MARGINALIZED SUBSISTENCE:
FOOD SECURITY, HIV/AIDS, AND HEPATITIS C IN A SASKATOON FOOD DESERT

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ABSTRACT

This thesis examines the ways in which people who access services (PWAS) at the HIV/AIDS service provider AIDS Saskatoon utilize specific survival and subsistence strategies in an urban food desert within Saskatoon, Saskatchewan. Utilizing a community-based, ethnographic approach that is primarily situated within the critical-interpretive theoretical foundation and syndemic framework in medical anthropology, this project aims to contextualize the experiences of marginalized persons who use substances living with, or at risk of, HIV/AIDS and Hepatitis C (HCV) within the formal and informal communities of a low-income urban space. Balancing a plethora of barriers to food security, compounded with experiences of illness, violence, colonialism, substance use, and housing instability, the participants within the current project undertake a number of strategies to survive and acquire food amidst heightened surveillance and control from outside forces. PWAS maintain a sense of agency and autonomy through the use of alternative or "marginalized" subsistence strategies, such as through illicit income generating activities, to meet basic needs when formal interventions and programming are inadequate. PWAS resist overt surveillance and control in their lives, including imposed qualifiers of vulnerability, through specific and direct prioritizing and decision making regarding the intake of consumptive products, through the use of street based economic activities to acquire food, and through participation in moral economic practices around food acquisition. Programming aimed at building a secure status on the food security spectrum can be classified as a harm reduction tactic for PWAS given that it decreases certain risks that come with marginalized subsistence, increases available protective factors, and offers a means of resistance against outside governing bodies. In order to increases the uptake of food programming while building capacity and autonomy in those who access services, food programs centered on choice, dignity, and those which boast low barriers to accessibility, can contribute to positive health and social outcomes for marginalized groups struggling to survive in urban spaces.

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DEDICATION

For Gavin. Thank you for encouraging me to always reach higher and for all of your support in the tough moments. And for Adrienne, Aine, Krista, and Megan. Thank you for all of the laughs, advice, love, and encouragement. I am so very lucky to have been given the opportunity to complete this program alongside you all.

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CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

In the face of adverse conditions, individuals often employ specific and wide-ranging survival strategies for the purpose of navigating tumultuous social, cultural, and environmental landscapes. Economic and social survival strategies are becoming increasingly more dynamic and complex with rapid globalization and technological development. Whether such tactics involve hunting for food in a wild landscape, scavenging landfills in urban cities for valuable waste, or hitchhiking to a pharmacy to obtain life saving medication, survival itself can be viewed as a culturally contingent and ever-changing process. Cultural approaches to food security, and the associated interrelationships with chronic and acute infectious disease, requires direct engagement with the concept of survival. Food security is indeed only one facet of subsistence. The ways in which individuals persist and utilize resourcefulness and resilience in the face of scarcity and illness is of specific importance when examining survival in marginalized groups. Examinations in this area must include peripheral strategies contextualized within broader social systems.

The anthropology of survival is wrought with extensive syndemic relationships on both micro and macro scales. Food security within Canada, and the examinations of political, economic, cultural, and biological syndemic relationships therein, are no exception to this. Food security occurs "when all people, at all times, have physical, social, and economic access to sufficient, safe, and nutritious food that meet their dietary needs and food preferences for an active and healthy life" (Anema, Fielden, Castleman, Grede, Heap & Bloem 2014, 478). The food security spectrum put forth by Hendriks (2015) lists "insecurity" as one state along a food security continuum, meaning that the concept of food security also encompasses varying modes of being and experience depending on where an individual falls on the spectrum. Food "security" and "insecurity" are both used as qualifiers, speaking to different states along Hendrik's (2015) model.

The province of Saskatchewan is of particular interest in the study of the food security spectrum and infectious disease syndemics given that the area has amongst the highest rates of HIV/AIDS infection while also boasting extremely high numbers of food insecure familial units and individuals with acute Hepatitis C (HCV) infection. As of 2015, the province reported a rate of 14.4 new HIV/AIDS diagnoses per 100,000 persons, as compared to the national average of

5.8 per 100,000 persons (Government of Canada 2015). Saskatchewan was also listed as one of eight provinces and territories that reported a higher number of novel HCV diagnoses than the national average of 29.6 cases per 100,000 persons (Public Health Agency of Canada 2016). Specifically, Indigenous Peoples remain disproportionately affected by HIV/AIDS within Saskatchewan and are disproportionately affected by HCV and food insecurity within Canada (Bourgeois, Edmunds, Awan, Jonah, Varaneux, and Sui 2017; Duncan, Reading, Borwein, Murray, Palmer, Michelow, Samji, Lima, Montaner, and Hogg 2011; Public Health Agency of Canada 2010; Willows, Veugelers, Raine, and Kuhle 2011).

The relationship between HIV/AIDS and food security has been examined at length within the literature, though explicit research on HCV and food security has been limited (Anema et al. 2014; Claros, de Pee, and Bloem 2014; Cox, Hamelin, McLinden, Moodie, Anema, Rollet-Kurhajec, Paradis, Rourke, Walmsley, and Klein 2017; de Pee, Grede, and Bloem 2014; Friis, Olsen, and Filteau 2017). Both HIV and HCV positive individuals are more likely to live in food insecure environments (Cox et al. 2017). In British Columbia, it was found that 73% of people living with HIV/AIDS who used HIV/AIDS specific service organizations had poor dietary quality resulting in severe food insecurity (Miewald, McCan, and Temenos 2017). Thus, HIV/AIDS and HCV can be viewed as socially and culturally mediated diseases, where virulence and prevalence are often exacerbated by socio-structural factors such as food security status, poverty, substance use, and other variables (Farmer 2004; Singer and Clair 2003).

A history of colonialism combined with rampant structural violence, unequal access to resources, and both implicit and explicit oppression has created an adverse environment for populations of First Nations, Metis, and Inuit peoples that reside in both rural and urban areas of Saskatchewan. Indigenous populations experience disproportionate rates of food insecurity as compared to other populations, affecting approximately 41% of on-reserve Indigenous households and 33% of off-reserve Indigenous households (Elliott, Jayatilaka, Brown, Varley and Corbett 2012). Such struggles have ultimately led to the emergence of alternative, or marginalized, survival strategies meant to be undetectable to larger governing bodies that seek to manage the actions of individuals situated on the peripheries of society. Governance and control over marginalized groups often takes the form of situational interventions via governmentally and non-governmentally run social assistance and community health programs that are known to alleviate structural burdens for homeless peoples, substance users, HIV positive persons, and

other individuals struggling to enact agency amidst societal constraints. As will be shown in later chapters, this governance has the capacity to both constrain and enable autonomy and capacity in important ways.

During the summer months of 2018, I conducted ethnographic fieldwork in the city of Saskatoon, Saskatchewan at the local HIV/AIDS and Hepatitis C service provider AIDS Saskatoon. Situated at the crossroads of a residential and commercial intersection in an increasingly gentrified neighborhood, AIDS Saskatoon serves people from all corners of the city. Participants in my study come from a number of backgrounds, but almost all are in the throes of, or have once been in the throes of, severe food insecurity.

The overall goal of this research project was to collect stories about the lived experiences of people who access services (PWAS) at AIDS Saskatoon in order to better elucidate how marginalized persons living with, or at risk of, HIV/AIDS and Hepatitis C engage with food acquisition and experience everyday life within food insecure environments. Additionally, the current research project sought to compile information on how PWAS manage their own of health and wellness while living with, or being at risk of, chronic and acute viral infections. By examining these circumstances, the current project sought to contribute to current research on food security, HIV/AIDS, and HCV syndemics and the social determinants of health to inform food programming aimed at alleviating burdens related to food insecurity. My two research questions for this project are as follows: What meanings do people living with, or affected by, HIV/AIDS and Hepatitis C (HCV) in Saskatoon ascribe to food and eating? What role does food security play in prevailing understandings of well-being among those living with or affected by HIV/AIDS and/or HCV?

To address these questions, I explore participant experiences related to food acquisition, health, wellness, harm reduction, and other related themes utilizing data from community-based participatory ethnographic research. By analyzing the lived-experiences of people who access services at AIDS Saskatoon, I address the following sub-questions: How can experiences of both illness and wellness among people who access services (PWAS) be better understood through an examination of food, eating, and the body? How do participants see themselves as at risk of being food insecure due to their HIV or HCV status? How can access to nutritionally adequate food act as a harm reduction strategy in marginalized populations?

As I set out to examine links between food security, HIV/AIDS, and HCV, I will show that my participants are inherently more concerned with discussing their experiences related to community, agency, and substance use, rather than infectious disease or illness specifically. My observations reveal a complex network of peoples who find themselves in constant flux with the societal constraints around them. As if engaged in a dance or battle of wills with community programming and governmentality, moral economic practices, and the threat of withdrawal from substance use, this group of resilient persons are more determined to share narratives about the ways that they have come to survive, rather than to focus on the ways that greater society has deemed them to fail.

Following a critical interpretive approach that specifically focuses on neoliberalism, societal power imbalances, colonialism, and other matter deemed by Ortner (2015) to fall into the realm of "dark anthropology," I engage with the larger forces that come to present barriers to my participants. However, in following the narratives that emerged during the research process, I also come to question popular notions of vulnerability while seeking to shift current discourse away from an apparent fascination with the suffering of marginalized groups. When speaking to the experiences of marginalized persons, it is of course necessary to illuminate the ways in which the larger forces exacerbate inequalities, especially if one seeks to assist in the dismantling of oppressive power systems. But, as Ortner (2015) comes to state in her examination of the anthropology of the "dark," there may be something to be gained from moving away from voyeuristic presentations of suffering and towards what Robbins (2013) refers to as the "anthropology of the good." In this sense, I do seek to engage with the good insofar that my "more modest aim is to explore the different ways people organize their personal and collective lives in order to foster what they think of as good" (Robbins 2013, 457). The theoretical foundations that I engage with are therefore used to balance both this anthropology of the "dark" (examinations of governmentality and oppression) with the later use of the anthropology of the "good" (a focus on agency, resilience, and survival).

I argue here that PWAS often utilize specific survival tactics and subsistence strategies to traverse tumultuous social, cultural, and environmental spaces that are ingrained in daily food acquisition. These subsistence strategies contribute to an individual's positioning along a dynamic, individualistic, and temporally dependent food security continuum. Everyday decisions regarding consumption, health, and community are complex and are dependent on broader social

and cultural constraints. Experiencing a plethora of syndemic risks and pathways, persons living with, or at risk of, HIV/AIDS and HCV with comorbid use of illicit substances are often overseen by larger institutions that seek to both alleviate burdens while also simultaneously governing the behavioural activities that threaten the overarching social body. PWAS from AIDS Saskatoon move within the realm of the broader body politic, often finding themselves grappling with agency and personal capacity while attempting to dislodge messages of vulnerability that have been psychologically instilled over time. "Marginalized subsistence," then, often involves the uptake of "alternative," sometimes illicit, and very often hidden, livelihood and subsistence strategies to acquire food that require an enormous amount of resourcefulness while also proposing a fair amount of risk. By using these alternative subsistence strategies situated at the margins of mainstream economic practices to acquire consumptive products such as illicit drugs and food, PWAS challenge notions of personal fragility that the larger body politic both imposes and reproduces. Food security programs centered on choice, dignity, and social cohesion, rather than control and governmentality, can be used as a harm reduction strategy for persons living with, or at risk of, HIV/AIDS and HCV insofar that accessibility can help to alleviate the possible burdens that come with marginalized subsistence. Accessible food programs can therefore contribute to the establishment of agency and empowerment at both personal and structural levels.

1.2 Theoretical Foundations

1.2.1 Critical-Interpretive Approach

The critical-interpretive approach in medical anthropology refers to "the way in which all knowledge relating to the body, health, and illness, is culturally constructed, negotiated, and re-negotiated in a dynamic process through time and space" (Lock and Scheper-Hughes 1990, 44). The current project utilizes this theoretical foundation in the examination of the meanings and metaphors participants express about their own bodies and the bodies of others at the individual, social, and political level. This approach combines the critical evaluation of power structures that affect marginalized populations with the recognition that the body, culture, and self all fall into an ever-changing context of negotiated meanings. The ways in which PWAS at AIDS Saskatoon attach such meanings to health, illness, power, and the body are especially of interest when examining experiences related to food accessibility, HIV, and HCV.

Specifically, Lock and Scheper-Hughes (1987) concept of the "three bodies" will feature prominently throughout this thesis. A theoretical cornerstone of the anthropology of the body, the three bodies offer a means to deconstruct the individual, social, metaphoric, and political underpinnings of the human body as both a physical and symbolic entity within the world. The individual body, described by the authors as "the lived experience of the body self," is the variable experience of one's body as existing apart from other bodies insofar that the individual body lives as a zone of experience related to health and sickness (Lock and Scheper-Hughes 1987, 7). At the second level, the social body may first appear to some as the ways in which a body can be placed within larger society and societal practices. However, it is best to think of this level of the body as being a metaphor or symbol for the social and cultural forces around it. Lock and Scheper-Hughes consider the social body to be a "natural symbol with which to think about nature, society, and culture" (1987, 7). War metaphors used to describe the way an immune system might battle an outside organism is one such example of the social body metaphor. For the participants within this thesis, bodily metaphors as related to food, infection, and power are explicit. Finally, the body politic refers to the "regulation, surveillance, and control of bodies (both individual and collective),"where bodies, bodily products, sickness, and health are controlled by larger, macro forces that are deeply structural in nature (Lock and Scheper-Hughes 1987, 8).

The critical interpretive approach in medical anthropology also often engages with the concept of governmentality, especially in relation to the examination of power imbalances. Defined "succinctly as the 'conduct of conduct,' governmentality is the attempt to shape human conduct by calculated means" (Li 2007, 275). The purpose of governmentality is to ultimately control populations, individuals, and behaviour for the welfare of the people by mitigating perceived destructive processes through corrective interventions (Li 2007). Governmental interventions are best thought of as assemblages that are imbedded into cultural and social fabrics of being, rather than as "a monolithic state operating as a singular source of power" (Li 2007, 276). Behavioural control and surveillance measures are used as a tool of governmentality, where such measures contribute to the institution's or state's ability shape conduct. Governmental, non-governmental, academic, and private institutions all utilize governmentality to shape the conduct of specific populations of persons, with marginalized groups often targeted

for various reasons that will be discussed at length in Chapter 3 and 4. With the realm of health, the body politic acts as one such force in which governmentality is prevalent.

1.2.2 Biocultural Syndemic Approaches

The term "syndemic," as defined by Singer and Clair (2003), refers to the ways in which two or more epidemics come to exacerbate one another. Additionally, syndemics can also include social conditions that further aggravate disease within a given population (Singer and Clair 2003; Singer, Bulled, Ostrach, and Mendenhall 2017). Factors such as racism, structural violence, poverty, and substance use can therefore be studied alongside disease processes to further understand the synergistic relationship between culture and biology. By utilizing this approach, this project holistically examines the various syndemic pathways at play among food insecurity, HIV, and HCV.

Syndemic approaches both combine and differentiate between biological and sociocultural pathways of pathology. In this research, the biological pathways among HIV/AIDS, HCV, and food security are less explicit than the sociocultural pathways related to substance use, homelessness, and poverty. The reason for this is two-fold. First, PWAS were more likely to discuss exacerbations of social and cultural conditions than they were to describe biologically situated experiences of illness and disease. Second, variables such as poverty and substance use were often discussed within the context of community power relations and power imbalances. Biological pathways, as described below in section 1.4, were very much present and will be presented alongside sociocultural pathways, as it is near impossible (nor appropriate) to separate one from the other. However, the lived experiences of PWAS were, more often than not, largely discussed and contextualized within sociocultural frameworks where poverty, homelessness, and substance use appeared as the most obvious exacerbating factors to ill experiences of health and wellness. It keeping with the syndemic model of examination, it will be shown that health and disease cannot be separated from their associated social and cultural contexts, since each is affected by the other in profound ways.

1.3 Literature Review

Within Canada, it has been found that adults in food insecure households are more likely to suffer from a myriad of physical and emotional difficulties such as poor self-perceived general health, low life satisfaction, high levels of stress, and a weak sense of community belonging

(Willows, Veugelers, Raine, and Kuhle 2011). Previous research has indicated that food insecurity exacerbates adverse health outcomes in HIV positive individuals by limiting healthcare utilization, increasing non-adherence to ART, and weakening immunologic responses (Anema et al., 2014; Friis et al. 2017). In a study examining food insecurity among HIV/HCV co-infected populations in British Columbia, severe food insecurity was linked to injection drug use, where substance use was shown to both exacerbate, and become exacerbated by, food insecurity (Cox et al. 2017). The promotion of equitable access to nutritious food can therefore be conceptualized as a harm reduction strategy for those living with, or affected by, HIV/AIDS and HCV. Given that Indigenous Peoples are disproportionately affected by HIV, HCV, and food insecurity, incorporating Indigenous experiences with food, eating, and illness may play an important role in understanding how these syndemics behave within specific cultural contexts in Saskatchewan.

1.3.1 HIV/AIDS, HCV, and Food Insecurity Syndemics

Previous studies by Anema et al (2014) and Friis et al (2017) indicate that malnutrition can contribute to extensive immune suppression among HIV positive individuals. Nutritionally acquired immunodeficiency syndrome (NAIDS) occurs when micronutrient deficiencies lead to interrupted performance in immunological organs (Friis et al 2017). HIV can further affect an individual's nutrition status by increasing a person's metabolic rate and nutritional requirements, impeding appetite, and reducing over-all nutrient absorption (Anema et al 2014). An HIV-positive person is therefore more likely to experience a wide-range of negative health outcomes, including exposure to a plethora of secondary infections.

Undernutrition related to food insecurity can adversely affect the human gut microbiome (Murray and Manary 2015). Individuals with HIV/AIDS are also at increased risk of disruption to the gut microbiome, which includes damage to gut-associated lymphoid tissues and increased gut permeability, which can lead to possible disease progression (Douek 2007; Lozupone, Li, Campbell, Flores, Linderman, Gebert, Knight, Fontenot and Palmer 2013). With recent studies indicating that altered gut flora in the gastrointestinal tract can indeed influence neural pathways, potentially leading to the development of anxiety and depressive disorders (Foster, McVey, and Neufeld 2013), HIV positive individuals in food insecure households are thus at special risk of a myriad of adverse emotional health outcomes. Friis et al (2017) state that the "consequences of

inadequate dietary intake in turn increase the susceptibility to infection and the progression of disease and reduce the effects of medical treatment. Thus, food insecurity and malnutrition may be determinants as well as consequences of HIV infection" (271).

While studies directly examining the interrelationship between HCV and the biological effects food security remain limited, it has been found that "alterations of intestinal microbiota seem to play an important role in induction and furthering the progression of liver damage, in addition to direct injury resulting from different causal agents" (Cesaro et al. 201l, 431). In the above-mentioned research, it was found that gut alterations result in an over abundance of bacterial endotoxins in the blood stream, contributing to inflammation of the liver (Cesaro et al. 2011). The Hokuriku Liver Study Group found that malnutrition among 168 HCV positive patients contributed to impaired interferon signalling, resulting in poor uptake of interferon treatment for the disease (Honda et al. 2011). These initial findings indicate that household food insecurity has the potential to increase negative health outcomes among HCV positive individuals.

Determinants of food insecurity within a given population include multiple social, cultural, and political factors such as environmental degradation, poverty, protracted crises, and conflict (Anema et al. 2014). Groups deemed as vulnerable such as pregnant women, children, the elderly, individuals experiencing addiction, and Indigenous Peoples are often disproportionately affected (Anema et al. 2014; Power 2017). Sociocultural syndemic pathways between HIV and food insecurity are often determined by socioeconomic stability. As an example, HIV infection may impede an individual's ability to maintain employment, thereby reducing labour resources and total household income. HIV positive individuals in food insecure households have been shown to be at increased risk of a number of negative health and social outcomes, which are largely affected by emotional distress, stigma, health beliefs, the complexity of medication regimens, intentional non-adherence due to side-effects of medication, and use of alcohol and other substances (de Pee at al. 2014, 531).

There is an explicit association between life stress and disease progression among HIV positive individuals, where mental distress has been indicated in rapid disease progression to AIDS (Brezing, Ferrara, and Freudenreich 2015). Furthermore, stress has often been cited as a result of stigma, discrimination, and poverty, with individuals in food insecure households being at higher risk of psychological distress surrounding food availability (Hamelin, Beaudry, and

Habicht 2002). Psychological distress is thus one mechanism within the sociocultural pathway that can serve to exacerbate negative health outcomes among HIV infected individuals living in food insecure households. For Indigenous Peoples in Canada, historical trauma and stress play an integral role in HIV/AIDS infections. Brezing, Ferarra, and Freudenreich (2015) state that historical trauma is linked to the acquisition and transmission of the HIV virus, and is also "associated with the progression of the disease and poor quality of life, making the combination of these [two] conditions (i.e HIV infection and trauma) a syndemic illness" (108). According to Kolahdooz, Nader, Yi, and Sharma (2015), Indigenous Peoples in Canada have a life expectancy that is twelve years lower than the national average, where such populations are said to be at a substantially heightened risk of exposure to infectious diseases as compared to non-Indigenous Canadians. As with HIV and food insecurity, Indigenous populations within Canada are disproportionately affected by both HIV/AIDS and trauma, with women showing the greatest risk (Shea, Aspin, Ward, Archibald, Dicson, McDonald, Penehira, Halverson, Masching, McAllister, Smith, Kaldor, and Anderson 2011; Kolahdooz et al. 2015; Negin, Aspin, Gadsen, Reading 2015; McCall and Lauridsen-Hoegh 2014). The sociocultural and political syndemic pathways posited for such disparities are ultimately tied to social injustices and the perpetuation of harms brought about by social institutions or structures. Racial discrimination and stigma against people who use substances are some such examples that can further exacerbate negative health outcomes. To illustrate, a previous study by Shea et al (2011) found that, among Indigenous individuals in Vancouver who use intravenous drugs, "HIV risk related to IDU is well recognized. Social disadvantages precipitated by discrimination, the after-effects of residential schools and barriers to health care all play a role" (197).

When discussing the sociocultural pathways of the HIV/food insecurity syndemic among Indigenous Peoples in Canada, it is also imperative to note that there is "an additional level of food security beyond individual, household and community levels" (Power 2017, 95). Cultural food insecurity is a term that has been put forward to account for the social pathologies that Indigenous Peoples face within society, which includes cultural oppression and colonization. This term often refers to the barriers experienced by Indigenous Peoples as related to the acquisition of traditional foods, Indigenous identity, and notions of "Aboriginality" (Power 2017). This additional layer, which goes beyond typical suppositions surrounding food insecurity, further illustrates a sociocultural syndemic pathway between food insecurity and HIV.

Current literature indicates that the sociocultural syndemic pathways for HCV are very similar to that of HIV (Cox et al 2017; Harris 2009). Among individuals co-infected with HIV/HCV, social factors that serve to exacerbate these diseases include poverty, intravenous drug use, and depression (Cox et al 2017). Previous research by Harris (2009) indicates that stigma is also an integral social component in the management of HCV, where "associations with illicit drug injecting, infectiousness and societal aversion to chronic illness" all contribute to the ways in which HCV positive individuals come to conceptualize illness (33).

Such conceptualizations of health, illness, and food insecurity among HIV and HCV positive individuals are central when seeking to understand the ways in which these syndemics exert force upon individual and community bodies within Saskatchewan. Given this, the current project contributes ethnographic data to current syndemic theoretical models.

1.3.2 Cultural Approaches to Food and Eating

Counihan (1999) contends that "foodways influence the shaping of community, personality, and family. The study of foodways contributes to understandings of personhood across cultures and historical periods" (6). Cultural approaches to food and eating are often concerned with individual and collective experiences of identity, place, taste, and memory (Fischler 1988; Mintz & Dubois 2002). Utilizing a "food centered" framework, cultural conceptualizations of the body, gender, illness, and wellness, have been studied at length both within Canada and abroad (Chilton and Booth 2007; Counihan 1999).

One qualitative study of African American women's perceptions of food insecurity, violence, and health in Philadelphia found that participants often described the sensation of hunger as being experienced through both the physical body and the mind, where food, hunger, trauma, and distress were all interwoven within a complex cultural narrative (Chilton and Booth 2007). The meanings attached to the term "hunger" reflected not only individual and collective experiences with food, but also experiences related to interpersonal and structural violence (Chilton and Booth 2007). Food and eating thus come to represent not only physical processes, but also moral and emotional processes. In her work detailing "moral personhood" in Colombian Amazon communities, McLachlan (2011) found that kinship relations between community members were conceptualized within a food centered framework, where sensory experiences with sweet and bitter foods came to also represent the moral qualities of persons. Within the

town of Mentangula in east-central Africa, Huhn (2013) also noted explicit connections between food, emotion, and morality among villagers. Specifically, Huhn noted that "an individual's emotions when eating both modified his or her appetite and determined food's perceived taste and capacity to promote wellness", ultimately concluding that the sensorial experience attached to eating was both bodily centered and distinctly metaphorical, since such experiences become laden with personal, social, and political meaning (2013, 188).

Ethnographies that seek to examine Indigenous experiences of food and eating within Canada have found explicit connections between food and well-being. Modern hunting and foraging practices, such as the hunting wild game or the gathering and eating of traditional bush foods, have been shown to be integral components of Indigenous personhood and identity (Adelson 2000; Kirmayer, Laurence, and Valaskakis 2008). Indigenous conceptualizations of food security are often linked with community involvement and emotional and spiritual health (Elliott, Jayatilaka, Brown, Varley, and Corbett 2012; Power 2017), where access to nutritious, sustainable, culturally relevant food has been shown to increase perceptions of wellness and facilitate cultural assertion. Food and eating can therefore be conceptualized as practices that not only nourish the physical body, but also facilitate emotional and spiritual wellness.

1.3.3 Indigenous Food Sovereignty in Canada

The cultural meanings and symbols attached to food and eating for Indigenous Peoples in Canada cannot be separated from the political, economic, and socio-structural components of food accessibility, and indeed of food sovereignty. Food sovereignty is broadly defined as "the right of nations and peoples to control their own food systems, including their own markets, production modes, food cultures, and environments" (Wittman, Desmarais, and Wiebe 2014, 2).

Within Canada, Indigenous Peoples face a plethora of different challenges related to food sovereignty when compared to other groups. Higher poverty rates, diet-related issues, and unequal access to health care are all factors the come to affect over-all control and access to food systems (Desmarais and Wittman 2014). Colonial disruption of indigenous food systems and knowledge networks have resulted in a decline of the use of traditional foods, rising food prices in remote communities, and escalating transport costs (Desmarais and Wittman 2014). After "the initial waves of extermination, more subtle technologies of governance served to break Indigenous food systems. Forced dependence, first on government rations or treaty annuities,

then on state-funded commodities programmes and the provisions stocked at the corner store, sickened Indigenous Peoples, their homelands, and the critical link between the two" (Grey and Patel 2015, 437).

As previously mentioned, connections to traditional land and the acquisition of traditional foods has been cited as an important part of cultural identity formation for many Indigenous groups within Canada. Thus, control over food can be posited as a means of resistance against colonial interference. Food sovereignty, and its relationship to decolonization, is therefore crucial when seeking to understand Indigenous experiences with food and eating, food systems at the community level, and links among food, nutrition, and wellness.

Desmarais and Wittman (2014) state that community consultations with Indigenous Peoples in Canada have revealed the "importance of traditional foods and foodways to indigenous health and cultural wellbeing in both rural/remote and urban areas and have drawn attention to problems of lack of access to these" (1165). Therefore, it has been posited that food sovereignty frameworks should recognize the role of indigenous social and cultural relationships, community food-sharing, and trading, in order to address the specific needs of First Nations, Metis, and Inuit peoples in Canada.

1.3.4 Food Accessibility as Harm Reduction

Miewald, McCan, McIntosh, and Temenos (2017) found that increased food security among people who use drugs (PWUD) in Vancouver resulted in a marked reduction of drug-related harms. Furthermore, it has been established that increased food provision and the integration of food security programs within community settings can reduce over-all negative health outcomes for PWUD (Miewald et al. 2018). With drug-use being a major barrier to food acquisition, food security can act as harm reduction strategy for such marginalized groups, which includes HIV and HCV positive individuals who access services within community-service agencies (Miewald et al. 2017). Food programs have been posited as an integral component of everyday "foodscapes", which consists of all locations where people access food. For vulnerable persons, such programs inevitably become "part of the daily geographies of survival" (Miewald et al 2017, 3). Community-based food programs that seek to alleviate food insecurity report that participants experience improved connection to health services, make healthier nutritional

choices, and experience an increase in personal independence through the acquisition of cooking skills (Miewald et al 2017).

Wilson (2003) adopts the concept of the "therapeutic space" to describe areas that become "a zone of experience and meaning" for Indigenous Peoples when "out on the land" (84). However, Wilson also notes that therapeutic spaces can be any such area in which symbols are produced and reproduced to shape various aspects of health (Wilson 2003). Food programs within community-based agencies thus have the potential to become therapeutic spaces given the potential positive health effects and perceived meanings given to food and eating. Indeed, Meah and Jackson (2016) note that the kitchen acts as more than a physical location for the preparation of food. It also serves as a space in which material items (such as cooking utensils and culinary dishes) are put on display and subsequently become a part of the construction and reproduction of personal, familial, and community identities and memories.

By regarding food security as a potential means for identity formation, cultural assertion, and as a harm reduction strategy for marginalized groups, it may be possible to further reduce the burden of HCV and HIV within the province of Saskatchewan through the use of food programs like those mentioned above. Furthermore, ethnographic data reflecting the lived experiences of people who access HIV/AIDS community services may contribute to over-all public health knowledge related to harm reduction, program implementation, and community engagement.

1.4 Significance and Thesis Outline

1.4.1 Significance

Anthropological examinations of agency, governmentality, and resourcefulness in the face of health and social barriers have the capacity to contribute to public health and social programming by providing in-depth and culturally meaningful analysis that can then be used to create informed and competent interventions. Community-based research that situates the marginalized individual at the centre of the discourse may also contribute to societal viewpoints regarding the rights, capacity, and agency of peoples very often described as 'vulnerable'. As researchers in the social sciences begin to heavily engage with truthfulness and reconciliation with Indigenous Peoples, and while large swaths of First Nations, Metis, and Inuit individuals within Canada experience starvation, unclean drinking water, and rising HIV/AIDS infection while simultaneously living in an economically thriving country, medical anthropologists find

themselves in unique situations wherein they may be both academically and morally obligated to engage with systemic examinations of inequality.

This thesis seeks to engage with inequality on both macro and micro scales in the research areas of food security, infectious disease, and substance use using a critical-interpretive approach. By situating participants at the centre of the discourse and questioning popular notions of vulnerability, victimization, and governmentality, my goal is to shed light on the lived, everyday experiences of people often pushed to the margins of society. Through an intensive examination of survival strategies, cultural symbols, and meanings within a Saskatchewan urban foodscape, my hope is that information gleaned in this manner can be used to create positive systemic change for the people cited here and beyond.

1.4.2 Thesis Outline

In Chapter 2, I present my ethnographic setting and research methodology used to generate the data that informs my above research questions. This chapter outlines the various tools used to connect with participants and contextualize their experiences, such as ethnographic and community based approaches, person-centered interviewing, participant observation, and analysis of qualitative data. The subsequent data chapters in this thesis are formatted and organized around each of Lock and Scheper-Hughes (1987) "three bodies" in a specific and deliberate fashion. Chapter 3 approaches PWAS and their associated bodies and health experiences as highly individual and agentive. In this chapter, I examine the ways in which PWAS at AIDS Saskatoon access food in the city of Saskatoon and present the most common barriers to food security experienced by those living in the area of 33rd Street and Avenue F. Decision making processes around food acquisition and consumption, substance use, health, and identity are illustrated as variable and person-centered, framing these agentive strategies within the context of survival in precarious conditions. The end of Chapter 3 marks a shift towards embodied experiences and bodily sensations framed within the context of the social body itself. Metaphorically, PWAS are described as social infectors and their associated bodily experiences of pain, hunger, and withdrawal are subsequently framed through this lens with a discussion of the "addicted body". This section will describe the similarities and differences between experiences of withdrawal and hunger, before finishing with a discussion on the concept of

vulnerability and how such a qualifier can be constraining to personhood and autonomy while also simultaneously offering interventions and benefits.

In Chapter 4, the body politic takes centre stage where I describe and examine the ways in which community can constrain or enable bodily autonomy for PWAS living in precarity and scarcity, linking such examinations back to current overarching cultural assumptions surrounding the agency and capacity of marginalized persons. Chapter 4 begins with an examination of community supports and how micro and macro forms of community played a role in the lives of both PWAS and staff. Themes related to surveillance and governmentality feature prominently in this chapter when I describe the tactics used by PWAS to subsist in marginalized environments such as through the use of alternative income generating strategies and moral economic practices. The ways in which forms of surveillance and governmentality constrain PWAS at the level of the personal body and society will form much of this chapter. Chapter 4 will then feature a discussion of food programming as a form of harm reduction, using data from Chapter 3 and 4 to form recommendations for food service provision. This chapter concludes with a discussion on what can occur when access to community programming is removed, using the temporary closure of AIDS Saskatoon in June and July of 2018 as a case study.

Finally, Chapter 5 discusses the implications of this research, limitations to the project, and recommendations for moving forward with food security and access to food for individuals facing barriers such as substance use, HIV/AIDS, HCV, and homelessness.

CHAPTER TWO: ETHNOGRAPHIC SETTING AND METHODOLOGY

2.1 Ethnographic Context

2.1.1 Saskatoon as the HIV "Capital" of Canada

Saskatoon is a mid-sized Canadian city located in the prairie province of Saskatchewan. With a population of approximately 246,000 persons of various backgrounds and ethnicities, the city is the largest within the province (Statistics Canada 2016). Indigenous Peoples account for approximately 5.3% of the total population of Saskatoon, with 15,775 of self-identified persons within the city as of 2016 (Statistics Canada 2016). Both Saskatoon and the larger rural areas of Saskatchewan have a long history of colonialism and structural racism. Early colonization and contact with Europeans in the 18th and 19th centuries meant that various Indigenous groups experienced forced assimilation, familial displacement, infections with novel European diseases such as smallpox, and violent encounters with colonists. Forced residential schooling for Indigenous children, where children and youth were forcibly separated from their families for cultural "reprogramming", stretched to the end of 20th century. Thus, the cultural genocide of the Indigenous Peoples of Saskatchewan is one that is quite recent in the minds of those who have survived into the present decades.

The intergenerational trauma experienced by Indigenous Peoples within Canada and Saskatchewan has been cited, along with present colonialist policies that contribute to ongoing structural violence, as one of the main causative factors for the health and social ills observed today among Indigenous populations within Canada (Kirmayer, Gone, and Moses 2014). The causative factors behind the higher-than-average HIV and HCV transmission rates within the province are likely due to a number of syndemic factors that are ultimately situated within the history of the province itself and are rooted in governmental inaction, structural racism, and cultural moral panics around drug use and viral status. At the time of this writing, HIV/AIDS and HCV rates remain the highest amongst Indigenous Peoples in the province (Vogel 2015). Indigenous Peoples within Saskatchewan who use intravenous drugs have also been shown to have a history of residential school affiliation and were less likely to receive paid income, contributing to overall poverty status (Lemstra et al. 2012). Forced child apprehension is also a current problem. As of 2011, Statistics Canada reported that 87% of the children living in the foster care system of Saskatchewan were Indigenous Peoples, illustrating a current human rights crisis occurring for Indigenous parents today.

The social and health disruptions experienced by Indigenous Peoples within Saskatchewan are not meant to be presented here as an overshadowing of the resilience and capacity for advocacy that Indigenous groups possess in the face of colonialism, or to paint Saskatoon as an inherently pathologized space. Rather, I use these statistics as a way to contextualize the barriers that Indigenous PWAS at AIDS Saskatoon face in their everyday lives. Experiences of food insecurity, substance use, violence, HIV/AIDS, and HCV must be discussed within their associated historical and geographic settings in order to better understand how PWAS have come to be situated within the walls of AIDS Saskatoon and beyond. However, as will be shown in this Chapter, experiences of marginalization due to colonialism and structural violence are varied and heterogeneous. In Chapter 3, I also challenge the qualifier of vulnerability that has come to be superimposed onto Indigenous groups within Saskatoon, showing that everyday experiences of oppression are varied and are often framed within experiences of autonomy, agency, and resourcefulness.

In 2009, the "Truth and Reconciliation Commission of Canada began a multi-year process to listen to Survivors, communities and others affected by the Residential School system," which resulted in the "collection of statements, documents and other materials [that] now forms the heart of the National Centre for Truth and Reconciliation" (NCTR 2019). At the time of this writing, the Canadian Government as well as multiple academic and non-governmental institutions continue to take part in truth and reconciliation efforts, partnering with Indigenous Peoples in a plethora of ways. However, long before the establishment of the National Centre for Truth and Reconciliation, local Saskatoon organizations such as AIDS Saskatoon began efforts to combat the rising HIV/AIDS and substance use rates amongst Indigenous Peoples of Saskatchewan, utilizing a harm reduction and trauma informed approach.

2.1.2 AIDS Saskatoon

Established in 1986, AIDS Saskatoon first provided HIV/AIDS related services primarily to white, gay men, and facilitated a safe and secure space for "complementary therapies, support groups, and palliative care" (AIDS Saskatoon: A Time Line 2014, 3). Today, working within a harm-reduction model, AIDS Saskatoon provides services to a multitude of populations, with specific emphasis on addressing the disproportionately high rates of HIV within Indigenous populations in Saskatchewan (Rathwell 2016).

In response to the need for community-based harm reduction strategies and culturally sensitive HIV/AIDS programming, AIDS Saskatoon has established a number of services for people living with, and affected by HIV and HCV. Downe (2016) states that "AIDS Saskatoon is situated within national and international milestones—including the introduction of the red ribbon as the international symbol of HIV, the establishment of World AIDS Day, and the introduction of anti-retroviral therapies—while also attending to the details of local HIV-related realities" (5).

In addition to harm reduction programs such as the needle-exchange service and the dissemination of safe sex supplies, drug use equipment, and educational materials, AIDS Saskatoon also works in collaboration with a number of community partners, which includes the Sanctum Care Group, Westside Community Clinic, and the Saskatoon Health Region. These collaborations have come to form an HIV/AIDS response team (HART) meant to identify individuals within the community who may be in need of care. The 601 Drop-In Centre also provides a safe and welcoming atmosphere for PWAS, which includes telephone and internet access, free clothing, support groups, and a hot-meal lunch program that runs Monday-Friday beginning at 12:00pm.

The daily lunch program, first established as the "Soul Food Program" in 1999, is meant to create a community of sharing where PWAS gather at the 601 Drop-In Centre to enjoy a hot, nutritious meal in a communal atmosphere. These meals not only contribute to PWAS dietary nutritional requirements, but also helps to facilitate a setting where individuals can come to build companionship and community between PWAS, staff, and the broader neighborhood (AIDS Saskatoon: A Time Line 2014, 14). The implementation of these services falls under the "House Model of Service Delivery" framework where organizations such as AIDS Saskatoon come to "provide resources associated with a stable home environment in order to support those impacted by HIV/AIDS" (Ruschkowski 2016, 32).

The physical spaces within AIDS Saskatoon do indeed mirror what one might observe in a common family dwelling. The layout of the space can be described as a modified house insofar that typical home amenities are combined with service accessibility for a streamlined and comfortable atmosphere. Upon entering the main entrance to the drop-in centre, one finds a large space filled with three comfortable couches (the main seating area) in the centre of the room. Adjacent to this, a working flat screen television sits next to bookcases overflowing with fiction

and non-fiction books. A serving station, located opposite the main seating area, is a busy area where PWAS may help themselves to coffee before finding a seat at the computer desk for access to the internet. Décor in the space is colourful and whimsical. The ceiling tiles are adorned with all manner of artwork painted by PWAS, staff, and previous researchers. On the far wall hangs a "memory quilt" created by PWAS in memory of friends and family who have passed from HIV/AIDS and substance use related complications. Further into the building, the staff offices, laundry facilities, and full kitchen sit within a few feet of the drop-in area. PWAS are easily able to converse with staff members at a moment's notice. The layout of the agency feels distinctly unlike other social or health service institutions situated within fluorescent lit, multi-floor buildings, once again a reminder of the intimate and highly accessible nature of the "house model" style of service delivery.

From May 2018 to July 2018, specifically within the space of the 601 Drop-In Centre and the kitchen located at the rear of the building, I conducted much of my observations, conversations, and volunteer work, with interviews being carried out in a private office just outside the 601. Depending on the time of day, or time of month, the spaces within AIDS Saskatoon alternate between being bustling, noisy, and filled to capacity to quiet, contemplative, and shielded from outside worry. PWAS use these areas to socialize, debrief from stress, and access services while also simultaneously taking opportunities to sleep after extended substance use binges or to escape potentially violent street lives. In this sense, the 601 Drop-In Centre and the associated meal program offer an excellent setting from which to conduct ethnographic fieldwork, as the space itself never seems to remain the same during any one day, boasting a plethora of different experiences, activities, and associated meanings.

Dr. Pamela Downe's previous and ongoing relationship with AIDS Saskatoon facilitated my connection to the agency as a research space. Downe is a leading HIV/AIDS researcher in Canada and has a number of past and ongoing partnerships with hospitals, non-profit, and non-governmental organizations spanning research topics related to HIV/AIDS, violence, maternal health, and infectious disease. Having worked on research projects with staff and PWAS at AIDS Saskatoon for over a decade, Downe has an ongoing relationship with the agency and has connected multiple graduate students to community-based research projects at that locale. Downe's positive research relations with the site contributed to AIDS Saskatoon's openness to this current project. The research relationships between AIDS Saskatoon, the University of

Saskatchewan, and Downe marks an ongoing commitment to ethnographic research that aims to positively impact PWAS and other populations outside of Saskatoon.

2.1.3 Working with Marginalized Participants

The term "marginalized", while broad and somewhat homogenizing, is used here as a descriptor for the many different participants with whom I worked during my fieldwork at AIDS Saskatoon. Given (2008) defines marginalized populations as "those excluded from mainstream social, economic, cultural, or political life" (2) and contends that such groups "are by no means limited to […] race, religion, political or cultural group, age, gender, or financial status" (2). PWAS at AIDS Saskatoon are marginalized from mainstream society for a number of complex reasons and in a number of differing ways that will be discussed at length in a later chapter. However, it is imperative to first examine this concept here in an introductory sense.

Given (2008) asserts that the *extent* of marginalization within a population is highly contingent on cultural and social context. As cited earlier in Chapter 1, Goldstein (2004) argues that activities, not only people, can also be highly marginalized and "out of place". Such contentions frame marginalization not as a "one size fits all" term, but rather as a complex descriptor with many associated meanings. What the term itself does tend to evoke, in the most common use, is a sense of displacement from larger society, whether physical or symbolic, and as such this exclusion infers that the individual will experience risks or harms associated with that displacement. Anthropological understandings of the "Other" show a discipline that has long been concerned with the "how", "why", "where", and "when" of group-based devaluation that leads to active oppression and structural violence. Within this project, I outline the ways in which PWAS at AIDS Saskatoon live with marginalization and use this term as a broad descriptor. However, the nature and extent of this marginalization is questioned and is situated within the context of actions and activities, rather than within the context of marginalization as a homogenous and unchanging group identity.

In discussing marginalization as a population-based identifier in social scientific research, it becomes difficult to ignore or discount the associated terms of stigma and power. Goffman (1963) views stigma as an attribute that can be discrediting to the individual, where that attribute might be undesirable due to its inherent difference or deviance, resulting in an identity that is, by all accounts, spoiled or marked. Parker and Aggleton (2003) claim that social scientific research

on stigma in the context of HIV/AIDS has approached stigma from the starting point of Goffman's definition, which presents a number of problems when applying it to action oriented research that aims to enact change for those very participants. Treating stigma as a "thing" superimposed on the individual is also to treat it as static and unchanging. Instead, Parker and Aggleton propose that using frameworks around stigma that lean more toward Foucauldian understandings of power, culture, and difference makes it possible to "understand stigma and stigmatization not merely as an isolated phenomenon, or expressions of individual attitudes or of cultural values, but as central to the constitution of the social order" (2003,17).

Marginalization, in much the same way as stigma, is treated within this research project not as a homogenous group identity that is superimposed. Rather, the stigma and marginalization experienced by participants is dynamic and even individualistic while also being interwoven into the larger social order of their everyday lives, the larger social body, and the even larger body politic. Stigma is discussed here as a socially and culturally contingent force that contributes to the marginalization of PWAS, though the experience of this differs markedly amongst participants based on their own personal protective factors.

Of the 18 participants with whom I partnered to conduct interviews (including staff members), almost all had experienced marginalization and stigma in some form. Past and present life stories reflected experiences where nearly all individuals had been treated by larger society as peripheral or inconsequential due to identifying factors such as ethnicity or due to perceived deviance through illicit activities. In most cases, marginalization occurred through pathways of both identity, activities, and cultural meanings, such as in the case of an HIV-positive participant being marginalized due to that status, especially when a positive status infers that the individual has taken part in activities that are deemed deviant and dangerous by the cultural majority such as through intravenous drug use or unprotected sexual intercourse.

Additionally, a majority of the participants, as well as a majority of PWAS accessing services generally at AIDS Saskatoon, were Indigenous Peoples. Out of the 18 formal participants in my project, including staff members, three identified explicitly as Caucasian. Indigenous identity is an important factor insofar that the ripple effects of colonization, including the marginalization of Indigenous Peoples, can still be felt profoundly for many individuals residing in Saskatoon and Saskatchewan, whether directly through experiences of racism or more broadly in terms of structural and institutional practices rooted in colonialist policy. In recruiting

participants for the project, I additionally sought to achieve a gender balance where there were an equal number of female and male identifying persons. Experiences of marginalization based on gender were not as prominent as racially motivated marginalization in the associated analysis, though stories of sex-based violence were still explicit, especially among female identifying participants.

2.2 Methodology

This community-based participatory, ethnographic research project utilized person-centered interviews and participant observation at AIDS Saskatoon to address the central research questions. Hacker (2013) explains that "the CBPR approach encourages engagement and full participation of community partners in every aspect of the research process from question identification to analysis and dissemination" (2). The current project can be classified as CBPR given that AIDS Saskatoon was involved in the initial development of the project and research question and subsequently will have shared ownership of the resulting data and can choose to apply these data within the community accordingly. The results of the current project will be subsequently disseminated to AIDS Saskatoon in the form of an executive summary document that will outline the findings of the research project. This document can then be utilized by AIDS Saskatoon in whichever manner they choose, such as in program implementation and organization, funding requests, and other endeavours. While a community advisory board was not established in the initial development of the research project, staff members (such as the executive director of the agency) were consulted regarding topics of examination for the project and continued to have input throughout the study, thereby "creat[ing] an effective translational process" (Hacker 2013, 2).

Additionally, within community-based participatory research, a relationship of reciprocity between the researcher and the community agency is vital. During my fieldwork, I assisted AIDS Saskatoon in various capacities as a volunteer, which included helping with day to day Drop-In centre activities under the guidance of the 601 Drop-In Centre coordinator, assistance with the hot-meal lunch program, and other duties.

This section outlines the specific methodologies utilized during my three-month fieldwork experience, which were approved by the University of Saskatchewan's Behavioural Research Ethics Board (REB) in the spring of 2018 (Ethics I.D: Beh 18-92). Informed consent

was gathered from both participants and the executive staff of AIDS Saskatoon in a number of ways. First, each interview began with a review of the REB approved consent form that detailed the risks, benefits, and goals of the research study, as well as procedures for withdrawal of data. Participants were given the option of either written or oral consent. For participant observation procedures, the executive staff of AIDS Saskatoon provided consent for observation within the agency and PWAS within the 601 were made aware of my presence and my role. Data gathered from participant observation, where observed individuals did not directly consent via the provided consent form, were anonymized to protect the identities of those within the agency. Given that many participants have previously taken part in studies at AIDS Saskatoon, many are familiar with graduate researchers and are consistently motivated to participate in ongoing research with the University of Saskatchewan.

2.2.1 Participant Observation and Volunteering

Participant observation within anthropological research allows for an in-depth experience of the daily routines, rituals, and interactions imbedded within the field site, thereby giving the researcher an opportunity to "capture tacit aspects of culture as praxis as well as explicit culture" (Musante 2015, 251). This methodological approach is a foundational element of ethnographic research and was a central component of data collection during this project, allowing me to build rapport with participants and staff members while simultaneously giving me a comprehensive understanding of the research setting within AIDS Saskatoon. By taking part in the everyday lives of those I sought to partner with, I was able to gather intimate and thorough data that interviewing alone would have excluded.

This method of data collection began in May of 2018, continued into July of 2018, and totaled approximately 122 hours, not including time spent on-site conducting interviews. Participant observation took on a multitude of forms, which included time spent volunteering within the 601 Drop-In Centre, time spent speaking with PWAS in informal contexts while smoking cigarettes outside of the main entrance, sharing coffee in the main seating area, taking statistics for the agency by observing the general comings and goings of the 601 space, and assisting with preparing, cooking, and serving lunches to PWAS. Some participant observation was also conducted off-site in one instance where volunteer duties required that I visit the local social service provider the Friendship Inn for National HIV Testing Day. This off-site experience

was incredibly valuable as it allowed me to gain perspective on the workings of other agencies in the city offering similar services to AIDS Saskatoon, especially given that the Friendship Inn is centrally located within the downtown core of Saskatoon and also offers meals to individuals experiencing severe levels of food insecurity.

As discussed earlier in this chapter, the participants that I observed, spoke with, and formed relationships with had experienced multiple forms of marginalization and stigmatization at personal, political, and social levels throughout much of their lives. For this reason, a fair amount of distrust of outsiders was to be expected. Participant observation within ethnographic research facilitates an avenue of trust and familiarity between researcher and participant in ways that other forms of research may negate. Stigmatization via health and social service professionals and researchers still remains a very real risk for persons living with, or at risk of, HIV/AIDS, HCV, and substance use. Within the "shooting encampments" of San Francisco, anthropologist Phillipe Bourgois found that participant observation conducted among a population of homeless persons who used intravenous drugs garnered more precise information regarding the sharing of drug paraphernalia than did public health surveys and interviews alone (1998). Distrust among the men that Bourgois worked with was most explicitly geared toward public health researchers who were, quite pointedly, strangers. This resulted in the reporting of incorrect or falsified information due to fears of retaliation or judgement after sharing information related to illicit activities (Bourgois 1998). By living within the shooting encampments, Bourgois was able to build trust and rapport with participants and was able to directly observe drug use practices, data that were then used to fill the gaps left by the less "messy" and more organized public health research methods of surveying and short interviewing.

Participant observation within AIDS Saskatoon thus allowed me to break down barriers of mistrust that come standard when working with those who have experienced marginalization through both informal and formal sectors of society. As a white woman with formal education and no lived experience of the realities of living with HIV/AIDS or HCV, I was very much aware that I appeared as an outsider and possessed many gaps in knowledge related to the realities of living a marginalized existence. My own personal experiences with living in food insecure and low-income environments, the presence of substance dependence in my family, and a history of residing in the Ontario foster care system did, however, allow me to connect with

some PWAS and find common ground, especially PWAS of the same age and with similar life histories. I did inevitably choose to share some of my own past in an attempt to build trust and form relationships with the participants at AIDS Saskatoon. This balancing of various identities, such as my identity as an educated white woman, a researcher, a student, and a confidante, was difficult to maneuver at times. I strived to maintain professionalism while simultaneously attempting to break down power differentials between myself and the people who accessed services. I was aware that my identity as white woman meant that I possessed inherent privileges insofar that I had never experienced racism or oppression due to my ethnicity. This also meant that my presence could be perceived as some to be threatening, given PWAS past experiences with structural violence and racism at the hands of white settlers. These reflections did indeed inform my own positionality within the research and did contribute to my interactions and observations. Knowing this, I subsequently sought to create real connections with those I observed and spoke with, and as such this involved a relationship of reciprocity where life histories were shared and reflected upon.

My presence in the 601 Drop-In Centre in the weeks leading up to interviews was integral in forming relationships with PWAS that then allowed them to open-up during the interview process, resulting in what some might consider highly sensitive data that comes to form many of the contentions and arguments made in the following chapters. Perhaps the most difficult aspect of this method during my time at AIDS Saskatoon was when agency complications with staffing resulted in a gap of time where the closure of the 601 Drop-In Centre resulted in less opportunities to spend time at the field site and collect data. However, as will be discussed at length in Chapter 4, the closure of AIDS Saskatoon during in June and July of 2018 offered much insight into the problems that arise when services are suspended or taken away from a community that depends on such assistance.

2.2.2 Person-Centered Interviews

The person-centered technique has been described by Levy and Hollan (2015) as an "attempt to develop experience near ways of describing and analyzing human behaviour" (313). How community members are "constituted by their contexts" is emphasized within this methodological approach, where the interviewee is treated as both an informant and as a respondent (Levy and Hollan 2015, 313). Interview questions were based on elucidating

information on the personal experiences of PWAS and staff. Additionally, how PWAS and staff engaged with the experiences of others within the same community was included. From June 2018 to July 2018, I conducted a total of 18 semi-structured interviews at AIDS Saskatoon spanning over 18 participants, which included 14 PWAS and 4 staff members, with each participant being interviewed once only. While a gender balance was sought, a majority of the participants that volunteered to be interviewed were female. For the population of PWAS interviewed, a total of 6 males and 8 females was established. All staff members interviewed identified as female, resulting in a total of 12 females. Pseudonyms were subsequently assigned to each interviewee to protect participant identities. Interviews were conducted within private offices that offered a quiet, confidential atmosphere in a familiar setting.

The initial PWAS interview guide included questions related to experiences with food security, health and wellness, and questions about the use of the lunch program within the 601 Drop-In Centre. After conducting a few initial interviews, it became apparent that this guide was insufficient as the average interview time with PWAS would not exceed 15 minutes in length. The second guide was then modified to include general questions about substance use and experiences with addiction, since this topic was one that PWAS seemed eager to discuss. On June 12th, after conducting approximately 13 more interviews (including staff interviews), a second modification to the interview guide took place after a downward trend in interview length across participants was observed. This modification incorporated more experiential questions with additional detailed probes, including questions regarding income generating activities. This later change prompted some anxiety on my part, as I realized that the new questions would have elicited more detailed responses from PWAS who had already been interviewed, and thus I had likely missed some opportunities for interesting narratives and experiences that would otherwise have been shared.

Due to the semi-structured nature of the interviews, I was able to personalize each interaction with each participant, probing and investigating lines of enquiry as they arose, especially after I gained some confidence to go “off script” as fieldwork pushed forward. This particular methodological approach also prompted some reflection on the ways in which qualitative interviewing poses some risks to participants in relation to the re-telling of traumatic personal life narratives. While no participants within this project refused to answer questions, requested to be removed from the study, or asked to stop the interview at any time, I was acutely

aware that, in asking questions on sensitive topics, I was expecting participants to be unguarded or "vulnerable" in their interactions with me insofar that I was hoping that they would share personal and private information about their lives and their experiences. Among the benefits of this person-centered, semi-structural approach is the tendency for this methodological tool to require intensive reflexivity and sensitivity on the part of the researcher (Corbin & Morse 2003; De Haene, Grietens, and Vercheueren 2010), an aspect that I feel both benefitted my personal education as a graduate student and in interactions with PWAS who are often asked to recount potentially traumatic narratives to those in positions of power as a requirement to access services. By engaging with the idea that PWAS often had to share life histories as a requirement of engagement with community programming or services (and that this requirement might cause distress or frustration), I was able to begin to not only reframe my own approaches with participants at AIDS Saskatoon during the interview process but was also able to begin to conceptualize notions of governmentality and surveillance in ways that I had previously not considered.

2.2.3 Analysis

Analysis of data gathered through the person-centered interviews and participant observation first began with the transcribing of audio recordings. Full transcription was completed for 18 interviews over the course of a few months. During the transcribing process, I began a very rough analysis where broad themes were recorded into an electronic document as they arose, though formal analysis began after the completion of transcription in a much more systematic way.

Content and in-vivo coding were completed by hand in the first round of analyses for each interview, using a number of coloured highlighters and physical markings in the margins of each individual hard copy. Concept coding is the process by which a researcher assigns "meso or macro meanings to data or to data analytic work in progress" where a "concept is a word or short phrase that symbolically represents a broader meaning" (Saldana 2016, 292). In-Vivo coding is more direct insofar that it "uses words or short phrases from the participant's own language in the data record as code" (Saldana 2016, 294). An electronic file was kept for each interview where such codes were organized into respective categories and themes. Each document featured an area for concept codes, narrative data, quotes of interest, and miscellaneous notes taken

during each interview as the respondent spoke. Using data from these individual interview sheets, I further organized all codes into a thematic master code sheet where such codes were organized under associated broader themes. This allowed me to branch themes together and further elucidate which themes appeared to generate the most codes, thereby giving me some indication on which aspects of the data to concentrate. During the second round of analysis, cross-codes (phrases and words that could be organized under multiple themes) were highlighted and marked within the master sheet to generate a visual example of thematic overlap. Additionally, numerical counts were assigned to each theme, showing the total number of codes *across* interviews.

This approach to coding allowed me some flexibility in terms of how I might engage with data. The amount of information collected during the research process (when factoring in participant observation data from field notes) meant that I needed to quickly determine which themes to focus on for this thesis alone. As an example, the theme of Space/Place, while emerging multiple times throughout analysis and revealing some interesting and important cross-codes related to the theme of Community, could have generated a section or chapter all on its own. The interconnectedness of data for this field site and population meant that there were a multitude of avenues of enquiry that could have been investigated. After taking numerical count totals for themes into consideration while also reflecting on data gathered from my field notes through participant observation, I settled on the examination of five main themes: Community, Substance Use, Agency/Barriers, Moral Economies, and Body/Health. While I considered governmentality and surveillance as a theme of its own, I also felt that organizing these terms into a specific category was somewhat limiting insofar that many of the concept codes and themes generated had implications of governmentality and surveillance already imbedded therein. The theme of Agency/Barriers as an example, includes codes that feature objects, situations, and concepts that serve to either constrain or enable an individual while searching for ways to survive and subsist, with governmentality being listed as one such code. As will be discussed in later chapters, governmentality *both* facilitates and constrains agency while also sometimes acting as both a symbolic and physical barrier to wellness and/or health services in the community. Additionally, governmentality could also be found as cross-coded under Community, Food/Subsistence, Substance Use, and Body/Health, making it a powerful code by which to frame thematic discussion and present findings.

I believe that the interview data and data gathered via participant observation paints a holistic and in-depth picture of everyday life for both staff and PWAS at AIDS Saskatoon. These methodologies allowed me to extract intimate details of the experiences of PWAS living in the area of the 601 Drop-In Centre. Limitations in the data set include an imbalance of PWAS demographics related to age and housing status. Many of the participants were middle aged, with only three participants appearing under the age of 30. Most of the participants had some form of secure housing, though almost all had experienced homelessness at one point in their lives. In the analysis to follow (Chapter 3), I use the data gathered at AIDS Saskatoon to begin a discussion on individual experiences of food insecurity and substance dependence and contextualize such experiences within everyday survival tactics and individual decision making.

CHAPTER 3: MANAGING HUNGER: CONSUMPTION, WITHDRAWAL, AND VULNERABILITY

> "Drugs are automatic. Drugs take our money, they take our rent, they take our livelihood. They take our jobs, our women, our kids. It takes everything. That's all drugs do. They just take take take. And it pretends to be your best friend, your lover, you know? And you know, so you can't, I mean you can't really…when you're addicted to drugs you don't buy food, you don't pay rent, you don't pay your bills." –Stephen (PWAS)

In this chapter, I examine the ways in which PWAS at AIDS Saskatoon prioritize the consumption of food and drugs while managing the bodily sensations and psychological processes of withdrawal, pain, and hunger in their everyday lives. I begin first with a description of the food desert environment around AIDS Saskatoon. I then present environmental and social barriers that PWAS experience while attempting to subsist, where access to food and the types of insecurity felt are highly varied and dependent on a number of factors. While the above quote by participant Stephen, a Caucasian man in recovery from an opiate addiction, shows that he experienced a state of a powerlessness and disenfranchisement that is commonly felt by people who use substances, further examinations in this chapter will show an intricate process of everyday decision making around the prioritization of basic needs that runs contrary to interpretations of drug users as slaves to their own bodily desires. When organizing decision making processes around the body, PWAS manage illness, hunger, and dope-sickness in very similar ways. In section 3.3, I expand on this by drawing similarities between hunger and withdrawal, focusing on the consumption of goods such as food and drugs, which I refer to as consumptive products. I conclude this chapter by arguing for a re-evaluation of vulnerability by challenging popular notions of the concept. I contend that the everyday decision-making processes regarding the body and consumption, partnered with a dynamic food security status, serve to question the implied powerlessness and lack of resourcefulness that is inferred within the designation.

3.1 "A Security Risk": Barriers to Food Accessibility in a Pseudo Food Desert

3.1.1 Defining Food Security

To the casual observer, AIDS Saskatoon might not necessarily be located in a typical food desert setting, though many PWAS and staff report a lack of *affordable* grocery stores in the area. I argue that the area around 33rd Street and Avenue F is located within a pseudo food desert where grocery stores may exist but access to affordable, nutritious food is limited due to the inflated prices of foodstuffs reported by staff and PWAS living in the area. Typical food deserts in urban settings are defined as those areas where food accessibility is limited due to the availability of supermarkets (Smoyer-Tomic, Spence, & Amrhein 2010). In the area of 33rd and Avenue F, one grocery store is located within 700 meters of the agency, with another seven convenient stores that sell food located within 2km to the south of the general area. These grocery stores and "food markets" are generally regarded by both PWAS and staff as being too expensive when compared to the larger chain grocery stores located in the more affluent suburban areas. The lunch program and associated mobile outreach at AIDS Saskatoon therefore fills an urgent need within the community, a viewpoint that was expressed by multiple PWAS during interviews. Sara, a Cree woman in her 40's explained:

> I always make sure we have something to eat or something in the fridge. But I'm glad that they have places like this to come to. So, I don't have to worry about lunch time. […] Like, suppers are the main priority to make. I bet you if they didn't have places like this, people would starve.

When I approached Jordan, an Indigenous PWAS who's Indigenous ancestry was not specified, regarding his experiences with the lunch program at AIDS Saskatoon, he replied "Geez, I don't know what I would do without it. […] I imagine there are other one's in town, but nothing in my area."

Community and geographic need was made apparent when discussing other agencies that offered meal assistance. This includes other service agencies such as the city food bank and the Friendship Inn located in the downtown area far from the 601, which offers PWAS food baskets to take home at a maximum of two times per month (in the case of the food bank) and other meals such as breakfast and lunch (in the case of the Friendship Inn). However, these are cited as often troublesome for PWAS to access due to transportation or mobility issues and fear

of violence from gang affiliated patrons. Jordan was himself acutely aware of the food desert status of the immediate area of the 601 and expressed frustration regarding food pricing at the local Safeway while also assuming that the increase in prices at certain times of the month were not due to chance alone, and explained as such: "A person has to eat in order to survive. And for 80 dollars at Safeway you don't get very much. […] It is very expensive and they know when people are getting their cheques. They aren't stupid. They know and they raise the prices." I probed Jordan on this statement and asked if he thought that the Safeway specifically raised the prices around that time of the month, to which he replied: "They do! They do!"

It was also reported that some mobile food programs refuse to service the most underserved populations in the area due to fear of violence against the support workers. This fact was made apparent during my first interview with staff member, Kara, on June 4th 2018:

> [Program Redacted], that's a great program, but they have entire neighborhoods that they've blacked out and will not deliver food to because they deem it a security risk. And that's all of my people. Everybody who lives in the core, or in a bad building, are deemed a security risk and they will not deliver food there. So, we've been able to work with them in a sense where we are the one's delivering because we aren't afraid to go to someone's home because we know they need it. But that really needs to be addressed.

PWAS residing in the area of the 601 face very specific and context dependent barriers related to food security and food accessibility. Fear of violence spurred by stigmatization further marginalizes those individuals living in "the core", where even some of the more well-known programs appear to impose their own biases based on perceived inclusion in socially "deviant" groups, thus exacerbating the food desert status of the area. While violence did pose a risk for PWAS living in the area, that these individuals were reported as being serviced largely without issue by the staff of AIDS Saskatoon perhaps shows incongruity between the perceived risk of violence and the actual violence taking place. This observation sets the stage for an intricate and complex set of circumstances that contribute to food security status for those living in the area.

The men and women who access services at AIDS Saskatoon generally meet the most accepted definition of being "food insecure", especially when using the widely accepted

definition of food security given in section 1.4 of Chapter 1. However, it is argued that food security is best understood along a spectrum or a continuum, rather than as one precise definition that tends to be "constrained by the plurality of ways of understanding the causes and consequences of food insecurity, and the effects of economic, social, political and environmental interventions" (Hendriks 2015, 609). Household and community food security status is dynamic and is interwoven with complex variables that change depending on a number of wide ranging factors. Hendriks (2015) poses a continnum of food security ranging from "secure" to "vulnerable" to "insecure", with variation including other qualifiers such as "adequate quality and sustainable intake" to "inadequate intake", "chronic hunger", "starvation", and others. This continuum is then expanded upon to include characteristics of each level, strategies employed to mitigate harms, and appropriate interventions (Hendriks 2015). Hendriks also notes how status along this spectrum can "be temporary, cyclical, medium-term or long-term", and may be "caused by sudden reductions in the ability to produce or access enough food to maintain the necessary quantity and quality of dietary intake" (2015, 614).

This continuum approach to food security status is consistent with participant's own self-perceptions of food security severity and level. Participants express varying levels of such severity of food security in their lives in that they present as *both* secure and insecure in their ability to access food. The most explicit variable in the self-perception of food security status is the personal ability to be resourceful: a PWAS may not necessarily have the self-perception that he/she is typically food insecure if he/she is able to acquire food in that given day or week without issue, speaking to the temporal nature of Hendrik's model. Indeed, it was observed that PWAS often seem to conceptualize food security status within the context of time, such that food security status ebbs and flows depending on when food programs are open or closed, when income assistance cheques are available, and the availability of shared food within moral economic transactions. While many participants did not outright believe they had trouble accessing food at the time of the interviews, almost all discussed having been food insecure at one point in their lives. Most notably, past food insecurity was almost always discussed alongside homelessness and substance use, as exemplified by long-time staff member Joanne's account of her early experiences with food insecurity:

> I spent part of my early adulthood and late teen years quite transient and not with stable housing and often didn't eat. I was a crystal meth addict and sometimes went weeks and weeks without eating. […] I've seen and experienced having no way to get food or stealing food or that sort of thing. You know, meth being the drug of choice I had, I wasn't often seeking out food. But access to what I had was very limited. A lot of fast food. Macs store. I was a lot more mobile in my young years. I didn't have children attached to me. I definitely didn't have a home for a long time, so I didn't have somewhere to cook or have regular meals. The place I lived the longest, we didn't have heat or power for over a year in that house. And I lived there for about 6-8 months.

PWAS who no longer actively use illicit substances and those with stable housing are the least likely to consider themselves as severely food insecure, even if they access the lunch program on a daily basis. Although many PWAS openly admit to using multiple food provider programs within the city of Saskatoon to meet basic needs, most do not think of themselves as struggling to maintain a secure spot on the food security spectrum so long as community food programs such as the AIDS Saskatoon lunch program and other food programs remain accessible. Severity of food security status framed within the context of homelessness was discussed by both PWAS and staff at length:

> It's also difficult to store that food, depending on where you're living. I mean, a lot of our folks, when one person is housed they let a lot of their friends or homeless individuals stay with them so they don't go hungry too. People also get their stuff taken a lot. It's almost a safety precaution. Don't buy in bulk because it's going to be taken anyway. That removes the safety of having food there for a week, but it's also like…if that's going to be stolen from you then why spend the money anyway
> –Kara (Staff)

Such observations provide context for examinations of vulnerability within the community of PWAS at AIDS Saskatoon insofar that personal perceptions of agency and food security status indicate that PWAS do not necessarily view food accessibility as an indicator of

powerlessness. However, these personal perceptions are quite dynamic. Perceived food security status transforms and fluctuates depending on variables such as time, place, access to community programs in both the 601 and Downtown area, and other factors. Interestingly, while HIV/AIDS and HCV are cited as factors that may impede someone from accessing food, the syndemic relationships cited as the most catastrophic are less about the biological impediments of disease and disability, and more consistent with sociostructural pathways such as poverty, addiction, and homelessness.

3.1.2 Food Security Syndemics

> HIV is not the concern. It's things like medication adherence and the issues that keep you from being adherent. This would indicate your food insecurity. They are not stable on their medication, they don't have stable housing. So, now HIV compounds when comparing it to someone who doesn't have HIV." – Kara (Staff)

While the literature on food security syndemics ties HIV/AIDS status to experiences of food security in very explicit ways, many staff members and PWAS describe syndemic relationships tied to food insecurity as much more subtle and indirect. Early on in my fieldwork, I sat in the back courtyard of the agency smoking a cigarette with staff member Kara after our interview session. We talked casually about the state of HIV/AIDS in Saskatoon and the role of disease in food accessibility. To my surprise, Kara quite pointedly said that "we don't have an HIV problem in Saskatoon, we have a drug problem".

This quote set the stage for what would come to be revealed as a common theme throughout subsequent interviews and participant observation. Both PWAS and staff members regard substance dependence as a larger barrier to stable food security status than HIV/AIDS or HCV alone. In the above quote, Kara describes the role of factors, including homelessness, that keep an individual from adhering to medical treatment for HIV/AIDS. This quote serves as an excellent example of the ways in which food security syndemics enact profound force upon PWAS at AIDS Saskatoon.

Merrill Singer's (1996) conceptualization of the violence, HIV/AIDS, and substance use syndemic mirrors much of what was observed during my time at AIDS Saskatoon. The strongest social pathway within Singer's syndemic triangle is that of HIV/AIDS and substance use insofar

that there are observable and powerful manifestations of distress and dysfunction as a result of withdrawal, non-adherence to anti-retroviral therapies (ART), and fears regarding transmission from drug use supplies. However, homelessness and substance use are two factors that reveal their own syndemic pathways and exacerbations, perhaps more profoundly than those pathways tied to HIV/AIDS specifically. Whether a PWAS lived with HIV/AIDS or HCV was discussed with less importance than whether or not an individual was in active substance dependence and whether or not they had stable housing. With HIV/AIDS being considered a chronic condition due to modern medical treatments that decrease viral load to undetectable levels, and with HCV being seen as less debilitating with the advent of curative treatment, homelessness and drug use form some of the more complex syndemic clusters in the lives of PWAS. While HIV/AIDS and HCV do indeed present barriers for PWAS and does serve to exacerbate other social and health conditions, substance use and homelessness appear to be more the explicit aggravating factors in terms of food security status.

PWAS utilize many resources and protective factors against such syndemic forces, some of which have been discussed in this section. The use of multiple food programs to stave off hunger and the rejection of food security as a static state are two examples. As will be shown in later sections, PWAS often take part in specific decision-making processes regarding the acquisition and eating of food, the sharing of food, and the prioritization of needs when maneuvering the food desert setting of the 601 area. Whether a PWAS is dependent on illicit substances, homeless, in recovery, on income assistance, HIV or HCV positive, or disabled, each individual utilizes multiple survival tactics based around the gathering of consumptive goods.

3.2 Prioritizing Consumption: Access to Food in Times of Scarcity

3.2.1 Everyday Consumption and Foraging

In June of 2018, I stood in the kitchen of AIDS Saskatoon while a pot of tomato soup bubbled and spattered on the stove. Michael, a staff member, talked about Hepatitis C treatments while stirring the soup with a long wooden spoon. We were interrupted when a woman entered the kitchen. She was a PWAS from the drop-in and had become a familiar face from my time there, though in that moment, I could not remember her name. She started speaking to Michael, inquiring as to when the food would be ready: “You got anything sweet or bread or something?” the woman asked. Michael looked annoyed. “It’s not lunchtime. You can’t wait?” he replied. The

woman scratched her arm nervously and laughed. “I’m coming off a six-day stint. I need something now, for my stomach.”

This was the first time I had observed a PWAS talk openly about being “dope sick” after receiving their monthly income assistance. Though I was told by staff members that it is normal for the 601 to be quiet at this time of the month because of the delivery of monthly income assistance cheques, this moment gave me first hand insight into the interrelationship between food accessibility and illicit substance use. The kitchen was a space that was always bustling with activity. It was a space where coffee was made on a constant cycle so that the pot was never empty. The radio constantly played, chatter was always constant, and staff could be seen coming and going to warm their lunches in the microwave. On this particular day, Michael oversaw this space. Michael handed the woman a piece of multigrain bread, still warm from the stove. “Here you go,” he said. “This is good for you”.

The above incident in early June of 2018 illustrates the complex relationships among hunger, health, and substance use that PWAS contend with in their everyday decision-making processes. In this section, I argue that such everyday decisions around prioritizing the consumption of both drugs and food are not random or chaotic in nature, but rather are done with precision and agency. PWAS from AIDS Saskatoon use many of the same subsistence strategies that anthropologists have long examined within both modern and historical human populations, and these strategies are utilized and chosen amidst adverse social conditions in the face of resource scarcity. Foraging within an urban landscape, PWAS depend on resourcefulness, knowledge sharing, community, family, and time to make decisions regarding where and when to consume food and other consumptive goods such as coffee and even illicit substances. These decisions are, first and foremost, based not only on relieving feelings of hunger and withdrawal, but are also based on the prioritization of loved ones, relationships, and health.

While PWAS make everyday decisions within the confines of the agency, it is outside of the walls of AIDS Saskatoon that most foraging strategies take place. Within the Drop-In, Michael takes care of many decisions regarding what, when, and how PWAS eat. Outside of the Drop-in, PWAS find themselves maneuvering variable landscapes to gather their required meals. Within the realm of cultural geography, researchers have looked at urban foraging as the act of acquiring foodstuffs that grow naturally in urban spaces, such as through the harvesting of mushrooms or herbs (Poe, LeCompte, Mclain, Hurley 2014). Urban foragers have intimate and

varying relationships with both the natural and urban landscape, where space, place, and identity all come together to create "relational ecologies of belonging" (Poe et al 2014, 1). While PWAS at AIDS Saskatoon did not indicate participation in urban foraging as it is defined above, I argue that they do forage within an urban setting in such a way that they experience their own complex relational ecologies that are dependent on time, place, and use of community resources.

Food bank foraging, where multiple food programs could be used in a given day or week to meet need, is the main subsistence strategy used by those living in the area of the agency. For most PWAS, day time activities are planned around accessing food during the lunch period at AIDS Saskatoon, where breakfast, dinner, and other meals are accessed at the Friendship Inn, city food bank, or various churches offering meal hampers. Since accessibility is inherently time and place dependent, PWAS often plan their foraging habits by taking into account variables such as distance to location, the transportation of food stuffs, availability of family members and friends to share food, whether or not a child or dependent would be present and in need of a meal, medical appointments in the area, presence of withdrawal symptoms, and so on. In the case of Amy, a Cree PWAS and regular user of the lunch program, her everyday consumption was often planned in accordance with her methadone treatments, which she describes as follows: "I usually come here on Mondays because I go to get my carries ["take home" methadone prescription] every Monday. Then I stop in here and have a cup of coffee before going anywhere. I always have the coffee and a meal no matter what." For Sara, access to the lunch program was only planned for when other resources failed, such as when the biweekly food bank hampers ran out before she was able to restock. She explained that "When I'm out of food at home, that's when I run out. So, I have somewhere to come and have a meal when I run out food, because food is expensive nowadays. Very expensive."

Community barriers, such as requirements regarding identification, a fixed address, specific HIV/AIDS status, HCV status, and disability status in order to access food were experienced by all PWAS at various times and were often factored into such decision-making processes. These barriers will be discussed at length in Chapter 4 when examining the role of community in subsistence strategies.

3.2.2 Choice and Dignity

Every day consumption for PWAS was both personally and socially contingent. Just as Counihan (1999) states that foodways influence identity and personhood, so too does Gofton (1990) state that the consumption and choice of foods happens as an "individualized event", especially when those choices are predicated on an understanding of food as being for the health and function of the individual body (78). However, in times of scarcity and severe food insecurity, PWAS appear to have less of a choice about what they directly consume, since consumption is based on dependence on multiple food provider programs and of consuming what is made available to them by larger governing persons and institutions.

Both staff and PWAS have views on choice, taste, and waste that are inherently at odds with one another. While some staff members boast about the food program offering PWAS a sense of agency and choice around what foodstuffs they consume, observations and interview data found a different narrative embedded throughout. Michael's decision making about what to serve PWAS is mostly dependent on foods that are less likely to go to waste, foods that are easy to consume for PWAS who happen to be missing teeth or on certain medications, and foods that offer ease of preparation. For this reason, soup is the main lunchtime staple insofar that it was seen as both nourishing and impossible to pick apart out of distaste. Michael explained:

> I find the easiest is soup because you can throw everything in it. You have your meat, you have your vegetables, you have your spices, your different spices. And a lot of the people that are infected with HIV, they need a good meal. For some of them, this might be the only meal they get during the day. So, I like to do a real thick soup.

During one of our cigarette breaks on a hot July morning, Michael described, with exasperation, another important reason as to why soup had become a food staple for the lunch program. He explained that PWAS were less likely to pick things out or leave foods uneaten. Plates of separate food items, such as vegetables and meat with a side of starch, inevitably ended up in an overflowing garbage can with complaints about certain food items not tasting correctly. Waste and taste were two themes that became pervasive during my time with Michael in the hot kitchen that summer. Donations of bread from a local bakery only came at specific times during

the week, and the agency budget for groceries followed extremely tight margins, meaning that food needed to last. Waste indicates, for Michael, a sense of carelessness on the part of PWAS, where inability to consume the food given is viewed as a symbol of thanklessness.

The old adage, "beggars can't be choosers", came to mind many times when speaking with Michael about the eating habits of PWAS. I spoke about this phrase with staff member, Kara, during our interview together:

> About the beggars can't be chooser's mentality…that's such a huge part of food security. And that's not me trying to slight any other agency. It's just about capacity. But I think that, when we are looking at, like our agency is about harm reduction and that really focuses on autonomy, self-determination, and dignity. It's not right for us to say "just take this bowl of cereal, it's what you're getting"

Dignity itself is cited by staff members and PWAS as an important variable in healing and recovery, whether that recovery is from an infectious illness or that of addiction. The home-based model of care mentioned in Chapter 2, where the agency is specifically made to feel less "institutional" than other service providers, very much speaks to the concept of dignity. AIDS Saskatoon does indeed facilitate a sense of normalcy for PWAS in the design and implementation of agency layout and programming. This model also challenges the medicalization of social issues, thereby offering a sense of dignity insofar that PWAS are treated not as their illness or disability, but rather as persons with complex identities and needs.

However, I did observe that choices around the types of food consumed were very much constrained for PWAS. Food service providers generally "offer what they offer", where PWAS are seen as thankless or unappreciative if they show choosiness. It can be argued that choice plays an integral role in the formation of dignity. Dignity can be gained through agency and autonomy, denoting a sense of responsibility and trust on the part of society towards the individual. In one study (Hoffman and Coffey 2008) that looked at homeless people's perceptions and experiences of service providers, it is shown that infantilization and objectification on the part of the service providers inevitably contribute to the dismantling of dignity and self-respect in those who access services. The authors contend that power imbalances in the service provider-client relationship serves to perpetuate homelessness in the area itself,

stating that "homelessness is not internal to the homeless individual as many claim, but rather may be embedded in the service industry itself, which subjects *both* clients and providers to bureaucratic forms of authority and experiences of disrespect" (Hoffman and Coffey 2008, 207).

For anthropologist Phillipe Bourgois (2003), his participants within the ghettos of Harlem in the 1990's gain dignity and respect not through the uptake of service provision, but rather through hierarchal placement in the crack dealing economy. Such a role comes with specific responsibilities, economic freedom, and freedom from jobs that are seen as demoralizing, such as janitorial or fast food positions (Bourgois 2003). For PWAS at AIDS Saskatoon, dignity is gained through their own decision-making processes, the prioritization of basic needs, and the uptake of alternative livelihood and subsistence strategies, especially in the face of food service programs that offer little choice or autonomy, community programs that seek to govern everyday behaviours, and the societal views of people who view substance users as infantile and in slavery to their own bodily desires.

3.2.3 Prioritizing Needs

When dictating everyday practices around consumption, PWAS prioritize what, where, and when to ingest multiple consumptive products, including that of illicit and legal drugs. Illicit substances and legal medications often take precedence in such decisions in order to avoid states of withdrawal and dope-sickness that might impede ability to eat, sleep, or function:

> Going through withdrawal stages, they have no energy to do anything. Food is the last thing on their mind. Why put something in if it's going to come out the other end? And then when you're withdrawing you have no energy. You have no…you're questioning your every move and every thought. .-Michael (Staff)

Staff member Kara echoed Michael's above statement when she described her own observations of PWAS managing withdrawal symptoms. She explained: "You don't want to become dope sick. So, maybe, out of what I'm going to consume, I should consume this substance before I'm going to consume the food. Because that's going to make me well in my own way." In my interview with Sara, a PWAS at the 601, this viewpoint was also shared and contextualized within the experience of appetite suppression: "I don't shoot up or anything. I

just…I just smoke. And I notice that I don't want to eat. My kids will always try and pass me food, but I don't have the appetite to eat"

Decisions regarding the prioritization of consumptive goods are indeed made with precision and planning in much the same way that PWAS plan daily food bank and food service foraging. While Stephen's quote at the beginning of this chapter does imply a sense of powerlessness over addiction where both PWAS and larger society view substance dependence as that of removing autonomy and agency over one's body, prioritization of needs and decision-making processes regarding the use of illicit substances implies that autonomy and agency remain and do so in explicit ways.

Wellness is conceptualized here as not necessarily the absence of dope sickness or substance dependence, but as an active process of consumption where the choice of one good (drugs) may make the consumption of another good (food) easier. PWAS choose drugs in order to reach a state wherein they are able to function and meet their basic needs, including the basic ability to eat foods that can nourish the body and provide energy. I observed many instances of PWAS falling asleep on the 601 Drop-In Centre couches, a bowl of soup or cereal sitting lazily in their hand, poised to spill onto the floor. They dozed either because they had been awake on a "bender" for multiple days or because their methadone dose, heroin dose, or antiretroviral treatment had prompted fatigue. Yet, each PWAS that I observed in this state had either consumed, or were waiting to consume, a meal that may not have been possible to consume in a safe atmosphere before they had prioritized the consumption of both illicit and legal drugs. This observation also illuminates how sleep plays an integral role as a basic need and priority. Dope-sickness not only acts as a barrier to the physical act of eating, but also the physical act of sleeping. Prioritization of drugs in these instances ultimately speaks to the prioritization of survival.

In my interview with Amy, an Indigenous PWAS whom I spoke with regularly in the Drop-In centre , it was revealed that many PWAS came to AIDS Saskatoon to "shoot up" in the bathroom before then taking a meal. Here, space and place are organized around consumption insofar that AIDS Saskatoon is used to meet multiple consumptive needs *safely*. From May 2018 to July 2018, Saskatoon did not offer a safe injection facility. With AIDS Saskatoon offering a familiar place to eat, sleep, and exchange needles, PWAS sometimes use this space to additionally consume illicit substances, even if the staff members and other PWAS speak

vehemently against it. Amy (PWAS), went on to assert that "People should have more respect for the place because some people are using in the bathroom over here". She further explained that "if they are coming here to eat, they should respect it. The people that work here too, eh. Everyone should be respectful."

Family and loved ones are some additional factors present in the everyday prioritization of consumption. PWAS with children talked at length about their tendency to prioritize their children's needs over their own, even when threatened with withdrawal. Nora, a PWAS and mother of a large extended family, explained her own experiences balancing familial responsibility with substance use: "Like, me, I've spent all my money on my drugs and then didn't even buy food. I've done that more than once." I probed her further. "So, food isn't really a priority for you when you need to buy drugs?" She responded with a scenario that she had faced on more than one occasion. "Like, when my son used to go down and visit on my reserve, I used to not buy groceries the whole time he was gone. But when he comes home then I'll make sure to buy food. Family is always a priority."

While Nora did not make it clear as to whether her decision to prioritize food detracted from her ability to then purchase substances, observations and conversations with other PWAS indicates that similar situations do arise in which some PWAS will choose to feed their children or dependent family members, rather than to purchase illicit drugs, when facing the threat of withdrawal. Conversely, some PWAS will choose to buy drugs before food in fear that their ability to parent and adequately supervise their children will be impaired while undergoing violent withdrawal symptoms.

Consumption was not always spoken about in terms of prioritizing drugs over food, however. Many PWAS utilize difficult decision-making processes regarding the choice among food, housing, and family responsibilities. Amy explained this to me when reiterating her own experiences with caring for other family members and her decisions to prioritize food over rent: "And sometimes my cousins will come to stay because they have nowhere to stay and they'll come live with us. So, we have to buy more than we need. And then it's hard because we are low on our rent too. So, we just got an eviction." I asked Amy if she often needed to prioritize food over rent and she responded that this was not the first time that she had needed to make the difficult decision.

In keeping with anthropological theoretical foundations of the body, including Lock and Scheper-Hughes "three bodies" (1987), the relationships between withdrawal, pain, and hunger can be examined further to better understand the embodied experience of food security for PWAS at AIDS Saskatoon. It has been argued here that everyday decisions regarding the gathering and consumption of foods and illicit and legal drugs are complex, multifaceted, and meticulous, speaking to notions of dignity and agency. In the next section, I move on to experiences of hunger and withdrawal at both the individual level and also at the level of the social and political body.

3.3 Organizing the Body: Relationships between Withdrawal and Hunger

3.3.1 The Addicted Body

> Addiction is really hard on the body and we have many people who have been accessing services their whole lives. [Addiciton] has an affect on your body and you look at the side effects of certain substances like crystal meth, you don't want to eat. And it gets to the point where you physiologically and psychologically can't eat. That whole process becomes very intentional, painful process sometimes. And so, people go weeks without eating, which really speeds up physical and mental deterioration. –Joanne (Staff)

At the beginning of Chapter 3, Stephen spoke of drug addiction as a consuming process that removed power from individual decisions. Here, Joanne speaks about addiction as a force put *upon* the body, removing the desire to take part in basic needs such as the consumption of food. Joanne and Stephen are not the only participants to speak about addiction as a contaminating force that rendered people vulnerable. Normative approaches to the addicted body often portray it as chaotic and unpredictable. Addicted bodies have often been illustrated through mainstream sources as zombie like, undead, and bereft of humanity, ultimately leading to stigma and mistreatment of people who use substances.

I do not seek to discount the lived experiences of participants who use metaphors of powerlessness to describe substance dependence, such as Stephen and Joanne above. Just as marginalization should not be used as a universal qualifier with unchanged meaning, so too should substance use and substance dependence be examined as a variable and person-centered experience. However, even as participants might describe themselves and others as "slaves" to

substances, their actions and survival strategies very much imply agency, autonomy, and a strong will to survive, as was discussed in the previous section. The tendency for participants to adopt specific language around addiction and the addicted body reflect imbedded symbols and metaphors used at the level of the individual body, social body, and body politic.

Martin contends that "the portrait of the body conveyed most often and most vividly in the mass media shows it as a defended nation-state, organized around a hierarchy of gender, race, and class." (1994, 45). Western conceptualizations of the addicted body do indeed follow this organization, where both substance users and health professionals may use specific and meticulous language to describe the body as becoming contaminated or polluted by illicit substances, and even further, with addicted, gendered, or racialized bodies as being social infectors. Following this, Douglas, speaks of *pollution ideas* as working as an instrument for the control of behavior within society (2002). The social body metaphor that emerges is one where society and the dominant culture form a body or nation-state, wherein certain persons or activities become polluting or contaminating to the larger social order, prompting surveillance, governmentality, and pollution mitigation tactics that can take many institutional forms. Douglas defines pollution as being "matter out of place" and dirt as being "order out of place" (2002,44), bringing to mind a plethora of situations wherein an addicted body may be seen as socially infectious or "dirty" due to its positioning on the periphery of society. For Diane Goldstein, certain behaviours, such as intravenous drug use and unprotected sex, can also be regarded as "activities out of place" (2004), since such activities serve to create moral panic and are often seen as dangerous to the order of the nation-state.

Marginalized bodies may indeed be situated on the periphery due to perceived deviance from larger society, both physically, biologically, and morally. Addicted bodies may be portrayed as "bad", 'broken", or "polluted". When seen in the throes of withdrawal, notions of pollution and dirt become actualized in physical bodily processes, such as in the act of vomiting, where culturally embedded feelings of disgust and shame become prevalent. That substance users engage in activities that are often regarded as dangerous, risky, and out of place also infers that the mind of a substance user has also come to be polluted or contaminated, where control over desire and morality is lost.

For the PWAS at AIDS Saskatoon, contamination and the body is often discussed within the context of food and illicit drugs. The associated experiences of withdrawal and hunger serve

as excellent vantage point from which to further study bodily experiences of marginalized persons.

3.3.2 Withdrawal and Hunger

While withdrawal might bring to mind pictures of a body that is, in some sense, purging both physically and morally, PWAS describe withdrawal as a process of *wanting* and *needing.* When the consumption of illicit and legal drugs are normalized by PWAS, withdrawal is described as a deviation from one's normal state. Below, Amy details her fears around withdrawal and how everyday drug use has become a normal ritual for her own daily functioning:

> It's just a normal thing for me because I've been on it [methadone] for so many years. And now I need it. It's like I'm dependent on it. If I don't have it, I'll get sick. I'm scared to get off of it because I've heard a bunch of stories about people getting off of it and getting withdrawals really bad. I went through that too. For two days I never had any and I was just puking and having dry heaves. I was in the bathroom on the floor. It was just awful. That's why I'm scared to get off of it. They say you can't sleep for quite a while too. –Amy (PWAS)

Many participants who were substance dependent did *not* speak of illicit substances, such as heroin, as being negative to everyday function. Rather, withdrawal was cited as the feared disturbance to overall physical and psychological functioning, especially when discussing use of opiates. Since many PWAS require some form of drug to optimally function, such as in the case of Amy and her methadone treatments, daily drug use is often viewed as a basic need.

Like withdrawal, hunger was also described as a state of wanting and needing, where lack of food prompted a disturbance to normal functioning both physically and mentality. Just as Chilton & Booth (2007) find that experiences of hunger among African American women in food insecure environments were often experienced at physical, psychological, and political levels, PWAS also describe their experiences with hunger as tied to experiences of emotional and physical derailment.

Stephen describes his own hunger as follows: "Well, I mean, when we have an empty stomach we are kind of moving on an empty gas tank. We are more liable to be angry, frustrated, and not think rationally. If I have a full belly, I can go to sleep, you know?" In addition to describing hunger as an avenue toward mental and emotional distress, many PWAS also discuss hunger in relation to disability and weight loss, as explained by Amy:

> There are times that I've gone hungry. Yeah. A couple times I would say. Because I had a sprained leg and I lived on Avenue B. I couldn't go anywhere. So I stayed home and I had nothing to eat and I was eating bread. Yeah I lost a lot of weight. I got real skinny. I got depressed. -Amy

Withdrawal and hunger, then, were often described with much of the same language and were also sometimes treated by staff within the agency as compounding states that could be mitigated with some of the same tactics. Below, Kara explains how she, as a staff member, approaches treating both hunger and withdrawal in PWAS who come into the agency in crisis:

> Meth will keep you up for days. And all of your other needs like thirst or hunger don't really register. Even sleep. You won't sleep for three days and then you'll crash. So, that's one of the reasons that when people come into the office and they present as if they are in psychosis or, like very up…first thing I try to get them to do is have a drink of ensure or some kind of water. Because as soon as you get that in your system, your body is like "oh right, I need to sleep, I need to eat, I need to stop."

Methamphetamine is the main illicit substance cited as being most problematic to everyday functioning, where heroin and other opiate related drugs are discussed as being the most potentially lethal. PWAS and staff organize illicit and legal substances into differing categories of "bad", "good", or "acceptable", where drug use practices are set along a continuum of risk. Stimulants, while affecting ability to eat and sleep, are not necessarily viewed as the riskiest in terms of threat of overdose, whereas benzodiazepines, opiates, alcohol, and other combinations of drugs are cited as the main causative agents of overdose deaths. Methadone is regarded as

especially acceptable as it signifies steps toward sobriety and is also viewed as a "cleaner" drug, since it cannot be contaminated with potentially lethal pollutants such as fentanyl when unopened.

Foods are also organized by PWAS into discrete categories of "good", "bad", "unhealthy", and "healthy". Bad foods that have the potential to contaminate and pollute the body are items such as sugar, grease, starches, and other "junk" foods. Foods regarded as good for the body are fresh fruits and vegetables, meats, juices, and many items that don't come frozen or boxed. Healthy foods are regarded as those items that are often too expensive to buy, whereas unhealthy items are considered inexpensive, but also often result in the development of chronic diseases such as diabetes.

3.3.3 Managing the Virus

Contamination, pollution, and infection narratives, while especially interesting in the context of consumptive goods, are of course the most explicit when tied specifically to HIV/AIDS, HCV, and other infectious diseases. All PWAS within AIDS Saskatoon are regarded as either living with, or at risk of HIV/AIDS, HCV, and other STBBI's, so fears around transmission and bodily contamination are explicit.

Experiences of stigma and marginalization due to societal perceptions of PWAS as being infectious by their nature, both biologically and symbolically, is perhaps the most profound lived experience of the social body metaphor that PWAS manage in their everyday lives. AIDS Saskatoon battled societal stigma against PWAS at both micro and macro levels, including the management of language used in the agency when providing safe drug use supplies.

During my time as a volunteer assisting with the needle exchange clinic, I was firmly advised not to use words such as "dirty" or "clean" to describe needles. To do so was to imply that the bodily products on the needles were also clean or dirty, thereby furthering the view that a PWAS with HIV or HCV was "dirtier" than one without. AIDS Saskatoon staff aim to mitigate stigma against people living with HIV/AIDS and HCV through repeated efforts to communicate that PWAS living with HIV and HCV are not made dirty or naturally infectious by their status, actions which directly battle common infection narratives and folklore that pervades broader society in inherently damaging ways.

Diane Goldstein contends that stories and narrative ultimately shape societal responses to disease and disease control (2004). Indeed, damaging infection narratives have been shown to prompt pollution and risk mitigation tactics that tend towards treating marginalized peoples as scapegoats for the spread of disease (Goldstein 2004). PWAS contend with such narratives in their everyday experiences of stigma. As they move throughout the area of 601 Drop-In Centre, managing viral loads, antiretroviral medication, novel curative treatment for HCV, and balancing symptoms and side effects, they encounter the biases and judgements of health and social service professionals, peers, and broader society. Such experiences of stigma decrease the uptake of community programming and inevitably impacts where and how a PWAS might choose to acquire food. Preferences for food banks and food programming outside of AIDS Saskatoon are often predicated on how a PWAS might be treated by staff members or peers at that locale. While experiences of perceived discrimination and stigma do become a part of the everyday decision-making processes in food acquisition for those living with HIV/AIDS and HCV, dependence on those programs also means that PWAS will continue to use those services out of need, despite feelings of distress that might occur in the process.

PWAS living with HIV/AIDS and HCV manage infection and illness through many of the same tactics that have already been discussed in this chapter. Use of multiple food programs to acquire adequate nutrition and prioritizing consumption of food, and illicit and legal substances, are survival strategies that are used by all PWAS within AIDS Saskatoon, regardless of viral status. The additional barriers for those with HIV/AIDS and HCV mainly come about from disability, stigma, and non-medication adherence due to substance use and housing status, prompting an extra level of risk for secondary infections and mobility issues, and further exacerbating food insecurity.

At the level of the social body, PWAS living with HIV are viewed as disembodied from broader society via their marginalized status and are viewed as at risk of infecting the societal body in the same way that a virus is thought to infect a physical body. They are regarded as infectious both through both their biology and through their behavioural activities out of place, making them “disembodied bodies” in the same way that a virus might be viewed as a disembodied organism with the power to contaminate whatever it comes into contact.

Substance users, those living with HIV/AIDS and HCV, homeless persons, and other marginalized groups therefore face structural barriers that are deeply imbedded into enculturated

views about the body and contamination. Infection narratives that serve to scapegoat these populations are pervasive even within the institutions that seek to serve them. AIDS Saskatoon takes an explicitly destigmatizing approach and serves as an example of some of the ways that such narratives can be battled such as through the dismantling of everyday language used to describe addicted bodies. At the most macro level of service provision and accessibility, bodies of those who access services are also very often described as vulnerable, a qualifier that I argue plays a problematic role in the stigmatization and marginalization of PWAS. Just as bodies can be seen as infectious, contaminating, and powerless, bodies seen as vulnerable are very often controlled and governed in ways that can be both empowering and disempowering. As will be shown, food security status, and the imbedded, dynamic nature of the food security continuum, can act as a proxy for rethinking and redefining vulnerability.

3.4 Questioning Vulnerability

3.4.1 Defining Vulnerability and Risk

As stated above, food security is best conceptualized as a spectrum to account for the variability and plethora of barriers experienced by groups of people living in precarious situations. For the PWAS at AIDS Saskatoon, vulnerability as a concept is tied to dynamic positioning along this food security spectrum and the associated tactics used to survive while maneuvering hunger and withdrawal. While many of the PWAS fit demographically into populations that have often been regarded as "vulnerable", observations and discussions in the field indicate that many PWAS do not necessarily view themselves in this light, especially when they are able to meet their basic needs through service provision. Instead, participants are more concerned with sharing stories of overcoming obstacles related to food security status. They instead discuss resilience and resourcefulness when faced with everyday problems in food accessibility and substance dependence.

Indigenous Peoples, substance users, and those living with HIV/AIDS and HCV have long been conceptualized as vulnerable by larger governing bodies, both academic and otherwise (Mackenzie, Rogers, & Dodds 2014). Investigations into governmental definitions of vulnerability generally reveal policies, procedures, and investigations mainly related to the elderly and elder abuse, however, the government of Canada does specifically designate groups of people who are "at greater risk" of environmental, social, and health related harms, which includes children, pregnant women, seniors, and people with pre-existing health conditions

(Government of Canada 2018). Within the areas of public health, vulnerability has been defined in numerous ways, but generally includes groups of peoples at risk of greater harms (Hurst 2008), those susceptible to being mistreated or discriminated against (Ganguli-Mitra & Biller Andorno 2011), or those persons who have an "inability to protect oneself" (Shroeder & Gefnas 2009, 113). Rogers (2014) states that "within public health practice, vulnerable populations have been identified as those who are more likely to suffer from an increased burden of ill health and therefore require extra support or protection", (90) further asserting that vulnerability as a concept has sometimes become "shorthand for all of those who are the least privileged in whichever society they live" (90).

Shroeder and Gefnas (2009) argue that vulnerability as a concept might be too broad insofar that any special protections afforded by this qualifier become lost when it is over applied. If vulnerability has become so broad that almost every population is included under it, what benefits does the qualifier offer? While this and other questions about defining vulnerability are important, my aim is not to utilize this section to question academic definitions of vulnerability only within the context of academic opinions.

The definition of vulnerability within the field of public health is interwoven with the concept of "risk" in multiple ways. Vulnerable persons are deemed "at greater risk" of poor health outcomes, discrimination, death, and violence, inferring that protection and intervention is required. The psychological behaviourist paradigm of "individual health risk behaviour" conceptualizes risk as that of an individual, agentive, practice. Risky behaviours are those that can lead to poor health outcomes, with the term often separated from the macro social environment it is contextualized within (Bourgois 1998). PWAS at AIDS Saskatoon are deemed "at risk" due to behaviours that could potentially lead to HIV, HCV, and other STBBI infections, overdose, death, and physical and sexual violence. The responsibilization of risk for groups deemed as vulnerable is widespread. Pregnant women, as an example, are frequently besieged with messages that encourage the individual mother not put her child "at risk" of poor health outcomes through behaviours deemed deviant to society such as through smoking, consuming alcohol, unprotected intercourse, and the consumption of illicit drugs.

Risk and food security are also intertwined at the site of health, the body, and individual behaviour. As was shown in Chapter 1, examinations of food security status and poor health outcomes show that individuals living in food insecure environments are at greater risk of

nutritional deficiencies, mental health pathologies, and disability. Food insecurity implies vulnerability, where risk acts as a precursor to undesired (and potentially unfulfilled) outcomes. Here, responsibilization for PWAS is enacted in terms of food choices and the prioritization of illicit substances over food. Just as a pregnant woman is besieged with health narratives that discourage contamination of the physical body to avoid poor health outcomes for both mother and child, PWAS are also inundated with messages from health and social service providers that encourage a "balanced diet" or adherence to a culturally normalized food guide, even in the face of abject poverty or in the absence of choice regarding what can be consumed. The prioritization of drugs over food is a risk behaviour insofar that it can increase the potential for undesirable health outcomes. In the case of withdrawal, many PWAS will choose the *risk* of negative long-term health outcomes in the face of *guaranteed* dope-sickness.

Risk can then be regarded as a concept that infers unfulfilled harm. For PWAS at AIDS Saskatoon, a risky behaviour is one that does not guarantee a negative outcome, but instead merely heightens the possibility of that outcome. The sharing of needles as a practice in intravenous drug use is "risky" insofar that it carries the chance of HIV and HCV transmission and infection. PWAS are therefore deemed vulnerable (in part) *because* they engage in risky behaviours that carry the possibility of harm. When adding Indigenous ethnicity into discourses of vulnerability and risk, however, there is a shift away from responsibilization. Instead, vulnerability is given as a fundamental state of being that comes with Indigenous identity. Risk is generated not necessarily from behaviours, but rather is explained as an outside force, such as in the case of increased risk of racial discrimination. Responsibilization again manifests when Indigenous identity is paired with negative health outcomes, such as with alcohol dependence or diabetes due to increased intake of sugary foods and carbohydrates. Risk, in this case, once again becomes a dynamic activity that is approached mainly at the level of the individual.

3.4.2 Resisting Vulnerability

Without discounting the explicit ways in which PWAS at AIDS Saskatoon face barriers to health and wellness as a result of factors such as colonialism and structural violence, the tendency for PWAS to question and resist the qualifier of vulnerability is what is particularly important. Vulnerability, as stated in the previous section, is inherently tied to risk and autonomy. Public health approaches to vulnerability almost always cite increased "burden",

"risks", or "wrongs" as some of the main requirements for the identifier of vulnerability. The concepts of risk and vulnerability carry inferences of responsibilization, decreased capacity, and moralization and these inferences have the potential to lead to increased control and surveillance from outside forces as a way to mitigate undesirable "activities out of place". Additionally, what is "risky" and what is not is very often dictated by larger governing bodies and intrinsic cultural norms and practices, and as such can often be used as a means of behavioural control in the guise of assistance and group preservation. In many definitions, the capacity of the vulnerable group to utilize agency, autonomy, and other means to protect themselves against such risk is viewed as severely diminished, which can also manifest in increased intervention efforts. It is unsurprising then, to observe resistance to the qualifier of vulnerability, especially when it holds within it implications of distasteful behaviour and infers that an individual or group holds diminished capacity, and indeed, when it holds the risk of increased social and behavioural control from threatening sources.

PWAS are considered vulnerable insofar that they are at risk of experiencing negative health and social outcomes due to risky behaviour. They are also vulnerable in that they experience societal marginalization and the associated stigma and oppression that often comes with that marginalization. Experiences of violence, disability, and destabilization occur in their everyday lives in very serious ways. However, the extent of that vulnerability becomes less static when examining individual survival tactics used. Resistance to vulnerability as a qualifier is an active process that manifests in everyday activities to subsist and survive. I do not argue that vulnerability is not present within the population of PWAS at AIDS Saskatoon. However, using this designation as a blanket qualifier is problematic in a number of ways. In the same way that food security as one concept is constraining to diverse experiences, and in the same way that marginalization as a superimposed identifier does not always account for diverse experiences, so to is vulnerability a broad concept that does not properly mark the lived experiences of the people it is imposed upon, since it almost always infers diminished group capacity and therefore has the potential to devalue the resourcefulness and resilience of a given group.

3.4.3 Rethinking Vulnerability

Importantly, marginalization and vulnerability are also very often defined and imposed by a dominant cultural group, which in the case of Indigenous Peoples in Canada, is be

inherently colonialist in nature and sparks a number of problematic inferences in that the "vulnerable" group in question does not take part in the generation and production of their own identities. To revaluate vulnerability in terms of PWAS and other groups means to facilitate a regaining of agency over imposed colonialist notions of powerlessness that are often rooted in preconceived cultural biases towards "normal" and "acceptable" behaviours and states of being. PWAS are deemed vulnerable in part because of their "risky" behaviours and activities that are out of place from larger socially acceptable practices. The designation of vulnerability, while offering needed interventions and supports for the community, is also used to facilitate heightened forms of surveillance and governmentality, which in themselves can be debilitating and are often predicated on the control of populations deemed to be as socially infecting.

Re-defining vulnerability to include variable lived experiences and capacity for autonomy is important for a number of reasons. I argue that we must revaluate vulnerability in the terms of the population in question because 1) inability to recognize agency and autonomy devalues and disempowers the population under which this qualifier is superimposed; 2) ignoring the perceptions of such populations regarding their own agency reinforces paternalistic interventions, infantilization, and colonialist approaches; 3) examining the ebb and flow of vulnerability and barriers and risks associated with varying states of vulnerability will better inform health interventions and public policy; and 4) changing overarching views of vulnerability will assist in battling stigma and will further empower these populations to utilize agency and resourcefulness to advocate for themselves and for systemic change.

Using the same approach to the food security posited by Hendriks (2015) in section 3.1, vulnerability might be best conceptualized along a spectrum or continuum that is culturally, environmentally, and temporally dependent, and most importantly, is designed and informed by the groups it is striving to describe. To describe vulnerability only within the context of the psychological risk behavioural paradigm is problematic since this approach assumes that negative health outcomes emerge as a product of an individual's failing, and not as a result of social, cultural, environmental, or political contexts. Hendrik's food security spectrum recognizes that a food insecure status is often informed by multiple barriers and outside forces in addition to individual choices around food consumption. The PWAS at AIDS Saskatoon, as an example, are not food insecure *because* they engage in the "risky" behaviour of prioritizing illicit substances over food to stave off dope sickness. This prioritization is only one aspect of food

insecurity that is felt amidst a sea of other constraining variables such as positioning within a food desert setting, poverty, disability, and familial responsibilities. If one were to approach vulnerability as a spectrum that can fluctuate depending on the protective factors possessed by the group or individual, it could be argued that (like food security status) a PWAS could be both vulnerable and invulnerable in a given moment, day, week, or month.

In the next chapter, how designations of vulnerability lead to increased governmentality and surveillance will be discussed. Examining the ways in which community institutions offer assistance, it will be revealed that PWAS often contend with heightened control over their everyday food acquisition practices, which inevitably creates further structural harms. Despite the complex prioritization, planning, and decision-making processes that PWAS utilized to maintain autonomy, their bodies and behaviours are still governed in profound ways.

CHAPTER FOUR: SURVIVING IN AN URBAN FOOD DESERT: COMMUNITY, MORAL ECONOMIES, AND ALTERNATIVE LIVELIHOODS

On the morning of June 15th, 2018, the 601 was bustling. I counted over sixty people coming and going while taking statistics at the entrance as part of my volunteer duties, and this number kept growing throughout the subsequent lunch period. The heat outside that day was oppressive. Many individuals in the neighborhood sought shade in the confines of the Drop-In for a glass of cold water or a pick-me-up of hot coffee. The line for lunch was unsurprisingly long come 12:00pm. Because the small space was packed that day, I was able to take part in multiple conversations. As PWAS ate and socialized, they described their frustrations and experiences in acquiring income assistance and food, and discussed feelings of powerlessness with their participation in community programming throughout the city. They expressed anger at being "treated like children" while also describing how they felt disrespected by being "ordered around" by governing bodies that claimed to offer help and assistance.

In this chapter, I discuss how community as both a macro and micro category played a role in the lives of both PWAS and staff at AIDS Saskatoon. I examine how PWAS utilize community to maneuver harms and barriers faced in their everyday lives as related to lack of access to food while also focusing on how community surveillance acts as a constraint and how such constraints can exacerbate marginalization and oppression. In the face of community governmentality, PWAS often uptake alternative strategies of subsistence to maintain some agency, autonomy, and respect. The above interaction with PWAS in the 601 very clearly indicates a sense of powerlessness and lack of respect from broader community interventions. Social, behavioural, and even biological control and surveillance are explicit for many PWAS and are directly tied to structural harms that serve to impede wellness. This chapter concludes with a discussion of how food and food programming can act as a harm reduction strategy while also promoting agency and autonomy for marginalized populations. Section 4.4 also ends with an examination of the harms and risks that occur when access to food programming is removed from a community.

4.1 Support and Surveillance: Social and Institutional Communities

4.1.2 Informal and Formal Communities

The communities centered in and around AIDS Saskatoon take on a plethora of forms and functions. Within the agency, PWAS generate their own social communities predicated on bonds with both peers and staff. Outside of the agency, familial communities, peer communities, and institutional communities are numerous. I define informal communities as those that include peers, family, gang affiliations, and alternative income networks (such as sex worker communities), whereas formal communities consist of those that often offer formal services. Formal communities include health providers, social service providers, non-governmental organizations, and othering governing bodies.

Both formal and informal communal networks function with their own sets of socially and culturally appropriate rules of behaviour and each level of community offers a different benefit to the individual taking part. Just as everyday subsistence often involves food bank foraging and the use of multiple service providers for PWAS living in the area of the 601, formal and informal communities also become an important part of urban survival in everyday subsistence. Both levels of community networks are intertwined with one another, meaning that a PWAS often depends on a blend of both formal and informal networks to meet everyday basic needs.

Interview data and participant observation data explicitly show that informal networks tend to have less barriers to accessibility than formal networks. For an HIV or HCV positive PWAS, accessing formal networks to gain the benefits associated with membership is often very difficult if they are also homeless and substance dependent. Control and surveillance are indeed heightened in formal networks, making it extremely difficult for some PWAS to maintain autonomy or agency, which often results in a preference for the use of informal networks.

4.1.3 Biological Surveillance and Control

To meet basic needs and survive in the urban environment of Saskatoon, many PWAS rely on a number of assistance programs to subsist and gather food. Almost all participants were on some form of governmental income assistance, which was described as being too minimal to cover monthly needs. Staff member, Kara, explained: “The current social assistance rates are a huge barrier because they don’t allow people to have sufficient enough income to have rent paid, bills paid, food paid. You know, we have essentially an area of about five or six neighborhoods

in Saskatoon where we see the highest low-income rates." When speaking with Jordan, the Indigenous PWAS participant introduced in Chapter 3, he also outlined his own experiences with the minimal income assistance rates in Saskatoon: "At the beginning of the month, I usually have about $80 [for food]. I have about $140 left after I pay my rent and my bills. I have $140 and I try to budget $80 [for the rest of the month]." In my interview with staff member Joanne, I asked about the minimum amount a PWAS might receive on income assistance. She replied "I can't remember for basic. For housing for a single person, I think their maximum is about 480 dollars. And for families, um, like we have…a woman I talked to this week, she's got eight children. She get's 849 dollars per month for rent."

Gaining access to income assistance is dependent on an individual's ability to meet certain criteria. Identification, a fixed address, and commitment to finding employment were just some of the requirements mentioned by PWAS. Additionally, income assistance that is centered on support for a physical or mental disability has even stricter guidelines, where proof of medical need is required and often fiercely interrogated. Most PWAS have experienced some form of heightened surveillance and control over their own biology, especially when in the context of HIV/AIDS and HCV.

Staff and PWAS at AIDS Saskatoon report that curative HCV treatment is not provided until Stage 2 of the disease, leaving many individuals at risk of both transmitting and becoming infected by the virus through sexual intercourse and intravenous drug use before treatment is available. Access to curative treatment is governed at the biological level insofar that the body becomes a site of governance based on biological markers of disease progression. Emancipation from disease can only come when damage to the body meets certain criteria and when very specific biological guidelines are met. Although PWAS discuss their relationship with HCV as temporary due to access to curative treatment, HCV treatment is often regarded as a highly surveilled process that takes time and dedication. This surveilled process sometimes proposes barriers to treatment while also offering specific benefits in terms of subsistence.

Access to meal benefits, including extra income for food through income assistance, can only be gained when endorsed by a doctor. PWAS need to show medical need, such as through a formal diagnosis of HIV/AIDS or HCV, in order to receive approximately $50 dollars per month to go towards meals or packs of Ensure meal replacements. Jordan was one of the PWAS to confirm this during our interview:

> Welfare, they have um, it's called special diet or special needs. You can get that, it's 53 dollars. Or you can get, instead of the 53 dollars, they'll let you have Ensure. You have to have, it's to do with medical. So, you have to get your doctor to show medical need. You know some people, when they're addicted to morphine, they don't eat properly. So, they have to drink the Ensure, or Boost, or whatever. 53 dollars I believe it is. I think it varies though. For me, it's 53 dollars.

To maintain access to food supplements based on viral status, PWAS with HCV often need to offer ongoing reports to their income assistance provider that illustrate their ongoing need. Testing throughout treatment means more appointments to be kept and time to be managed, a large barrier for many PWAS with mobility and transportation issues, substance dependence, and homelessness. Sara describes her own experiences with HCV as follows:

> I was Hep C. And I took things to try and fight it. We got needles and stuff to try and fight the Hep C. And, um, I'm not quite sure if I still have it or not. I haven't been retested. But we had a health nurse come in to check and stuff like that. But I never bothered checking it. I couldn't get there.

There is an explicit incentive for PWAS, beyond the promise of health, to engage with treatment for both HIV/AIDS and HCV, especially in the form of food and monetary assistance. And yet, the incentive to testing and treatment is made more complex by barriers such as mobility, appointment requirements, requirements of identification, housing, biological status such as viral load (in the case of HIV/AIDS) or HCV disease progression status, and requirements for sobriety. These requirements vary by institution. AIDS Saskatoon features some services onsite in an attempt to mitigate such barriers for PWAS. AIDS Saskatoon itself boasts low barriers to accessibility in that individuals do not need to provide proof of HIV or HCV status, familial HIV or HCV status, nor do they need to prove they are at risk of becoming infected in order to access services.

4.1.4 Social Surveillance and Control

Time, scheduling, and resource allotment are forms of governmentality that are not specific to PWAS experiences alone. However, while most organizations, workplaces, and educational institutions keep specific schedules that limit accessibility to weekdays, weeknights, or evenings for almost all populations accessing them, PWAS at AIDS Saskatoon feel these scheduling limitations more profoundly than other populations accessing businesses during regular hours. The food bank, as an example, only allows access every two weeks for one individual or family, which severely limits the amount of food that can be gained from accessing the service. A food hamper is assumed to last for a two-week period, though anecdotal experiences reported by PWAS say otherwise. A food hamper may only last one week, or less than a week, depending on the size of the family. When income assistance runs low, PWAS become extremely dependent on community agencies to fill food gaps, especially when unable to afford expensive groceries at the Safeway in the area. During evenings and weekends, PWAS often experience temporal hunger based on the closure of food service programs during that time period. Travis, one of the younger Cree PWAS I had the opportunity to interview, states that "Whenever I'm starving for a couple of days, like over the weekend, I get excited for Mondays because I can finally eat." This excitement is just one example of the emotional states that temporal hunger prompts. Excitement for the weekend to conclude is often preceded by panic and dread when the weekend begins. Lily, a Caucasian PWAS in her 40's, explains this in more detail:

> There are no places for people with addictions or homelessness to go on weekends. Where you can sit and have coffee and relax. I've talked to everybody that basically comes here and they say "yeah man we need something on the weekends". See, the Friendship Inn is only open from 8-2 in the afternoon and this place is open from 10:30-4 during the week, so Saturday and Sunday we need something like that.

In addition to food provision programs, surveillance, control, and policies aimed at assistance both constrain and enable agency in complex ways. Agency may be facilitated for PWAS through services, but they must adhere to specific behavioural guidelines. As an example, to gain income assistance or access certain substance dependence treatment programs, PWAS must illustrate that they are following certain rules of behaviour in order to access services that

may promote further agency and autonomy. If a PWAS maintains secure housing and an employment search in line with income assistance policies, that person will receive financial assistance that enables the individual to become socially successful. Activities that fall out of such guidelines, such as illicit substance use or illegal livelihood strategies, are often viewed as socially unacceptable. The behaviours that do not fit into specific behavioural guidelines are often regarded as too risky to be sustainable and are condemned as polluting to the social order and indeed to individual wellness. Governmentally controlled social assistance programs are the most explicit form of social control within the lives of PWAS, where variables such as income, monetary provisions for food, parenting strategies, and use of substances are closely monitored, with many behaviours outright banned with the threat of consequences such as child apprehension, loss of income assistance, or loss of enrollment in other community programs. Travis detailed the various criteria that he and his girlfriend needed to meet to gain custody of their young daughter who had previously been apprehended by child services. He began by describing how they needed to first fix their living quarters:

> And then like, the back porch. There's this big hole from the mice and you can see right through when it rains. And you can slowly see outside. So, step number one is to get out of that house. Step number two is that [girlfriend] has to go to detox. And then after that she has to provide three clean tests to get [child] back. […] There were people going around saying that she [girlfriend] was smoking crystal meth in front of her baby and she would never never do that. Never.

While detailing the intricate and structurally violent child apprehension crisis for Indigenous Peoples in Saskatchewan is too broad an undertaking for this thesis, it should be noted that the threat, and enactment of, child apprehension was a tactic of behavioural control on the part of the government with which PWAS often contended. Any substance-use, even use that might be considered as "functional", is enough grounds for apprehension, even without the presence of violence or abject poverty in the home. Food and food provision itself can act as a protective factor to child apprehension, an argument that will be outlined in more detail in section 4.3.2.

Whether PWAS contend with either biological or social barriers to membership in formal community networks, most participants spoke of their lives as being closely monitored and controlled. Trust and respect are rarely qualifiers that are used to describe experiences with formal community systems, leaving many PWAS searching for opportunities for agency in other informal networks. Marginalized subsistence strategies, such as involvement in street economies and alternative livelihoods, are used as a way to survive when formal systems failed, were inadequate in providing basic needs, outright rejected PWAS from membership, and in the quest to secure status on the food security continuum.

4.2 Livelihoods on the Edge: Alternative Subsistence and Moral Economies

4.2.1 Moral Economies

A moral economy, defined by E.P Thomson in 1971, refers to informal economic practices in small, closed-knit communities that are based on principles of reciprocity and fairness (Gotz 2015). Some moral economic practices can fall outside of mainstream economies, where such transactions occur at the periphery of society due to the oppressive, inadequate, or unreachable nature of more acceptable economic activities such as formal employment. Bourgois (2009) speaks of the moral economies of drug users and drug dealers as being intertwined with that of the "street economy", where reciprocal interactions surrounding the sharing of drugs and drug supplies were also bound by informal economic transactions situated within alternative income generating activities that were common among homeless substance users. Moral economies are indeed present both in formal and informal communities, where reciprocity is valued at all levels of human interaction, including within family units, peer groups, work places, and non-governmental organizations.

PWAS within AIDS Saskatoon utilize moral economic practices daily. Rules of behaviour within such moral economies very often depend on the context of the given situation, such as whether or not reciprocity is used within familial units or among peers within the agency. Cigarette sharing is one such moral economic practice, where requests for cigarettes are serviced with the expectation that this consumptive good will be returned at a later time of need. Drug sharing, including the sharing of legal substances such as methadone, is not talked about explicitly within the agency or within ear shot of large groups of persons, mainly under the fear that there will be too many requests from people to adequately share, or due to fears of theft. Resource hoarding and sharing, whether such resources are cigarettes, drugs, clothing, alcohol,

illicit drugs, or food, is a common strategy used by PWAS to subsist when income assistance cannot adequately cover basic needs.

Food is one consumptive product that is used in moral economic transactions quite frequently, though there were many situations cited as being less about reciprocity and more about altruism and sharing. PWAS often share food with family members and roommates without citing an expectation of return explicitly, as explained by Jordan during our interview: "I'm living in like, it's like a rooming house. But if somebody is around there and I know they haven't had anything to eat I'll offer them what they can. You know, an extra sandwich ain't gonna break me. Or a bowl of soup." Family also prompted self-sacrifice and altruism in profound ways for PWAS. Sara explained "Like, my grandkids, I always make sure they have something to eat. Yeah, I'll let them eat before me."

Rhonda, an Indigenous elderly woman who did not specify which First Nations group she belonged to, explained her own stress and worry when assisting her daughter with food, housing, and child care:

> And we help each other, me and my daughter. My daughter is having a hard time too. Well, two of them. They have to pay their bills and that. They have to pay their power bill. And I know that welfare isn't helping her. She's on the program and they aren't helping her. She has to pay all her bills with some of her family allowance. She kind of has a hard time buying and keeping up with the food because she has a lot of kids. She has five kids. I was keeping one of them but she wants to go back to her mom now. But I know her mom is struggling right now with food and that.

4.2.2 Alternative Livelihoods and Street Economies

The street economy is used here to specifically refer to marginalized economies and transactions that are often illicit in nature and do not hold an expectation of reciprocity. Street-based economic practices examined within the literature emerge as practices that carry a fair amount of risks as compared to mainstream economies. Gwadz et al (2008) contend that "activities of the 'street economy' are linked to a number of adverse consequences including incarceration, trauma and victimization, HIV infection, and even death" (358). Sex work, drug

dealing, gang involvement, theft, the selling of stolen goods, informal labour, bottle collecting, and panhandling are all examples of alternative income generating activities that can be found within the street economy.

During my interview with PWAS Jordan, he alluded to his own experiences in the street economy of Saskatoon. He began by asking me "And you want to know about some shady stuff?". My interest was peaked, so I replied: "Sure! I want to know everything!" He began to explain:

> I'm on the methadone program. And I know a few other people that need the methadone, and I actually sell a few bottles here and there. Just for, you know…I need the extra money for food. I went through the addiction stuff, you know. But now I need, uh, I'm addicted to food maybe!

I responded by beginning to ask "And that helps you to—", when Jordan finished my sentence with "survive."

Staples (2007) contends that an individual's "search for income, whether in cash or kind, through which they can access resources to sustain themselves and their families, is a significant factor in understanding how people structure their everyday lives and in plotting their movements" (11). Indeed, situating livelihoods at the centre of discourses on survival is a pivotal and needed method of analysis when examining how marginalized persons survive. In the area of public health, anthropologist Bourgois (1998, 2323) calls for a shift toward understanding moral economic transactions and marginalized income generating activities within the context of risk by arguing that "public health researchers need to reconceptualize their psychological behaviorist paradigm of 'individual health risk behavior' because the pragmatics of income-generating strategies and the social symbolic hierarchies of respect, identity, and mutual dependence shape risky behavior". PWAS at AIDS Saskatoon enter into street economies and alternative livelihoods for a number of reasons, most of which are based around notions of dignity, respect, agency, and freedom from governmentality and surveillance. Risk behaviour within the street economy is not inherently individual, but rather is contextualized around moral and alternative economic practices.

The most explicit example of risk at the level of the social, rather than at the level of the individual, came about from my interview with Travis in mid-July of 2018. Travis, a young Cree man in his twenties, had previously been involved in gang activity while searching for a way to generate income to sustain his methamphetamine habit. Travis joined one of the local Indigenous gangs to gain social and financial capital, and described both his meth use and gang involvement as invigorating:

> Only reason why I was into it was because when I was down with (Gang affiliation redacted), I'd smoke a couple bowls and end up feeling really fearless. I didn't give a fuck if I died or not. If you're gonna kill me, then kill me. I guess I had a death wish. […] After getting held hostage at gun point, I was gonna go do something to these guys, but then I said fuck it. I've seen the road. I've seen how people are, I've seen how people be. And honestly, where they're gonna be five years from now…I just thought about it and I thought that my mom wouldn't have been proud of me.

After leaving the gang and attaining sobriety, Travis described the ways in which he balanced both formal and informal income generating activities in order to survive outside of the gang:

> Honestly, I used to sell drugs. That's before…and I've been trying to get myself out of that lifestyle and become a better person. Other ways to make money are hard jobs, going to Labour Ready [employment program], working for my grandparents, and working for people who want their grass mowed.

For Lily, a PWAS in her 40's, sex work and drug dealing had, at various times in her life, offered income and resources that were needed to live securely on the streets. Sex work provided income that could not be tracked by governing bodies. This alternative livelihood also provided a community of other workers with their own moral economic practices. Lily benefitted from inclusion in this informal network in multiple ways, which included increased social connection, financial freedom, and ability to generate her own schedule and time commitments. However, she also contended with increased risks of sexual violence, persecution by police, increased use of substances to maintain emotional resilience, and increased risks of HIV and HCV infection.

Travis and Lily offer important insight into the ways that participation in informal income generating activities within the street economy offered multiple benefits and risks in securing resources such as money and food.

Some months after finishing fieldwork, while giving a guest lecture in an introductory anthropology class, I was surprised to see a familiar face in the audience, another PWAS who had been employed in the formal employment program at AIDS Saskatoon and whom was introduced at the beginning of Chapter 3: Stephen. Stephen had started classes at the university that semester and was, at that time, enrolled in the introductory class that I was lecturing in that morning. After the presentation, we caught up over a cigarette at the university bus station on campus. Stephen relayed to me that he had been let go from the employment program at AIDS Saskatoon for selling his sons medication to pay for food, bills, and illicit substances. Stephen offered an explicit example as to the effect of governmentality and surveillance on the everyday lives of PWAS who are forced to engage in informal economies in order to meet basic needs. Barriers to maintain steady employment and food security for Stephen included active substance dependence, low wages within formal employment positions, and minimal income assistance that did not cover needed expenses for both him and his son.

Alternative subsistence strategies that are not monitored or governed by any outside formal community are preferred as they offer a sense of agency. PWAS gain benefits from these behaviours in a number of ways: 1) Extra income on top of social assistance cannot be taken away or "docked" when such income exceeds the allotted amount allowed to be earned, 2) engagement with alternative livelihood strategies such as gang involvement, drug dealing, and sex work also create a sense of belonging with other members of such communities, where inclusion in such subcultural realms help to foster a sense of identity, 3) extra resources in the form of food or illicit drugs gained through alternative subsistence contributes to an individual's ability to be well, where withdrawal from illicit substance use and hunger are managed, and 4) alternative subsistence offers resistance to governmentality, giving PWAS a strong sense of capacity and ability, allowing them to challenge both societal and personal preconceived notions of vulnerability as a qualifier of self.

4.3 Access to Food as Harm Reduction

4.3.1 Food Security as Identity and Connection

The use of food bank foraging can be considered as part of the daily and weekly geographies of survival for PWAS, where such foodscapes offer a means to subsist, even under heavily controlled environments where choice and agency are limited. However, food acts as more than a consumptive good to fuel the body. PWAS often used food and drink as a way to explore spirituality, a way to define social systems, and as a tool of connection to past memories of home and family outside of AIDS Saskatoon. Access to the daily lunch program at AIDS Saskatoon offers opportunities to build social networks, to reminisce of times past, and to connect with tradition and heritage. Food is often seen as invigorating, life giving, and transformative not only to the body, but to the soul and the mind. Staff member, Michael, shared his own observations on the transformative nature of food:

> They [PWAS] evolve. There're quite a few guys who have come here or have started coming here, and they're dirty. They would not meet my eyes, would not smile and would not talk to anybody. They came in, had their coffee, had their lunch, watched some T.V, went on the computer, did their calls, and they left. They never hung around. But now, those are the guys who help me get the coffee, they help me make the lunch. They're happy. They smile. One's got a job. Just to see the difference in them. On a scale of one to ten when they first came in here, they were a one. They were just alive, but they weren't living. But now to see them smile, to give advice, to joke, and to have homes

In terms of spiritual and cultural identity, most participants do not distinctly express a want or need for the incorporation of traditional Indigenous food into the lunch program. Accordingly, Michael did not recall ever having received requests for traditional foods from any PWAS during his employment with the agency. However, Michael spoke fondly of the times in which the agency incorporated traditional Indigenous foods, with many PWAS expressing a sense of contentment and feelings of connection at having been able to take part. Michael elaborated on one particular holiday in great detail, and with excitement, during our interview together:

> When we used to have a day of the feast…day of the dead…a feast of the dead. It's in November. And you make a pot of soup. The last one I made, I used moose. I had to start it at five in the morning at home. Cause it all has to be prepared that same day. And when the Elder comes in, they know what they're doing. Um, you never throw away food. All the leftovers are given out to everyone at the end. Nothing is thrown away. If you can't eat what you were given, like soup or berries, fruit, bannock, if you can't eat any of that, the rest goes into a little pail and the Elder burns it because it is for whoever has lost somebody. So, it's not just for one person, it's for everybody. And when they came in that day, [the PWAS] were so respectful and so quiet. They spoke in hushed whispers. It was fantastic.

Indigenous Peoples coming from both urban and rural areas around the province gather at AIDS Saskatoon with diverse backgrounds and experiences, some of which run contrary to popular notions of "Aboriginality". Many PWAS have never consumed bush meat, wild food, hunted game, attended Indigenous spiritual ceremonies, or taken part in other cultural milieu often associated with Indigenous identity and identity formation. Cultural programming at AIDS Saskatoon is often the first point of contact for "Indigenous culture" for many of the participants. I was surprised to see a lack of information given to me during interviews related to experiences with Indigenous food sovereignty, connections to home, land, and food, and stories related to nutritional transitions between traditional and colonial western food stuffs. Only one elderly participant spoke fondly of memories of bush foods, fishing, and the dangers of mainstream foods on the body, noting that she regretted not having access to wild foods, but would not eat them anyway due to fears of contamination from environmental pollutants.

Food is almost always invariably linked to memories of home and family, however. PWAS and staff speak of food preparation and the transmission of knowledge related to cooking and eating as contextualized within early experiences of family and familial bonding. Staff member, Kara, explained:

> I mean the silver lining of being food insecure is that I'm very good and making meals last a long time. I'm good at making sure they go a long way. And I learned to cook at a very young age because my mom had to work. So, I was cooking full

> meals by the time I was about eight. At seven, I could do eggs or whatever but by eight I was making soups. I mean, that's a benefit. I come from a big family. We didn't live here, we lived up at Meadow Lake. But, my family in Saskatoon is quite large. We take communal meals very seriously. So, Christmas meals, birthday celebrations, pot lucks. It's definitely been a source of love and safety. One of the ways that I was taught to show love was to cook for people. Making food for birthdays, making food for whatever. It's definitely an act of service to show that you love somebody.

Travis, whose mother profoundly impacted various aspects of his life, including his choice to leave gang life, expressed his appreciation towards his mother within the context of cooking and food: "My mom, I don't know how she did it, but she knew how to cook man. And it was always good. She would whip up stuff with very little. My mom just knew how to make a meal for me and my sisters and my dad and there would still be seconds." When I approached Lily regarding her own experiences with food, family, and shared meals, she explained that her biological family resided too far away to take part in such rituals, and instead she viewed staff and peers at local organizations in Saskatoon as her chosen family: "All these organizations are basically family to me. They are all I have. I don't know what I would do without them."

Food programs can be used to increase feelings of connectedness for marginalized persons by offering a zone of experience and meaning where individuals can interact with peers, family, and the broader community. Data from AIDS Saskatoon are consistent with the findings of Miewald et al., (2017) and other researchers who contend that food programs and the associated social aspects of food security increase resilience for marginalized persons. Additionally, such findings are consistent with Wilson's (2003) concept of the therapeutic space in that the food program of AIDS Saskatoon offers a physical space of healing, social connection, and safety, with food acting as a connecting piece to identity and bonding. Whether seeking to connect via food as a symbol of culture and identity, taking part in cooking classes that increase capacity, or in seeking a shared space to enjoy a meal and connect with other community members, food programs increase conceptualizations of wellness, thereby building positive health effects and minimizing harms related to substance use, homelessness, and chronic and acute diseases. Framing food programming within the context of control and surveillance,

food programming can increase the utilization of certain protective factors that can shield PWAS and other populations from the structurally violent interferences of formal institutional communities.

4.3.2 Food Security as Protection

> When we [staff] see neglect identified as a primary barrier to child caregiving…food security is a big part of that. Social workers come to the house, and they are checking your cupboards, they are checking your fridge. And if you aren't sufficiently stocked on those things, your children can be taken. So, even saying to somebody, 'we will drive you to the food bank every two weeks, we will drive you to the grocery store so you can not be going just to wherever is close, we can work on budgeting'. You know, there's not a lot of emergency food services in Saskatoon, but we have a lot of families that we give options to, like churches that will give out food when needed, different agencies and what they will give out. Food security is a number one transportation that we provide. -Joanne (601 Staff)

Miewald et al. (2017) define harm reduction service providers as those who "operate low-barrier programs […] in order to mitigate the negative health, social, and economic consequences of drug use" while not outright demanding abstinence from the use of illicit and legal drug consumption (587). In the above quote, 601 staff member Joanne describes one such avenue of harm reduction that AIDS Saskatoon provides for PWAS battling potential child apprehension. Food acts as a means of harm reduction in that food becomes a protective factor against the harms that may come with child apprehension which may include mental and emotional distress, social stigma, and increased surveillance and control from outside forces.

The effects of trauma, stress, and emotional and mental instability in the everyday lives of PWAS were pervasive. Survival and subsistence are inherently stressful activities that require a large amount of prioritization, planning, and balancing, where substance dependence and withdrawal can have drastic effects on one's ability to function optimally. Additionally, increased surveillance and control of everyday behaviours adds an extra level of stress and trauma that constrains capacity and self-esteem. Food programs, such as the AIDS Saskatoon lunch program, remove some of the daily stresses cited above. Many PWAS divulge that access

to the lunch program removes the need to worry about locating at least one meal, where energies could instead be placed on other important areas related to everyday survival such as the need to find shelter, care for loved ones, and locate illicit substances to stave off withdrawal.

Almost every participant cited the need for increased nutrition and food to maintain energy and functionality, especially for those with HIV/AIDS and HCV. In this case, food acted as a protective factor against the threat of disease and illness, as explained by Jordan: "Your body needs vitamins and stuff like that just to survive and if you're not eating properly and if you do have Hep C or AIDS or something, your immune system ain't very good. So, if you're not eating healthy. Your body is going to fight itself." Staff member Joanne also explained the role of nutrition at length during our interview together:

> But with HIV, nutrition is a huge part of trying to stay healthy. Having a good diet and access to healthy food is really important. HIV medication, you know, there's side effects. One of the main side effects is the nausea and upset stomach and that sort of thing. So, having access to foods that are going to nourish your body even if you're going to only take in a little bit sometimes, it's something that a lot of people that we work with don't have.

4.3.3 Food Security as Agency and Resistance

While many Indigenous PWAS did not outright request access to traditional foods or discuss Indigenous identity formation as linked to food and food sovereignty at the time of interviews, it should be noted that food can be used a tool in resistance against colonial interference and governmentality for Indigenous populations who may desire it. As an example, Grey & Patel (2014) argue that food sovereignty and increased control over access to traditional foods is a form of decolonization, where current Indigenous struggles over food sovereignty can be viewed as ongoing colonialism in action. Within many Indigenous populations, identity and the gathering and eating of traditional foods are intertwined (Power 2008). The associated practices surrounding the acquisition of food can been seen as acts of resistance against outside colonial intervention in that such activities facilitate cultural assertion, encourage the rejection of an imposed way of life, and motivate autonomy. In addition to Indigenous identity formation, food is often connected to notions of wellness and health, where traditional foodstuffs serve to

reinvigorate and heal the body (Adelson 2000). Food programming that incorporates traditional food acquisition and preparation under the guidance and request of the Indigenous population it serves can increase agency, autonomy, and resistance to colonial interference, thereby increasing capacity and wellness within food insecure Indigenous communities. However, approaching all Indigenous populations with the assumption that access to traditional foods is wanted in all contexts can cater to "pan-Indianism" and homogenized notions of "Aboriginality". This includes assumptions and definitions of "traditional" foods. Bannock, a fried bread often seen as a traditional Indigenous foodstuff, serves as one such example given that it is a dish with Scottish origins. It is important in this instance to treat cultural food interventions under the same umbrella that one should treat marginalization or vulnerability. Population-based interventions can sometimes homogenize large swaths of people in negative and constraining ways. Cultural programming, such as traditional food programs, should, first and foremost, be designed and implemented by the persons it is meant to serve to minimize paternalistic interventions designed by settlers with limited knowledge of the variability of Indigenous cultures.

Food can also be used as a tool of agency and resistance by offering marginalized populations choice and dignity in the food acquisition process. In section 3.2.3, the concepts of choice and dignity were discussed, describing how the mentality of "beggars can't be choosers" can serve to decrease capacity and increase mistrust of service providers. Food programs that offer choice, consistency, and those which provide adequate and lasting basic necessities, have the potential to minimize harms that come about from marginalized subsistence. This approach to food provision should be low-barrier in design, where surveillance-based requirements (such as the presentation of a health card or proof of address or viral status) are minimized as much as possible. AIDS Saskatoon offers an excellent framework by which to examine the negative and positive aspects of food service provision. The agency offers low-barrier points of access for all of its services, meaning that PWAS can benefit from membership in a formal community network without the increased control and surveillance so very common with governmental service providers.

4.4 What Happens When Access to Food is Removed?

4.4.1 The Temporary Closure of AIDS Saskatoon

I arrived at the 601 on the morning of June 18th 2018 to find that it was closed, a sign on the door indicating that it would not be open again until the following Wednesday. At this time, no explanation was given as to the reason for the temporary closure. Upon leaving, I bumped into a familiar, and exasperated, PWAS by the name of Robby. He expressed dismay that the centre was closed and discussed how he wasn't sure how he was going to eat that day. He explained that he had talked to others within the community that morning upon discovery of the sign, and that a large amount of PWAS were panicked that they couldn't get lunch given that many of them had exhausted other avenues of obtaining food. Shortly after this, when heading to my bus stop, I bumped into another PWAS, Brian, on a bicycle a bit further down 33rd street. He asked me why the centre was closed and expressed disappointment, also wondering where he was going to find food. He wondered aloud how he was going to find a place to rest in a safe and secure location, since he was currently homeless and had run out of methadone. I had no answers for him.

The above interactions with PWAS speak to the temporal nature of food security for those who access services in the food desert setting of the 601 area. When PWAS have unfettered access to multiple food services within the community, they do not necessarily conceptualize themselves as food insecure. Yet, the temporary closure of AIDS Saskatoon, which lasted on-and-off for approximately two and a half weeks after the above date, illustrates how feelings of urgency and panic around subsistence become clear when access is removed within a dependent community. As examined in Chapter Three, food security and hunger are thus experienced not as an overarching state of living and being, but rather are understood as fluctuating and dynamic.

The temporary and sporadic closing of the 601 Drop-In Centre from mid-June to early July of 2018 illustrated the precarious nature of food security for PWAS in explicit ways. Protective factors generated from food access were stripped away to create heightened risks of harm, including prolonged hunger, no access to safe shelter for individuals needing a secure environment, and decreased access to necessities and facilities.

On June 26th, I returned again to find another sign on the door, this time indicating that it would be another seven days until 601 services would be available. Standing outside of the Drop-In, I spoke with a group of PWAS who once again reiterated their fears about food

acquisition, with one woman expressing her frustration about not having access to the Wednesday night support group, the absence of which meant that she would be unable to connect with her 601 peers for emotional support. Many of them had no other way of being contacted. After connecting with the executive director and other staff members by telephone later on that week, it was revealed to me that a staff member had taken an abrupt medical leave, meaning that the 601 had no one to guide it during that time. The 601 would open intermittently in the following weeks, but only when staff had the capacity and time to run it. Even the executive director took charge of the kitchen to provide lunch on more than one occasion. By early July, the 601 opened again.

This interruption in services allowed for an in-depth look into the immediate and very real panic that ensued for PWAS when access was removed. The various mornings that I stood outside of the 601 doors, equally as confused as the PWAS around me, I was able to observe both vulnerability and resilience in real-time. I listened as they worked together to generate ideas for alternate places to rest, eat, and obtain shelter. I observed as some sat down in defeat on the concrete steps and lit a cigarette in exasperation. I watched as those with shelter offered others access to their homes for the day. I was an observer to the everyday decision-making processes of PWAS when formal systems fail. They were persons at great risk of instability and yet they also possessed the remarkable capacity to think quickly and move forward in order to keep surviving, resourcefulness being a feature that almost every participant shared. These moments, which occurred more than once over the end of June, were highly emotional in nature. Each day that I arrived at the 601 Drop-In to find that it was closed, I would sit with the PWAS on the steps and share cigarettes, a consumptive good that facilitated trust, and allowed me insight and participation into the community in a small but powerful way.

These chaotic summer weeks also illustrated the immediate need for funding and governmental support for those agencies that strive to serve populations in need of assistance. Despite the best efforts of staff at the agency, the disruption in staffing brought to light the limitations that non-governmental service providers face when governments freeze or decrease funding, or when social services are cut or ignored by various political parties and leaders. AIDS Saskatoon often depends on community donations, fundraising, and government funding to meet the needs of PWAS. Like other service providers, the reporting of indicators is a needed action to maintain funding. AIDS Saskatoon thus faced similar surveillance and the consequences of

governmenality that PWAS experienced in their everyday lives in that the agency also needed to meet certain criteria to continue to offer services to those in need. Both the agency and the people who access services within the agency therefore strived to maintain some functionality in the face of precarity and scarcity, although this was experienced in wholly different ways.

CHAPTER FIVE: CONCLUSION: MOVING FORWARD WITH FOOD SECURITY IN THE HIV CAPITAL OF CANADA

In this thesis, I present the various ways that PWAS at AIDS Saskatoon survive and acquire food in socially and environmentally adverse conditions. Such conditions are considered adverse in that marginalization, stigma, governmentality, and surveillance create structurally violent environments that are intertwined with colonialism and oppression from dominant cultural powers. Challenging a "one size fits all" definition of food security (Hendriks 2015), I argue that PWAS experience varying levels of food security in their lives that are dependent on a number of variables, which includes access to protective factors, time, and community connectedness. The participants within my fieldwork make precise and meticulous decisions regarding the gathering, use, and prioritization of consumptive products such as food and illicit substances, thereby challenging popular notions of powerlessness that are often attributed to persons who use drugs. Their ability to be resilient, resourceful, and exercise choice in their everyday decision-making processes regarding subsistence and survival also runs contrary to this group as being characterized as inherently "vulnerable," since public health definitions of the term tend to devalue and/or ignore capacity and the ability of the marginalized to protect themselves against harm. I also argue that vulnerability, when applied in ways not agreed upon by the group in question, can be used as a form of social control and as an excuse for heightened surveillance that can both simultaneously increase structural harms while also providing heightened, and beneficial, interventions.

The ways in which surveillance and control are used to constrain and enable PWAS is discussed in Chapter 4. Distinguishing between formal and informal networks, it is shown that PWAS often face increased barriers to accessibility when trying to engage with formal networks, where membership is only given when specific behavioural requirements and criteria are followed. Additionally, the very bodies and biologies of PWAS are often profoundly governed and interrogated, especially when attempting to access benefits from governmental assistance programs such as medically needed food subsidies. PWAS are then forced to fill gaps in survival through the participation in more informal economies, which include the utilization of alternative

livelihood strategies such as sex work, gang affiliation, and the selling of both illicit and legal drugs to acquire basic needs such as food and housing.

However, a number of risks and harms do come with the accessing of marginalized subsistence strategies, even as such strategies offer the benefits of freedom, dignity, and respect. Violence, stigma, and persecution from police are only a few such harms discussed. In order to better mitigate such risks, food provider programs can fill gaps in service by offering marginalized groups choice, consistency, dignity, and low barriers to access, rather than barriers to access based on heightened control that are all too common among service providers, such as requirements for sobriety, identification, and requirements for a fixed address. Additionally, increased funding to service providers is needed so that harm reduction principles can be applied optimally and consistently.

The theoretical foundations presented within this thesis, such as the critical interpretive approach, the syndemic approach, and foundations centered on the anthropology of the body, allow for a grounded, critical analysis of the experiences of marginalized groups as related to power relations and structural violence. The metaphor of the social body (Lock & Scheper-Hughes 1987) is used heavily throughout. PWAS are described as "social infectors" to the larger body nation-state in that their very person is seen as contagious both biologically and socially. PWAS use of behavioural "activities out of place" (Goldstein 2004), such as the use of illicit substances and unprotected sex, make them targets for scapegoating based on infection narratives which paint them as dangerous and contaminating. What follows are structural mitigation tactics in the form of public health surveillance and interventions that seek to alleviate the threat of societal contamination. PWAS are then pushed to the periphery of society, both symbolically and physically, as part of such infection control measures.

Given the barriers that the PWAS at AIDS Saskatoon face within society, it becomes important to ask: how do we move forward with food security in the HIV capital of Canada? In Chapter 1, I outline the goals of the current research project, which are as follows: 1) to collect and examine the lived experiences of people who access services (PWAS) at AIDS Saskatoon in order to better elucidate how marginalized persons living with, or at risk of, HIV/AIDS and Hepatitis C engage with food acquisition and how such persons endure everyday life within food insecure environments and 2) to compile information on how PWAS manage their own health and wellness while living with, or being at risk of, chronic and acute viral infections. This

information was sought in order to contribute to current research on food security, HIV/AIDS, and HCV syndemics, and the social determinants of health to inform food programming aimed at alleviating burdens related to food insecurity. The current project achieves this goal in that valuable and in-depth information was gained on the lived experiences of PWAS subsisting in food insecure environments, which were then situated within broader survival tactics used in food acquisition and, more broadly, in everyday survival. At the beginning of this project, I did not expect substance use to present as explicitly as it did, nor did I expect surveillance, control, and the accessing of alternative subsistence strategies to feature so prominently. I argue that this unexpected turn is in line with the goal of the research. Health, wellness, infection, and food security status for this population cannot be adequately discussed without proper engagement with substance use patterns, control, surveillance, housing status, and marginalized subsistence patterns, as these variables are a part of everyday engagement in food insecure environments for PWAS and must also be taken seriously when implementing programming to alleviate burdens.

In Chapter 1, I also ask the following research questions: What meanings do people living with, or affected by, HIV/AIDS and Hepatitis C (HCV) in Saskatoon ascribe to food and eating? What role does food security play in prevailing understandings of well-being among those living with or affected by HIV/AIDS and/or HCV? These questions are significant in that the lived experiences of individuals experiencing food insecurity, the meanings they attach to food and eating, and their own understandings of health and wellness are integral for the formation of informed food programming that also addresses the syndemic pathways of HIV/AIDS and HCV.

The meanings that PWAS attach to food and eating are complex and are contextualized within the broader formal and informal communities in the area of the 601 Drop-In Centre and beyond. In Chapter 3, I describe the gathering and eating of food as a deliberate and systematic process that requires planning, forethought, and agency. Within these food acquisition processes, the meanings PWAS attach to food and eating are intertwined with notions of autonomy and indeed with experiences of withdrawal and substance use. Food is regarded as a basic need that can nourish the body, but more importantly, it is viewed as a consumptive product that requires effort and energy to acquire and consume, and therefore can cause feelings of distress and discouragement when not adequately provided. Embodied experiences of hunger are likened to experiences of withdrawal, where an empty stomach can cause emotional as well as physical

distress. More broadly, food bank foraging is used as way to resist the status of "food insecure" and indeed that of "vulnerability". Food and eating can therefore contribute to the meanings an individual ascribes to personal perceptions of internal resilience and resourcefulness. Resistance to the qualifier of "food insecure" illustrates that PWAS feel a source of pride in obtaining a full fridge or a full stomach, and embarrassment when they are unable to adequately access food products in a given day, week, or month. As vulnerability tends to infer decreased capacity in the populations it is imposed upon, PWAS express their own resistance to this through the sharing of narratives that illustrate their capacity to be creative and resourceful in obtaining food for personal as well as familial use, which includes the use of marginalized subsistence strategies such as the uptake of alternative income generating activities and participation in moral and street-based economies.

Food also plays an integral role in social bonding, the generation of protective factors against harms, and as a harm reduction strategy in social and health programming. For many PWAS and staff, food is described as a connecting piece in the formation of social and familial bonds and that of spiritual identity formation. The meanings attached to food and eating are very much imbedded within familial expressions of love, nurturance, and self-sacrifice, as in the case of prioritizing food over other basic needs such as housing and illicit substances.

The role that food security plays in prevailing understanding of health and wellness among PWAS at AIDS Saskatoon is, perhaps, more explicit. Food often takes a secondary role to the consumption of illicit substances when an individual is faced with impending withdrawal. Here, wellness is understood along a continuum of functionality, meaning that consumptive products hold different values depending on the immediate benefits the good may offer. Long term health hold less importance than immediate embodied experiences of dope sickness since one is perceived as more debilitating than the other. Additionally, general access to food holds more importance than the content and nutritional value of the foodstuff itself. While PWAS differentiate between "good" and "bad" foods as related to the effects that such foods exert on overall health status, financial constraints and lack of choice mean that quantity often takes precedence over quality, especially when providing food to a familial dependent.

The syndemic pathways observed between homelessness, substance dependence, and food insecurity show that HIV/AIDS and HCV *were not the primary aggravating factors on food security status for the participants interviewed*. PWAS and staff mainly regard substance

dependence and homelessness as the primary barriers to obtaining a food secure status. Health and wellness were therefore mainly understood within the context of disruptions to functioning due to housing instability, substance use, and the barriers these two factors exerted on food security status.

The current project contributes to academic scholarship in the following ways. First, the research presented here focuses on both actions and bodies as sites of marginalization, contributing to current knowledge in critical medical anthropology as related to the theoretical foundations of the body and in the critical evaluation of power structures within urban spaces. Bodies are contextualized within macro power structures that inevitably affect food security status, linking notions of vulnerability and responsibilization to the broader framework of the body politic, rather than to individual behaviours alone. Second, the current project shifts away from syndemic models that include HIV/AIDS and HCV as primary factors in food security status. While HIV/AIDS and HCV still contribute to disability, dysfunction, and still explicitly exacerbate food insecurity, the syndemic pathways that perhaps need more attention in Canadian urban food deserts are those that center on homelessness and substance use. The current project thus begins a discussion on the ways in which harms related to substance use, food security, and homelessness can be diminished or dismantled completely. Third, this research offers a critical evaluation of barriers to food security with a focus on the ways in which current food programs can minimize such barriers to access, meaning that the data presented here can be used to inform future programming and in policy formation and public health intervention efforts that seek to use a trauma-informed, harm reduction approach to build capacity and minimize barriers to access.

More directly, AIDS Saskatoon can use this research in applied ways. An evaluation of the income generating and food foraging activities of PWAS was directly requested by the executive director of AIDS Saskatoon in order to better understand how PWAS survive outside of the agency. This information can be used to improve, continue, or modify the current lunch program, can be used in funding requests for the purpose of building a food secure status, and can inform staff within the agency of the viewpoints, worldviews, and actions around food and wellbeing that PWAS carry. AIDS Saskatoon, as an advocate for marginalized persons living with, or at risk of, HIV/AIDS, is an organization that is committed to reducing harms for the people who access services. This research can contribute to their efforts in that it also outlines

the syndemic pathways and institutional governmentality that PWAS face in many aspects of everyday life and in service provision. Outside of food security programming, this data can be used to inform agency practices aimed at advocacy, policy change, activism, and in the dismantling of discriminatory practices. AIDS Saskatoon will receive an executive summary document outlining the results of this research, which they can then disseminate or use in any way they see fit.

To move forward with food security in the HIV "capital" of Canada, further community-based research is needed to gain a holistic understanding of the lived experiences of marginalized persons, with emphasis placed on the political, social, and cultural power constraints that are felt. This thesis outlines the larger macro forces that can impede secure status on the food security spectrum, citing experiences of control and surveillance through service provision as an aggravating factor. Future research should be applied in nature and should build capacity in the populations it endeavours to study, thereby promoting agency, autonomy, and cooperation. The voices of marginalized groups should remain on the forefront of future change, where food security and vulnerability spectrums are designed and informed by the people they are placed upon.

In the undertaking of this thesis, my goal was to engage with both the "anthropology of the dark" and the "anthropology of the good". Examinations of power and the political, structural, and cultural reasons behind oppression must be engaged with in order to better understand the barriers that marginalized groups face within society. However, placing emphasis on the ways in which "vulnerable" groups survive and subsist is to also to acknowledge that such groups have power and agency even amidst such oppressive forces. I believe that this is an important endeavour, as recognition of strength and resilience can potentially shift discourses of suffering toward agentive change, where groups can use their own inherent resilience to dismantle the structurally violent systems that seek to disempower them. Critical anthropological research can partner with such groups in this endeavour, empowering populations such as the PWAS at AIDS Saskatoon through collaboration in community-based projects.

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APPENDIX: INTERVIEW GUIDES

Staff Interview Guide

Hot Meal Program Grand Tour Questions

- How long have you been with the agency?
- Can you describe a typical day at the drop-in centre?
- Can you tell me a bit about the hot-meal lunch program and your experiences with it so far?
    - Is there anything you would change about the hot-meal program?
    - What benefits do you think the hot meal program gives to PWAS?
    - Outside of the hot-meal lunch program, where/how do you think PWAS access food?

Views on Food and Nutrition:

- In your experience, what are some of the most prominent barriers that PWAS face in accessing food?
- Have you ever personally had a problem buying or getting food before?
- Are there any people in your life (coworkers, friends, family, etc) that have impacted your views on food, eating, or cooking?

Views on Health and Wellbeing

- How important is food to the over-all health of PWAS?
- How important is food to your health?
- Are there any people in your life (friends, family coworkers) who have impacted your views on health and/or what it means to be a healthy person?
- Do you think that HIV or Hepatitis C status has an effect on someone's ability to access food?
- Have you noted any changes in the wellbeing of participants taking part in the lunch program?

PWAS Interview Guide

Grand Tour Questions:

- Can you tell me a bit about yourself? (Are you from Saskatoon? Do you live in the area? Where did you grow up?)
- How long have you been accessing services at AIDS Saskatoon?
- How often do you use services at AIDS Saskatoon (including the hot meal lunch program)?
- Could you describe a typical day for you?
- What is your experience so far with the hot-meal lunch program? Do you have a favourite food that is served here? What about a food that you don't like?
- Has eating here helped you in any particular way?
    - (Yes) In what ways has it benefited you?
    - (No) Why don't you think it has been beneficial?
- Do you think the hot-meal program helps others who use it?

- (Yes) In what ways?
- (No) Why not?

Community and Peer Support:

- Do you have any friends in the drop-in centre?
  - Yes-Did you originally meet them here or did you meet them outside of the agency?
- Do you enjoy eating with the people here?
  - Yes-What do you most enjoy about it?
  - No-Why not?
- Is this a space where a lot of people come to socialize and just hang out?
- Have you ever come here on holidays to eat or to see people?
- Have you ever brought family and friends here before to eat?
- Would you say that having connections here at the drop-in centre has helped you in any way?

Poverty and Income

- Are you on income assistance?
- Are there any other ways that you make money?
- How do you get around town?

Experiences with Food and Nutrition

- Apart from the hot-meal lunch program, where, when, and how do you often get your food?
- Do you have to travel far to get your food?
- Have you ever had problems getting food before? Have you ever gone hungry?
- Do you have any friends or family that have had problems getting food before?
- Do you have a place to keep food?
- Do you like to cook? What foods do you find most enjoyable to prepare?
- Do you ever buy/prepare/share food for other people like family members or children?
- Has anyone ever taught you how to cook? Is there anyone in your life that you can think of that has made a big difference in what you eat or cook?

Views on Health and Wellbeing

- How important is food to your health?
- Can you list any foods that you think are particularly "bad" for your body? What about foods that are "good" for the body?
- Was there ever a time when you couldn't get food and not having that food ended up being bad for your health in any way?
- What things do you generally do to stay healthy?
- Do you have any friends or family members who have dealt with being ill?
- Do you think that being sick with HIV or Hep C might keep someone from being able to eat properly? In what ways?
  - In what ways might eating properly *help* with being sick?

- Have you ever used drugs or struggled with addiction?
  - Yes-Did that ever make it hard for you to eat or buy food?

- Do you have any family members or friends that struggle with addiction?
    - Yes-Did that ever make it hard for them to eat or buy food?

- Do you think that being addicted to drugs can keep someone from being able eat properly? In what ways?
    - In what ways might eating properly *help* with addiction?