFORMATION

PLEDGE OF CONFIDENTIALITY

Please read the statements below and indicate if you acknowledge/understand your responsibility under PHIA and University of Manitoba policies and procedures.

	DECLARATION
☑	I ACKNOWLEDGE that I have completed ***The Personal Health Information Act*** (PHIA) training offered by The University of Manitoba ("the University") and I am aware of my obligations under PHIA.
☑	I ACKNOWLEDGE that I am aware of the University's policy on confidentiality and security of personal health information as described in the Access and Privacy Policy, which is in accordance with ***The Personal Health Information Act***.
☑	I ACKNOWLEDGE that I am aware of the University's procedures on confidentiality and security of personal health information as described in the Access and Privacy Procedures, including procedures relating to collection, access, use, disclosure, retention and storage, and destruction of personal health information.
☑	I UNDERSTAND that in consideration of my association (including as a student, if applicable), appointment, employment, or contract with the University ("my relationship"), and as an integral part of the terms and conditions of my relationship, I hereby agree, pledge and undertake that: • I will not at any time, during my relationship with the University, access or use personal health information; • I will not reveal or disclose to any persons within or outside the University, any personal health information; EXCEPT as may be required in the course of my duties and responsibilities, in accordance with applicable laws, and pursuant to University and departmental policies governing proper release of the information.
☑	I UNDERSTAND that my obligations concerning the protection of confidentiality relate to all personal health information in the custody or under the control of the University that I may gain access to, directly or indirectly, as a result of my relationship.
☑	I UNDERSTAND that the obligations outlined above will continue after my relationship with the University ends.
☑	I UNDERSTAND that unauthorized use or disclosure of personal health information may result in disciplinary action being taken, and/or legal action at the discretion of the University.

Full Name: Anne Waugh **Position:** Student Research Assistant

Date: May 1, 2019 **UM Unit/Organization:** Foods and Human Nutritional Sciences

Access and Privacy Office Authorization:

(Administrative Use Only)

Submit your completed form to fippa@umanitoba.ca as an attachment.

Issued by the Access and Privacy Office, University of Manitoba on September 14, 2017

PANEL ON RESEARCH ETHICS

Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Anne Waugh

has completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **6 May 2019**

Appendix D: TCPS Certificate of Completion

Appendix E: Confidentiality Pledge

University of Manitoba
Faculty of Agricultural & Food Sciences
Food & Human Nutritional Sciences
209 Human Ecology Building
Winnipeg, Manitoba
Canada R3T 2N2
Tel 204-474-6411
Fax 204-474-7593
FHNS.generalenquiries@umanitoba.ca

Pledge of Confidentiality

I, _____Anne Waugh_____, agree to maintain full confidentiality of any and all research data received by me in the course of my involvement in the study entitled – ***Examining the acceptability of a sugar-sweetened beverage tax amongst white residents of River Heights, Winnipeg: A critical discourse analysis***

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual(s) that may be revealed during the collection or handling of research data, or in any associated documents.

2. To store all research data and materials in a safe, secure location as long as they are in my possession.

3. To delete all electronic files containing data from my computer hard drive and any back-up devices after I no longer need this information as directed by the study principal investigator.

4. To destroy as confidential waste, any hardcopy research data in my possession after it is no longer required by me as directed by the study principal investigator.

I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred to individuals if I violate this agreement.

[redacted]
Staff Member's Signature

_____Anne Waugh_____
Staff Member's Name (printed)
Date:_____November 2nd, 2020_____

[redacted]
Study Principal Investigator's Signature

Nov 3, 2020 Natalie Riediger
Study Principal Investigator's Name (printed)
Date

Appendix F: Consent Form

UNIVERSITY OF MANITOBA

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Individual Interview

Title of Study: "Sticky Money: Exploring the acceptability of a sugar-sweetened beverage tax among Canadian Indigenous populations"

Principal Investigator:
Natalie Riediger
Assistant Professor
University of Manitoba
407 Human Ecology Building
Winnipeg, Manitoba, Canada
R3T 2N2
Email: Natalie.riediger@umanitoba.ca

Sponsor: n/a
Funder: Canadian Institutes of Health Research

You are being asked to participate in a research study involving an individual interview. Please take your time to review this consent form and discuss any questions you may have with the study staff, your friends, or family before you make your decision. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of this Study

This research study is being conducted to study the acceptability of a proposed tax on sugary drinks in Canada.

Participants Selection

You are being asked to participate in this study because you are an English-speaking adult residing in River Heights, Winnipeg OR are employed at a small business in River Heights or other middle to high income areas of Winnipeg that sells sugary drinks.

A total of 20-25 participants will be asked to participate.

Study procedures

The method of data collection for this study will be an individual interview with a Research Assistant or Researcher as well as a short Demographic Questionnaire. Interviews are a way of finding out people's thoughts and ideas about a specific topic. Participation in the study will be for approximately 1 hour. You will be asked some questions relating to your experience with food, specifically sugary drinks, and your perceptions and acceptability of a proposed tax on sugary drinks. These questions will help us to better understand what the implications are if a sugary drink tax is implemented in Canada and what the considerations may be if such a tax is implemented.

The sessions will be audio-taped and the audio-tapes will be transcribed by an anonymous transcription services in Canada to ensure accurate reporting of the information that you provide. Transcribers will sign a form stating that they will not discuss any item on the tape with anyone other than the researchers.

No one's name will be asked or revealed during the individual interview.

The audio-tapes will be stored in locked filing cabinets before and after being transcribed. Audio files and the transcriptions will be destroyed *7* years after the completion of this research.

Risks and Discomforts

There are no anticipated physical risks to participants. However, you may find talking about your food environment and its relationship to health to be upsetting or emotional. You do not have to answer any question that makes you feel uncomfortable or that you find too upsetting.

Benefits

Being a study participant may not help you directly, but information gained may provide information regarding the merits or limitations in implementing a tax on sugary drinks.

Costs

There is no cost to you to attend the individual interview.

Payment for participation

You will be given a $50 gift card for your participation in this research study.

Confidentiality

We will do everything possible to keep your personal information confidential. Your name will not be used at all in the study records. Your business or place of employment will also not be used in any of the study records. A list of names and email addresses of participants will be kept in a secure file so we can send you a summary of the results of the study, if you want. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you were in the study. Please note that although you will not be identified as the speaker, your words

may be used to highlight a specific point. The collection and access to personal information will be in compliance with the Canadian provincial and federal privacy legislations.

Audiotapes of the interview will be typed (transcribed) and used to prepare reports, presentations, and peer-reviewed publications. The audio files, transcripts, questionnaire, consent forms, and typed notes will be kept for 7 years in a secure locked file cabinet and office. Only the research staff and Principal Investigator, Dr. Natalie Riediger, will have access to them and know your name. De-identified transcripts will be securely shared with researchers on the study team at other Canadian post-secondary institutions for data analysis.
Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy.

These people or groups are:

- The Health Research Ethics Board of the University of Manitoba which is responsible for the protection of people in research and has reviewed this study for ethical acceptability
- Quality assurance staff of the University of Manitoba who ensure the study is being conducted properly

Interview data will be transcribed, with transcriptionist agreeing to maintain full confidentiality in regards to all content of each interview. All records will be kept in a secure area and only those persons identified will have access to these records by a password protected computer. If any of your research records need to be copied to any of the above, your name and all identifying information will be removed. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

Permission to Quote:
We may wish to quote your words directly in reports and publications resulting from this. With regards to being quoted, please check yes or no for each of the following statements:

Researchers may publish documents that contain quotations by me under the following conditions:	
☐ Yes ☐ No	I agree to be quoted directly if my name is not published (I remain anonymous).
☐ Yes ☐ No	I agree to be quoted directly if a made-up name (pseudonym) is used.

Voluntary Participation/Withdrawal from the Study
Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time.

Questions
If any questions come up during or after the study, contact the principal investigator: Dr. Natalie Riediger at 1-(204)-480-1323 or Natalie.riediger@umanitoba.ca

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at 1-(204)-789-3389.

Consent Signatures:

1. I have read all 4 pages of the consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
3. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
4. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.
5. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.
6. I understand I will be provided with a copy of the consent form for my records.
7. I agree to participate in the study.

Participant signature_____ Date _____
(day/month/year)

Participant printed name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _____Date _____
(day/month/year)

Signature: _____

Role in the study: _____*[*

Appendix G: Research Ethics Board Approval

University of Manitoba | Research Ethics and Compliance

Human Ethics - Fort Garry
208-194 Dafoe Road
Winnipeg, MB R3T 2N2
T: 204 474 8872
humanethics@umanitoba.ca

PROTOCOL APPROVAL

To: **Anne Waugh** **(Advisor: Natalie Riediger)**
Principal Investigator

From: **Andrea Szwajcer, Chair**
Joint-Faculty Research Ethics Board (JFREB)

Re: **Protocol # J2020:068 (HS24335)**
Examining the acceptability of a sugar-sweetened beverage tax amongst white residents of River Heights, Winnipeg: A critical discourse analysis

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Effective: September 29, 2020 **Expiry:** September 29, 2021

Joint-Faculty Research Ethics Board (JFREB) has reviewed and approved the above research. JFREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.*

This approval is subject to the following conditions:

i. Approval is granted for the research and purposes described in the application only.

ii. Any modification to the research or research materials must be submitted to JFREB for approval before implementation.

iii. Any deviations to the research or adverse events must be submitted to JFREB as soon as possible.

iv. This approval is valid for one year only and a Renewal Request must be submitted and approved by the above expiry date.

Human Ethics - Fort Garry
208-194 Dafoe Road
Winnipeg, MB R3T 2N2
T: 204 474 8872
humanethics@umanitoba.ca

v. A Study Closure form must be submitted to JFREB when the research is complete or terminated.

vi. The University of Manitoba may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba Ethics of Research Involving Humans.

Funded Protocols: Please e-mail a copy of this Approval, identifying the related UM Project Number, to the Research Grants Officer at ResearchGrants@umanitoba.ca

Appendix H: Research Ethics Board Renewal

University of Manitoba | Research Ethics and Compliance

Human Ethics - Fort Garry
208-194 Dafoe Road
Winnipeg, MB R3T 2N2
T: 204 474 8872
humanethics@umanitoba.ca

RENEWAL APPROVAL

Effective: September 15, 2021 New Expiry: September 29, 2022

Principal Investigator:	Anne Waugh
Advisor:	Natalie Riediger
Protocol Number:	HS24335 (J2020:068)
Protocol Title:	*Examining the acceptability of a sugar-sweetened beverage tax amongst white residents of River Heights, Winnipeg: A critical discourse analysis*

Andrea L Szwajcer, Chair, REB2

Research Ethics Board 2 has reviewed and renewed the above research. The Human Ethics Office is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*- TCPS 2 (2018).

This approval is subject to the following conditions:

i. Any changes to this research must be approved by the Human Ethics Office before implementation.

ii. Any deviations to the research or adverse events must be reported to the HEO immediately through an REB Event.

iii. This renewal is valid for one year only. A Renewal Request must be submitted and approved prior to the above expiry date.

iv. A Protocol Closure must be submitted to the HEO when the research is complete or if the research is terminated.

Appendix I: Book Mark for participants

Sticky Money

The Acceptability of a Sugar Sweetened Beverage (SSB) Tax

Results from the 2019 River Heights Interviews:

- 18 Participants (16 Women, 2 Men)
- All participants identified as White
- 94% of participants had completed a university degree or a college diploma

Opinions on Taxation:

56% of participants were generally in favour of a tax on sugary drinks

22% of participants were generally against a tax on sugary drinks

22% of participants were unsure/ambivalent of a tax on sugary drinks

Principal Investigator:
Dr. Natalie Riediger
Natalie.riediger@umanitoba.ca

Acknowledgements:
Kelsey Mann, MSc
Anne Waugh, BSc

sugartax@umanitoba.ca

Common Themes:

Social Influences

- Pop was mostly consumed primarily at social gatherings
  - Examples included community events, parties or restaurants
  - Pop used to mix with hard alcohol or an alternative to alcohol
- In contrast, other participants would never consume pop outside the home

Weight Stigma

- Most participants identified that they would react (usually judge) to an overweight person purchasing SSBs
  - Reaction was pronounced if kids were involved
  - Most participants would never voice their concerns
- Some participants linked higher weight with pop consumption

Tax Targets

- The beverages likely to be taxed, if a tax were to be implemented:
  - Pop (All participants)
  - Juice, sweetened coffees, energy drinks (Most participants)

Tax Revenues

- Most participants felt tax revenues should go into health including programs, education, and research
- Some felt the money should be used for children including schools, lunch programs, and recreation
- Some also felt revenues should go to subsidizing food for Northern Communities