THE EXPERIENCE OF FOOD INSECURITY FOR RURAL FAMILIES: NURSING PRACTICE AND POLICY IMPLICATIONS

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Abstract

Food insecurity is a problem for almost 1 in 10 Canadians (Tarasuk & Vogt, 2009). There is a growing body of literature citing the negative physiological, social, and emotional consequences of food insecurity, yet little is known about the everyday lived experiences of families with food insecurity. This critical ethnography used semi-structured interviews to explore the experience of food insecurity from the perspective of seven mothers with children in rural Ontario, recruited through convenience and purposeful sampling. Critical theory and critical caring theory informed the qualitative research design and analysis, with attention to broad social, historical, political, and economic influences on food insecurity. Findings describe the great lengths participants went to make ends meet. These findings are framed using the social determinants of health. Influences of the rural environment, community supports, and broader sociopolitical policies on families' food insecurity are discussed, with practice and policy implications for community health nurses.

Dedication

I would like to dedicate this thesis to my devoted husband and two boys, Isaac and Gabriel. I could not have accomplished this without their patience and support throughout the past few years.

Acknowledgments

I gratefully acknowledge the support and guidance of my faculty advisors, Dr. Judith MacDonnell and Dr. Isolde Daiski. They have gently pushed me to learn more, dig deeper, and broaden my understanding of this important topic and how it is situated in the broader context of poverty and the social determinants of health. Their expertise has been invaluable, and their patience appreciated.

I would also like to thank the participants who were willing to open up their homes and share with me some of their intimate stories and experiences. The honesty of participants was heartwarming and their strength and perseverance admirable.

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Chapter 1

Introduction

Canada is often perceived to be a successful welfare state with a strong record on human rights and formal commitments to international declarations that recognize the right to food (Rideout, Riches, Ostry, Buckingham, & MacRae, 2007). A natural extension of this view might assume that reasonable access to sufficient, safe, and healthy food is common to all Canadians. Yet, increasingly Canadians are accessing food banks (Food Banks Canada, 2012) (See Glossary – Appendix A) and a disproportionate number of families with children experience food insecurity (Health Canada, a, n.d.) (See Glossary – Appendix A). With significant implications for the physiological, social, and emotional health of individuals and families (Alaimo, Olson & Frongilo, 2001; Vozoris & Tarasuk, 2003), and little known about the everyday experiences of families living with food insecurity, food insecurity is a topic that deserves attention within nursing practice and literature.

Although there are different ways to define food insecurity, the World Food Summit (1996) identified food security as existing "when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life" (World Food Summit Plan of Action section, para. 1). In contrast, food insecurity describes the experience of having inadequate access to sufficient, safe and nutritious food, and will be the definition used throughout this study (Food and Agriculture Organization of the United Nations [FAO], 2003).

In this thesis, I will address the experience of food insecurity from the perspective of rural families in Canada, and how this insight can inform public health policy and nursing practice. The rationale for a study about food insecurity in Canada will be described, followed by what is currently known about this phenomenon from various disciplines based on a review of the literature. The methodology section will describe the process undertaken to gather and analyze in-depth qualitative data from families, as well as the theories and frameworks that served to guide my procedures and interpretations of

the findings. I will then identify the themes that emerged within the results section, and go on to discuss how these findings relate to the literature and the implications for nursing practice, policy, and research.

Rationale for Study of Food Insecurity

As a registered nurse with a background in public health, a long time rural resident, and a nutrition conscious mother, I have a personal interest in the issue of food insecurity. I have witnessed the challenges in my personal and professional life that families face in trying to make ends meet on a low income (See Glossary – Appendix A), and the difficulties involved in accessing healthy, local, and affordable foods in the rural environment. While most Canadians are aware of the problems with the high prices of food in northern and remote communities, and the issues of poverty and malnutrition in the developing world, I believe that many do not recognize the day-to-day challenges that families in our own neighbourhoods face in making ends meet and feeding their families. This is a story that I feel needs to be told.

When reviewing the literature on food insecurity, I was able to find research from various disciplines and perspectives, although very little about the experience of living with food insecurity. There was also limited research from a nursing perspective, or specific to food insecurity in rural Canada. Yet I am keenly aware of the challenges of making ends meet in rural communities, and the need for nurses to help address this problem in order to be effective in our practice with individuals, families and communities. While working as a Public Health Nurse, it was frequently brought to my attention that healthy foods are less affordable. This was further exacerbated by the distance that some families had to travel to get to a grocery store. When a local grocery store was present, the prices were higher than in larger centres with discount grocery stores. These were problems families often felt helpless to address.

On a personal level, I became aware of these challenges as a rural teenager and young adult concerned about issues of social justice. I volunteered with our local food bank, and more recently I volunteered in a community garden that delivered fresh produce to that same food bank each week. I also have experience with food insecurity

through a close family member, who was raised as the child of a single parent receiving social assistance that was inadequate to meet the family's needs. This has provided some intimate knowledge about the experience of living with poverty and food insecurity.

In choosing the topic of food insecurity, I first explored the overlap between childhood obesity and poverty. This early process of choosing and refining my thesis topic was likely influenced by the predominance of media and scholarly attention to the growing "epidemic" of childhood overweight and obesity (Public Health Agency of Canada [PHAC], 2012a), combined with my personal understanding of the effects of poverty on one's ability to afford a healthy lifestyle. Gradually I came to see the overemphasis in the literature on lifestyle factors and the need to incorporate a broader understanding of food insecurity, which led me to choose a critical approach to this study. I also recognized the gap in literature on the topic of food insecurity, especially within rural Canada. By virtue of my place within a rural community and my interest in gaining an insider's view of what it is like to live with food insecurity, I felt critical ethnography was a fitting research method to explore the everyday experience of rural families with food insecurity as I aimed to help fill a gap within the nursing literature.

Nurses' Role in Food Insecurity

In conducting a literature review on food insecurity and nursing, I found very few research studies specifically addressing food insecurity issues within North America and nursing practice. Despite this dearth of nursing research, the Canadian Nurses Association (CNA) (2005) and Registered Nurses Association of Ontario (RNAO) (2010) acknowledge the importance of addressing the social determinants of health, including food insecurity, in nursing practice.

With statistics that suggest almost 1 in 10 families have struggled with food insecurity within the past 12 months (Tarasuk & Vogt, 2009), it is clear that nurses in all areas of practice will encounter individuals, families, and communities that have insufficient access or ability to acquire healthy foods. Yet without adequate knowledge of this phenomenon or with limited nursing literature to guide our practice, nurses may find their confidence in addressing food insecurity with clients and communities lacking. In

addition, some of the social determinants of health vary based on geographic location within Canada (Canadian Institute for Health Information [CIHI], 2006), and an appreciation for how these determinants influence food insecurity in rural settings is necessary to inform our practice. By exploring the experience of food insecurity among rural families, this study will help to fill a gap in the literature and provide direction for community health nurses as they intervene where social, economic, and political aspects of the environment affect health (Stevens & Hall, 1992).

Research Question and Study Aims

This Master of Science in Nursing thesis will address the following research question: What is the experience of food insecurity for rural, low income families in Southern Ontario? The study design is a qualitative, exploratory, critical ethnography which aimed to 1) explore the experience of food insecurity from the perspective of low income, rural families, 2) give voice to low income, rural families regarding everyday challenges of feeding their family, 3) examine the broader context surrounding food insecurity and the external influences on families' experience, and to 4) contribute to knowledge that, when disseminated amongst community stakeholders and health professionals, can inform policy and program development. The social determinants of health framework and the theoretical underpinnings of critical theories and critical caring theory, influenced by postmodernist thought, will inform this study.

Within the next section, I will review the literature on food insecurity from various disciplines and provide a summary of what is currently known about this phenomenon, and where knowledge is lacking. This will further support the need for a qualitative examination of the experience of food insecurity among rural families in Canada.

Chapter 2

Literature Review

As I began to engage with the literature on food insecurity, it became clear that there was very little research on the experience of living with food insecurity or the rural context of food insecurity within the nursing literature. The database I used most frequently was CINAHL, a database of nursing and allied health journals. Search terms included both food security and food insecurity, combined with several other terms like nursing, experience, family, children, poverty, resilience, community, stress, depression, outcomes, gender, and social capital. The Pubmed database was also used to search for biomedical literature, and the reference lists from relevant articles were reviewed as a strategy to find additional sources. For information about the social determinants of health and nursing, local statistics and food security initiatives, and key nursing organizations' roles and positions on the social determinants of health, Internet searches were conducted.

Several studies were found on the topic of food insecurity, conducted predominantly by dieticians and public health researchers using quantitative methods. Additionally, I reviewed research by social workers, medical doctors, sociologists, anthropologists, epidemiologists, geographers, and nurses, conducted using an assortment of methodologies. Much of the literature on food insecurity began to appear after 1995, when the United States government began measuring food insecurity in its annual population survey (Rose, 2010). The research focused mainly in two directions: instrumentation, to improve documentation of food insecurity among diverse populations; and consequences of food insecurity, particularly examining the associations between food insecurity and various health and social outcomes (Rose, 2010). More recently, the literature has focused on neighbourhood food environment, primarily by those with expertise in geographic information system techniques, and the link between food insecurity and obesity (Rose, 2010). Within Canada, the literature has predominantly been from a nutrition perspective in and around large urban centres like Quebec City (Drouin, Hamelin, & Ouellet, 2009; Hamelin, Beaudry, & Habicht, 2002), Vancouver (Broughton,

Janssen, Hertzman, Innis, & Frankish, 2006), and Toronto (Engler-Stringer & Berenbaum, 2007; Kirkpatrick & Tarasuk, 2009; Kirkpatrick & Tarasuk, 2010; Tarasuk & Eakin, 2003). While some of the research has occurred within the field of public health, there is very little literature written by nurses.

The geographic setting of the research was not part of the literature review criteria, however the majority of studies identified were conducted within North America. Some of the studies I will cite within this review involved samples from New Zealand (Carter, Kruse, Blakely, & Collings, 2011), Australia (Wicks, Trevena, & Quine, 2006) and the United Kingdom (Canvin, Marttila, Burstrom, & Whitehead, 2009). There were additional studies found about predictors and interventions related to food insecurity in Australia, the experience of food insecurity in Bangladesh, and several studies about food insecurity in other developing nations. These were omitted from the review of the literature and the study analysis, as it was deemed that predictors of food insecurity in Australia may be less relevant to the current study than the predictors identified from studies within North America. I also assumed that the experience of food insecurity in developing nations would reflect vast socioeconomic and cultural differences that would make this research less relevant to the analysis of my sample when compared to the studies conducted within the United States and Canada. The research reviewed in this section is therefore focused primarily within North America.

Within Canada, the term food insecurity is often used in relation to Aboriginal populations, primarily in the northern territories and in remote communities where reduced access to food increases the risk of food insecurity (Dietitians of Canada, 2007). There is no standard definition of a remote community, although the Rural and Northern Health Care Panel (Ministry of Health and Long-Term Care, 2010) suggested that typically remote means a community without year-round road access, or one which relies on a third party, like trains, airplanes, or ferries, for transportation to a larger centre. These challenges unique to northern and remote communities are an important aspect of the food security picture within Canada, although do not necessarily represent the same kinds of challenges experienced within this sample from Southern Ontario and therefore

the literature on remote and northern regions is not a part of this review. The literature focusing on Aboriginal issues of food insecurity were also omitted from this review due to cultural, historical, and socioeconomic factors that are unique to the Aboriginal populations and beyond the scope of this study.

The following review of the literature will provide insight into what is known about food insecurity with respect to its inclusion as a social determinant of health, the nursing literature on the subject, the experience of living with food insecurity, the factors that lead to food insecurity, the consequences of food insecurity, and strategies employed to manage when faced with reduced access to food. First, some background information regarding the origin of the term food security and the Canadian response to food security will be reviewed.

Recognizing Food Insecurity and the Development of Food Banks

According to the Food and Agriculture Organization (FAO) of the United Nations (2003), the concept of food security originated in the 1970s and was focused primarily on food supply problems of famine and hunger within an international context. In the 1980s and 1990s, the FAO expanded their definitions of food security to incorporate individual and family level food access, food safety, and nutritional quality (FAO, 2003). Despite broadening the discourse around food insecurity, with 870 million people chronically undernourished in the world, the international focus has often been on developing countries and the need for economic and agricultural growth accompanied by good governance and social protection (FAO, 2012). Food insecurity has proven more prevalent and lethal in the developing world than in affluent western nations such as Canada (McIntyre, 2003), yet the concept of food insecurity in Canada has transformed along a similar path to that described from a global perspective.

Within Canada, hunger and malnutrition were historically recognized as products of drought, depression, and war (McIntyre, 2003). In the 1980s, at the same time that the language around food security was emerging in the international realm, an appreciation was beginning to develop for the deprivation that existed within Canadian communities (McIntyre, 2003). McIntyre (2003) described an increase in food insecurity as one

example of the growing poverty and inequity among Canadians, further entrenched by the restructuring of social programs and cutbacks of the 1990s.

With community members increasingly recognizing the hungry in their midst, the response was the development of community-based, ad-hoc food assistance programs (Tarasuk, 2005). The development of these charitable "food banks" steadily increased during the 1980s and 1990s to meet the need of a growing number of food insecure Canadians, their use deemed a temporary solution to the recession of the 1980s and the government cuts to social programs of the 1990s (McIntyre, 2003). Food Banks, and "food drives" to solicit donations, gradually became a routine part of Canadian life (Tarasuk, 2001). In March of 2012, Food Bank usage statistics showed that 882,188 individuals (2.5% of the population) were assisted by food banks that month, the highest level of food bank use on record (Food Banks Canada, 2012).

Despite the proliferation of food banks in Canada, their highly public activity, and the growing public awareness and concern for those who do not have enough to eat, hunger and food insecurity persist (McIntyre, 2003). The first Canadian national survey included questions on food security in 1994, followed by larger national population surveys that assessed indicators of food security, including: worry about having enough food to eat, compromise in diet quality or variety, and not having enough to eat (Tarasuk, 2005). It soon became evident that food bank usage statistics, serving less than 3% of the population (Food Banks Canada, 2012), were a gross underestimate of the prevalence of food insecurity (Tarasuk, 2005).

The 2004 Canadian Community Health Survey (CCHS) identified 9.2% of the Canadian population as food insecure, believed to be an underestimate because the survey did not include the territories, on-reserve First Nations people, or homeless people, all of whom experience high levels of food insecurity (Tarasuk & Vogt, 2009). The most recent statistics available from the CCHS 2007/2008 showed that 7.7% of Canadian households were food insecure (Health Canada, a, n.d.), and in 2009/2010 that 8.5% of Ontarians were food insecure, although neither set of data is directly comparable to the CCHS data from 2004 due to changes in methodology (Health Canada, b, n.d.). These self-report

survey statistics demonstrate that an alarming number of Canadians are struggling with "insufficient or inadequate food access, availability and utilization due to limited financial resources, and the compromised eating patterns and food consumption that may result" (Health Canada, 2007, The Household Food Security Survey Module, para. 2).

Public and Media Attention to Food Insecurity

In addition to the statistics demonstrating that food insecurity is a significant problem in Canada, there has been recent attention paid in the North American entertainment media to issues of poverty and food insecurity. One example of the media shining a light on this issue is Sesame Street's new character Lily, who shared her experience of hunger and not knowing where her next meal was coming from (Adamjee & Martinez, 2011). Further public awareness has been raised with the Occupy Wall Street movement, in which food justice activists (See Glossary - Appendix A) joined forces with those concerned about wealth disparities and excessive corporate power within North America (Chrisman, 2011). More recently, the Idle No More movement, in which Indigenous peoples and many grassroots organizations from across Canada protested against the perceived federal government's policies of oppression, has highlighted issues of food insecurity. Food Secure Canada (2012), a national network of individuals and organizations addressing issues of hunger and sustainable food systems, stood proudly with the Idle No More movement to express their concern about the "outrageously high rates of hunger and rampant diet-related chronic diseases" among Indigenous peoples (Food Secure Canada, para 2). In the face of this public acknowledgement of food insecurity, the problem persists.

Given the basic human need for food among all peoples, and the impact of food insecurity on human dignity and health, I will next review the literature about food insecurity as one of the social determinants of health (Mikkonen & Raphael, 2010).

Social Determinants of Health

A traditional health sciences approach tends to view sources of health and illness as related to individual behaviours and dispositions, and many health professionals work within a discourse of individualism, in which responsibility for health falls on an individual alone (Raphael, Curry-Stevens, & Bryant, 2008). Further perceived

responsibility for ill health may fall to genetic susceptibility; yet the common causes of disease come and go much more quickly than the slow pace of genetic change (World Health Organization [WHO], 2003). The Commission on Social Determinants of Health (WHO, 2008) suggested that a high burden of illness can be largely attributed to the conditions in which people are "born, grow, live, work, and age" (p. 1), with political, social, and economic forces accounting for health inequities both between and within countries. A social gradient exists, in which the lower one's socioeconomic position, the higher the risk for ill health; these inequalities occur in countries of all levels of income (WHO, 2008).

Within Canada, income disparities have increased in the past 20 years, with only the wealthiest 20% of Canadians gaining in the share of the national income and the top 1% or "super-rich" making phenomenal gains (Conference Board of Canada, 2011). At the same time, one in seven or 15.1% of Canadian children lived in poverty (Conference Board of Canada, 2009). The relationship between income inequity and population health is complex, and the mechanisms that relate inequities to health have yet to be satisfactorily explained with theories (Falk-Rafael, 2005a). Mikkonen and Raphael (2010) suggested that the social determinants of health are stronger predictors of health than behaviours such as diet, physical activity, smoking, and alcohol use, and the Chief Public Health Officer of Canada stated that improvements in any of the social determinants of health can lead to improvements in health behaviours and outcomes at the individual, group, or population level (PHAC, 2012b). Bryant, Raphael, Schrecker, and Labonte (2011) argued that having already implemented universal public health insurance, the social determinants of health and their unequal distribution are the next frontier in Canada for reducing health inequalities.

The social determinants of health include Aboriginal status, early life, disability, education, health services, race, employment and working conditions, food insecurity, gender, housing, income, unemployment and job security, social exclusion, and social safety net (Mikkonen & Raphael, 2010). Although food insecurity itself is identified as one of the social determinants of health, all social determinants are inexorably linked to

the others. For instance, if a family had a secure income and affordable housing, there would be more money left for purchasing sufficient food.

In addition to the social determinants of health, it is clear that many of the socioeconomic conditions associated with rural living in Canada confer health disadvantages (Canadian Institute for Health Information [CIHI], 2006). Romanow, in conducting an inquiry into the future of Canada's health care system, suggested that geography should be considered a determinant of health (Romanow, 2002), while the Rural Poverty Discussion Paper (Agriculture & Agri-Food Canada, 2009) identified similarities between the social determinants of health and the determinants of poverty, which were significantly affected by urban versus rural residency. In conducting this study on food insecurity, it was important to appreciate the broader context and other existing challenges related to the social determinants of health and the rural environment, especially considering that food insecurity is almost always caused by a lack of economic resources (Mikkonen & Raphael, 2010).

Food Insecurity Within the Nursing Literature

Health inequities, the social determinants of health, and social justice have been identified as important components of nursing practice within the field of public and community health nursing (CPHA, 2010). The standards of practice that guide community health nurses emphasize the role of nurses in advocating for healthy public policies that influence health determinants (Community Health Nurses Association of Canada [CHNAC], 2008), and the CNA (2005) suggested nurses have an important role in addressing the social determinants of health, including food insecurity. The RNAO's (2010) document entitled "Creating Vital Communities: RNAO's Challenge to Ontario's Political Parties" identified their vision for a poverty free Ontario with food security identified as a fundamental human right. These documents serve to guide nurses in their practice toward addressing the social determinants of health, with an emphasis on the need to shift people's prevailing thinking about health beyond the current biomedical focus, and to challenge some of the ideas in our society about poverty, equity, and social justice (CNA, 2005).

Within the literature about rural nursing, Jackman, Myrick, and Yonge (2010) suggested that rural nurses who are a part of the rural population have an opportunity to understand and advocate for the social and economic needs of their communities (Jackman et al., 2010). Mills, Birks, and Hegney (2009) argued that based on the World Health Organization's report on the social determinants of health released in 2008, the role of rural nurses must shift toward the tenets of primary health care (See Glossary – Appendix A). Primary health care emphasizes a balance between health promotion, disease prevention, and curative interventions across the range of social determinants (WHO, 2008). Similarly, MacLeod, Browne, and Leipert (1998) suggested that the care rural nurses provide must demonstrate knowledge of the social determinants of health that influence their unique rural or remote populations, with a role for nurses to go beyond the limited goals of treatment to engage in broader policy-making initiatives with a focus on health promotion and disease prevention.

Despite the suggestion within the literature and among nurses' professional associations that nurses address food insecurity as a social determinant of health, there is a limited amount of nursing research to guide this practice. My literature search required several steps, beginning with key word searches in the scholarly literature databases and gradually expanded as I returned several times to revise my search terms. When using the key search terms of "food security" or "food insecurity", I found three studies that were either conducted by nurses or specific to nursing practice. The first was a qualitative study by Stevens (2010) that explored the experience of food insecurity of 21 young mothers, aged 16-24, in Washington State, USA. The findings of this study summarized the contributing factors for food insecurity (income, affordable food sources, housing, and transportation) and the strategies employed by participants to prevent food insecurity. This study was written from the perspective of a nurse, with implications for nursing practice focused on the need to assess food insecurity and its contributing factors as part of routine nutritional counseling for young mothers. There was no discussion of policy implications (Stevens, 2010).

A second study from a nursing perspective reviewed the literature on food insecurity and its impact on global health policy and nursing practice (Kregg-Byers & Schlenk, 2010). Kregg-Byers and Schlenk described food insecurity in developed and developing countries, the history of food insecurity, and the potential role of nurses from a clinical perspective regarding assessment, screening, education, and program development. Within this literature review, Kregg-Byers and Schlenk briefly suggested that nurses become involved in political advocacy involving food policy and law, however there was little emphasis on the role of nurses regarding the broader social determinants of health or how nurses can address food insecurity with individuals, families, or communities.

A final research study involving nursing was conducted by dietitians using quantitative methods to identify that less than one third of Ohio nurse practitioners (NPs) felt knowledgeable about the topic of food security (Tscholl & Holben, 2006). The authors speculated that this may have been because NPs were not familiar with the term food insecurity, or that their education or training was limited in this area of nutrition. While nurses did not conduct this research, the study's focus on NPs gives insight into the possible gap that exists in knowledge among the broader community of nurses on the topic of food insecurity.

Given that food insecurity has been formally measured in national surveys within Canada for almost 20 years (Tarasuk, 2005) and written about within the nutrition journals for just as long (Campbell, 1991; Kendall, Olson, & Frongillo, 1995), it was surprising to see so little nursing research and limited knowledge among a sample of advanced practice nurses on this topic (Tscholl & Holben, 2006). Despite the limited number of nursing studies found that were specifically addressing food insecurity, it became apparent that the phenomenon of food insecurity might be taken up differently as one aspect within the broader context of poverty. This notion is supported with a study by Pilkington et al. (2010), in which food insecurity was identified as one of a range of challenges to maintaining a diabetic diet among low income individuals with type II diabetes. The term food insecurity was used by Pilkington et al., however it was not one

of the authors' key words, and did not appear in the original search of the CINAHL database. In expanding the search terms used to include key words of "hunger", "access to food", and "child poverty", some additional literature was found with a focus on poverty and specific health conditions. This literature identified food access or diet quality as one of the influences within the larger phenomena of interest like obesity (Ward, 2008; Zenk, Schulz, & Odoms-Young, 2009), child nutrition (Kelly & Patterson, 2008), and homelessness (Kelly, 2001). It is possible that further research has been conducted addressing some of the key concepts related to food insecurity, but that food insecurity itself is not highly visible within this nursing literature as it was not the focus of the studies.

Further exploration of the history of food insecurity and when the topic began to appear within the nursing discourse and curriculum is beyond the scope of this thesis. However, it is likely that nurses are familiar with the concepts related to food insecurity from nurses' everyday work on the ground with individuals and families experiencing poverty (RNAO, 2010).

Nurses' Involvement in Poverty and Food Related Initiatives

While a focus on food insecurity specifically has been limited within the field of nursing research, nurses have engaged in initiatives addressing poverty and health inequities throughout history (CNA, 2000). Early examples of nursing leadership in the care of impoverished and vulnerable populations include Florence Nightingale's recognition of the broad determinants of health, and Lillian Wald's fight to abolish child labour and bring health care to the poor (Hardill, 2006). More recently, street nurse Cathy Crowe has gained recognition for her advocacy on behalf of the homeless in Toronto (Crowe, n.d.), and nurses have expanded the boundaries of health promotion and harm reduction through support to highly marginalized individuals with addictions within the first ever North American supervised injection site in Vancouver's downtown east side (British Columbia Nurses' Union, 2011; Lightfoot et al., 2009).

Organizations like the RNAO have supported and provided a platform for nurses' involvement in political advocacy on issues of poverty, issuing calls to action to the

Ontario government to implement a poverty reduction strategy (RNAO, 2008) and making recommendations for poverty reduction to all political parties as the next provincial election approaches (RNAO, 2013). These documents make reference to the difficulties families in poverty experience in affording basic necessities like food. Within the RNAO's publication, *RN Journal*, nurses' concerns about the high rate of child poverty in Canada have been discussed with brief reference to hunger (Kearsey, 2005), and another article described the on-the-ground response of nurses who joined an anti-poverty rally to encourage Ontario's provincial government to "put food on the table" (Egger & Innis, 2006). The RNAO, CNA, and Canadian Federation of Nurses Unions are all supporters of the Dignity for All campaign to "build a poverty-free and more socially secure Canada" (Dignity for All, n.d., para 2).

While nurses and nursing organizations work to alleviate food insecurity among vulnerable individuals, families, and communities, they have little peer reviewed research to guide this practice or shed light on the everyday experiences of these families. There is also literature suggesting that not all nurses feel capable or well supported in their role addressing the social determinants of health or as sociopolitical activists (Cohen & McKay, 2010; Falk-Rafael, 2005a).

Nurses' role as sociopolitical activists. While nurses on the front lines see the impact of the social determinants of health every day, the CNA (2005) suggested that they often feel helpless to deal with them. A study by Cohen and McKay (2010) elaborated on this feeling of powerlessness when the authors explored the perspectives of Public Health Nurses (PHN) about their roles in addressing child and family poverty within a large urban Canadian city. The authors found that nurses identified a gap between how they envisioned their potential role, involving political activism, community advocacy, and community capacity building, with what their current or actual role entailed. Some of the barriers to nurses fulfilling their potential role included perceived erosion of the PHN role, organizational culture and management structure, and lack of resources (Cohen & McKay, 2010).

Despite the barriers to sociopolitical activism identified by Cohen and McKay (2010), nurses recognize the importance of addressing the social determinants of health, have been working at the individual and organizational level to address these determinants as discussed above, and many consider the need to advocate for healthy public policy a moral obligation (Kearsey, 2005). In providing further support to nurses who are engaging in political activism, Falk-Rafael (2005a) suggested that research should be conducted with socially excluded groups to help translate knowledge of the social determinants of health into practice. This thesis sought to do just that, by providing a glimpse into the everyday experience of living with food insecurity among rural families, and identifying practice implications for community health nurses working with socially excluded groups.

Literature on the Experience of Food Insecurity

A small number of studies have examined the everyday experiences of living with food insecurity from the disciplines of nutrition and public health. Three of these studies were conducted within Canada. The first was a qualitative study by Hamelin et al. (2002), who explored how food insecurity manifested itself from the perspective of people in low income households of Quebec City. The authors' findings distinguished between the core characteristics of the experience of food insecurity, including the lack of food and the related state of alienation, and the family reactions to food insecurity, identified as "socio-familial perturbations", hunger and physical impairment, and psychological suffering. Hamelin et al. provided a rich description of the experience and coping strategies to deal with food insecurity in the sample of 98 urban and rural households, and based on my review of the literature, this is the only Canadian qualitative research study that has investigated specifically the everyday experience of living with food insecurity.

A second study by Tarasuk and Beaton (1999) used mixed methods to explore the experience of food insecurity within the context of using food banks in Toronto, Ontario, and how the participants' sociodemographic variables related to food insecurity. Many of the 153 women participants described their first experiences of attending a food bank as

shameful, followed by gradual acceptance of food banks as a necessary part of life. Even among those who described having accepted their ongoing need for food bank support, there remained a social stigma that was apparent by many participants' attempts to hide food bank use from their children (Tarasuk & Beaton, 1999).

The final qualitative study within Canada about food insecurity was related to participants' experiences with collective kitchens in Toronto, Saskatoon, and Montreal (Engler-Stringer & Berenbaum, 2007). The authors' findings provided insight into the increased sense of dignity felt among some participants when using a collective kitchen, in which pooling of resources and labour produced large quantities of food for participants to take home (See Glossary - Appendix A). When compared with using food banks, the participants described a positive impact that accessing the collective kitchen had on their management of resources, and some participants felt a reduced anxiety associated with their food insecurity (Engler-Stringer & Berenbaum, 2007).

Within the United States, three qualitative studies sought to understand the experience of food insecurity from the perspective of African American women (Chilton & Booth, 2007), rural and urban Oregonians (De Marco et al., 2009), and food pantry (See Glossary – Appendix A) users in Washington State (Hoisington et al., 2002). These studies provided insight about the challenges of considering nutritional adequacy when the family is hungry, parental concerns about child and adolescent eating patterns, juggling demands to find time for healthy meal preparation (Hoisington et al., 2002), the desire to work and provide for their families (De Marco et al., 2009), and the experience of hunger as a psychological experience in addition to a physical one (Chilton & Booth, 2007).

An additional qualitative study on the experience of food insecurity was conducted with 11-16 year old children in the United States, to understand the children's perspectives on food insecurity and the potential impact on their health and quality of life (Connell, Lofton, Yadrick, & Rehner, 2005). The results suggested that children adopt similar strategies to manage low food supplies as adults, with rural children in particular reported to eat less when food is low. Many children attempted to shield younger siblings

from their food insecurity, and most reported some degree of psychological impact, including feelings of anxiety or shame and concerns about being labeled as poor (Connell et al., 2005).

Gender and Food Insecurity

As one of the social determinants of health, gender impacts the experience of food insecurity through role expectations within the family and the socioeconomic characteristics of rural women. Given the discourses about traditional women's work and role within the family, it is possible that feeding the family, care of the children, and the burden of food insecurity may fall more heavily on women (Martin & Lippert, 2012). It is common for mothers to skip meals so that children have enough to eat, identified in several studies (Stevens, 2010; McIntyre, Walsh, & Connor, 2001; Hamelin et al., 2002; Hoisington et al., 2002). One study has also demonstrated that women suffer more frequently from psychological distress connected to their food insecurity than men (Carter et al., 2011).

A review of the literature on food insecurity and obesity by Larson and Story (2011) found an association among women and weight status, in which women were more likely to be obese if they experienced food insecurity. The findings were inconsistent among children and men (Larson & Story, 2011). A study by Martin and Lippert (2012) investigated these gender differences in obesity associated with food insecurity, and found there was a significant difference in weight status among mothers when compared to other adults. The authors concluded that mothers adopted unhealthy strategies, such as skipping meals, or eating less or later in the day, to protect their children from the threats associated with food insecurity. This led to higher rates of overweight and obesity, when compared to food insecure men and food insecure women without children. Martin and Lippert (2012) proposed that the gendered expectation that women are responsible for feeding the family is the mechanism for this association.

While a review of the literature found no additional research about how gender affects the experience of food insecurity, it is possible that gender contributes in ways beyond the physiological responses of weight gain and psychological distress. The

income gap between men and women in Canada, while narrowing in recent decades, remains significant with men earning an average of 19% more than women (Conference Board of Canada, 2013). There are also more hours spent by women than men on domestic work like cooking, cleaning, and caring for family (Organization for Economic Cooperation and Development [OECD], n.d.), which may leave women carrying a heavier burden with respect to the family's food insecurity.

Factors Leading to Food Insecurity

With limited research about what it is like to live with food insecurity, a review of the literature revealed several studies identifying factors associated with food insecurity, including individual level factors and those related to the social determinants of health. Among low income families in Vancouver, some of the factors that increased food insecurity risk were having less equipped kitchen facilities and lower self-rated cooking skills (Broughton, Janssen, Hertzman, Innis, & Frankish, 2006). A study by Hanson and Olson (2012) identified participants with a chronic health condition of two years or more and with lasting risk for depression as significantly more likely to experience food insecurity.

In addition to individual risk factors, social determinants of health impact the likelihood of experiencing food insecurity. Adequacy of household income is by far the strongest predictor of food security (Kirkpatrick & Tarasuk, 2010; Tarasuk, 2005), and several studies have demonstrated that when income declines, food quantity and quality decline as other necessities like rent and utilities take precedence (Partyka, Whiting, Grunerud, Archibald, & Quennell, 2010; De Marco, Thorburn, & Kue, 2009). Many households are living precariously on the brink of food insecurity, with factors that could tip a family into a state of hunger including the addition of another mouth to feed, a job loss, or health problems (McIntyre, 2003). A study by McIntyre (2003) showed the sole avenue to get a family out of hunger within a sample of low income mothers in Atlantic Canada was the increased income of the mother securing full-time work. Other characteristics that predicted food insecurity included single parenthood, higher number of children in the household, and income from social assistance (McIntyre, 2003), while

the proportion of income spent on rent, rent in arrears, and borrowing money for rent, has also been associated with food insecurity in Canada (Kirkpatrick & Tarasuk, 2011).

Within Ontario, an analysis of socio-demographic factors associated with food insecurity showed that the highest prevalence of food insecurity occurred in families on social assistance, including both Ontario Works (OW) and the Ontario Disability Support Program (ODSP) (Tarasuk & Vogt, 2009). Sixty one percent of households on social assistance experienced food insecurity, compared to 6.5% of those receiving salaries and wages, and 5% of those receiving pensions or seniors' benefits (Tarasuk & Vogt, 2009).

From a broad, community level perspective, the Ontario Public Health Association (OPHA) (2002) suggested that the systemic aspects of food supply, rather than simply individual food choices and intake, are the driving forces behind food secure communities. These systemic factors include "the security, safety, accessibility, affordability, acceptability and nutritional value of the food supply itself" (OPHA, 2002, p. 10). The concept of community food security was based on the Ottawa Charter for Health Promotion, and addresses health determinants in the economic, environmental, and social spheres (OPHA, 2002). As community health nurses with an emphasis on "promoting, protecting, and preserving the health of populations" (Canadian Public Health Association [CPHA], 2010, p. 8), the integration of systemic factors and social determinants are integral to the promotion of community food security as nurses carry out their roles as advocates, mediators, and enablers, with an emphasis on policy and shifting how programs are implemented (OPHA, 2002).

These factors associated with individual and community food security demonstrate a complex array of social, political, cultural, and economic influences that can be further exacerbated by the environmental circumstances of living in a rural area.

Rural Factors

A large scale Canadian analysis of rural health demonstrated that, on average, rural Canadians had lower socioeconomic status, lower educational attainment, exhibited less healthy behaviours, and had higher overall mortality rates than urban Canadians (CIHI, 2006). When combined with several environmental challenges unique to rural

areas in North America, these factors may increase the risk of food insecurity in rural communities. Drouin et al. (2009) examined the cost of fruits and vegetables in various food store types of Quebec City, and found the type of food store had a significant effect on cost, with convenience and small grocery stores the most expensive. Drouin et al. observed a lower number of food stores in rural settings, increasing the cost associated with a healthy diet through travel expenses. Smith and Morton (2009) similarly found that rural residents in Iowa and Minnesota, USA, expressed concerns regarding limited food choices, and reported that a lack of competition from the broader global market led to higher food prices in rural communities.

Garasky, Morton, and Greder (2006) identified that among rural Iowa, USA residents who perceived their area to have high food prices or not enough stores, food insecurity was higher. Those who were able to shop outside of their county experienced less food insecurity, emphasizing the importance of reliable transportation. Similarly, Yousefian, Leighton, Fox, and Hartley (2011) identified several strategies used by rural families to access food, including traveling to several large-chain supermarkets based on sales and coupons, buying in bulk for their freezers, and supplementing the food purchased with hunting, fishing, and produce from the garden. The use of alternative food systems, such as gardening, hunting, and fishing were identified among rural families in Minnesota (Smith & Miller, 2011) and Oregon, USA (Hoisington, Schultz, & Butkus, 2002), and families also used farmers' markets and collected road kill as a means of accessing food (Smith & Miller, 2011). These strategies helped rural families manage in an environment with fewer stores and less variety (Smith & Miller, 2011).

Some individual characteristics that have been associated with food insecurity in a sample of low income, rural families from 14 American states included mothers' lower levels of food and financial skills, depressive symptoms, and not owning a home (Olson, Anderson, Kiss, Lawrence, & Seiling, 2004). Additionally, rural families may experience increased economic hardship resulting from fewer educational, retraining, and employment opportunities, and fewer child care options, all contributing to lower incomes that make food insecurity more likely (De Marco et al., 2009).

Reducing the Risk of Food Insecurity

Some of the factors that have been shown to protect families from food insecurity included higher income (Tarasuk & Vogt, 2009), education beyond high school (Hanson & Olson, 2012), living with the maternal grandmother among low income, African American mother-infant dyads (Laraia, Borja, & Bentley, 2009), and high self-esteem and mastery among a sample of pregnant women (Laraia, Siega-Riz, Gunderson, & Dole, 2006). A study of low income, rural families in the US found that protective factors included owning a home and the combination of being non-White and having higher education, which the authors attributed to higher levels of human capital (Olson et al., 2004) (See Glossary – Appendix A). There was no discussion of the relationship between ethnicity and human capital or a definition provided for human capital, although the Organization for Economic Cooperation and Development (OECD) (2010) defined human capital as investment in training and education. It is worth noting that participation in food aid programs, including food banks and children's food programs, was not found to have a protective effect on food insecurity (Garasky et al., 2006; Kirkpatrick & Tarasuk, 2009).

Strategies to Stretch Food Dollars

Several studies have identified strategies for living with food insecurity. The low income Oregonians in the study by De Marco et al. (2009) used methods for stretching families' food dollars like coupons or purchasing food on sale, using public and private nutrition assistance, creative bill paying involving juggling of bills and negotiating with creditors, and drawing on social supports from family and friends. Skipping meals was a common strategy employed by food insecure families, especially by mothers in an attempt to protect their children from going hungry as already mentioned (Stevens, 2010; McIntyre, Walsh, & Connor, 2001; Hamelin et al., 2002; Hoisington et al., 2002; Wicks et al., 2006). Hoisington et al. (2002) found many households used strategies such as bulk cooking, substitutions, and freezing leftovers, while Hamelin et al. (2002) identified less frequent strategies of acquiring food, deemed "exceptional means" (p. 125), that included selling personal belongings, going to pawnbrokers, stealing, and poaching animals.

These studies about strategies to stretch food dollars identified some common themes related to caring, creativity, and resilience (See Glossary – Appendix A), not always acknowledged in the authors' analysis but apparent in my reading of the above strategies used to manage the participants' day-to-day challenges. A study by Canvin, Marttila, Burstrom, and Whitehead (2009) analyzed the concept of resilience in poor households of Britain, where society was perceived to have low expectations for those experiencing poverty regarding health, employment and family stability. In contrast to those low expectations, people in poverty found ways of thriving with tenacity, coping, and survival skills (Canvin et al., 2009). The authors suggested that commonplace successes and skills, like ensuring children are fed and advocating for services for their families, are often hidden behind the backdrop of society's low expectations of disadvantaged communities (Canvin et al., 2009). Resilience, which relates to how individuals can overcome adversity and become stronger or better equipped to deal with crises in the future (West, Buettner, Stewart, Foster & Usher, 2012), is not specifically identified in the literature reviewed above, although the strategies and skills employed by families with food insecurity are similar to the successes and survival skills identified by Canvin et al (2009).

From a community perspective, food banks have become the primary response to food insecurity and hunger in Canada (Tarasuk & Eakin, 2003), although Canadian studies suggest only a small portion of those who are food insecure are using this resource (Kirkpatrick & Tarasuk, 2009; McIntyre, 2003). In a sample of low income Toronto residents living in high poverty areas, 1 in 5 accessed the food bank (Kirkpatrick & Tarasuk, 2009), whereas data from national surveys showed that 35% of food insecure households sought help from a food bank, with 31% seeking help from their relatives and 29% from friends (McIntyre, 2003). Studies of food bank use, collective kitchens, and other community solutions to food insecurity like children's food programs, have been criticized for their limited capacity to increase food security due to their failure to address the underlying issue of poverty (Tarasuk, 2001). Research by Kirkpatrick and Tarasuk (2009) showed no evidence that using food banks or children's food programs had any

effect on household food insecurity. While community kitchens have been found to increase coping skills and provide social support (Tarasuk & Reynolds, 1999) as well as increase dignity compared to accessing charitable food resources (Engler-Stringer & Berenbaum, 2007), community kitchens and other food based solutions do not address the economic conditions that create food insecurity. "Hunger in families is alleviated by money to buy food, not by charitable sources of food from friends, or relatives, or from food banks." (McIntyre et al., 2001, p. 38).

Consequences of Food Insecurity

Food is essential for a healthy and active life, but also carries cultural and social significance that can be vital to our sense of wellbeing (Riches, 2000). The consequences of insecure access to food impact individuals and families in physiological, social, and emotional ways. Individuals from food insecure households are more likely to rate their health as poor or fair, have restricted activity, poor functional health (a measurement of attributes such as speech, hearing, vision, ambulation, and pain), and suffer from multiple chronic conditions including depression, heart disease, diabetes, high blood pressure, and food allergies (Vozoris & Tarasuk, 2003). Children from food insecure homes suffer more frequently from iron-deficiency anemia (Park et al., 2009), mental health problems (Slopen, Fitzmaurice, Williams & Gilman, 2010), negative academic and psychosocial outcomes among school-aged children (Alaimo, Olson & Frongilo, 2001), and poor developmental outcomes (Rose-Jacobs et al., 2008; Zaslow et al., 2009). Insecure attachment among infants and toddlers was also noted (Zaslow et al., 2009). From within the limited research of the consequences of food insecurity for pregnant women, associations with severe pregravid obesity, greater weight gain, and gestational diabetes mellitus have been identified (Laraia, Siega-Riz, & Gundersen, 2010), as well as increased risk of certain birth defects like cleft palate, spina bifida, and anencephaly in the newborn (Carmichael, Yang, Herring, Abrams, & Shaw, 2007).

The methods used to measure food insecurity varied between studies, and while the Food Security Core Survey Module was a commonly used and reliable tool for measuring food insecurity that includes the emotional component of worry in relation to running out of food (Holben, 2002), other studies defined food insecurity as an

inadequate amount of food intake due to lack of resources (Alaimo et al., 2001). This creates some challenges in direct comparison between studies; however, there seems sufficient evidence to confirm a relationship between food insecurity and negative health consequences.

Despite the established detrimental consequences of food insecurity, the mechanism for the associations between food insecurity and health outcomes is poorly understood. It has been suggested that the relationship could be related to nutritive pathways, such that micronutrient deficiencies develop from restricted quality and/or quantity of food consumed, or nonnutritive pathways, in which the stress and anxiety of having an insecure source of food impacts on family behaviours, relationships, and mental health (Rose-Jacobs et al., 2008). A study by Gowda, Hadley, and Aiello (2012) identified increased inflammation and altered immune response among food insecure individuals, which may be one mechanism by which food insecurity predisposes individuals to chronic diseases such as cardiovascular disease and diabetes. Regardless of the pathway, the vast array of physiological, emotional, and social health consequences identified in the literature provides the impetus for attention to the topic of food insecurity as a significant public health threat.

Summary of the Literature

In summary, the literature on the topic of food insecurity shows that inadequate household income is the strongest predictor of food insecurity (Tarasuk, 2005; Mikkonen & Raphael, 2010), with the highest prevalence of food insecure residents of Ontario being families receiving social assistance (Tarasuk & Vogt, 2009). Food banks were developed over the past three decades to respond to the growing public awareness of food insecurity within Canada, but research has shown food banks have little effect on household food security (Kirkpatrick & Tarasuk, 2009).

Several studies have examined characteristics of food insecure individuals and families, and a small number of studies explored the experience of living with food insecurity and strategies to manage resources when access to food or money is low. Despite public acknowledgement and recent media attention to issues of poverty and food insecurity, the well-documented negative physiological, social, and emotional health consequences of food insecurity, and the recommendations that nurses address the social

determinants of health, there is very little literature about the experience of living with food insecurity within Canada. This literature is especially absent from a rural (See Glossary – Appendix A) perspective and within the field of nursing, which this thesis has attempted to address.

Chapter 3

Methodology

This ethnographic study about the experience of food insecurity was informed by the theoretical underpinnings of critical theories and critical caring theory, with an ontological position influenced by postmodernism. In the attempt to understand others' lives and culture through fieldwork, cultural immersion, and reflexivity (Streubert Speziale & Carpenter, 2007), critical ethnography was deemed an appropriate fit for the research method. This design was in keeping with my personal philosophy and research goals, which relate to appreciating the strengths of vulnerable families and creating an opportunity for these families to share their experiences so that we, as health professionals, can learn from them, help families to gain control over the issues that are important to them, and create policies that provide opportunities for families to reach their potential.

Little is known about the lived experiences of families with food insecurity, or the influence of political, historical, social, and economic dimensions on their experience. As highlighted in the literature review, there has been research conducted from various disciplines that investigated the factors leading to food insecurity and the consequences of food insecurity, but very little within the nursing literature, from a rural Canadian perspective, or about the experience of living with food insecurity. In order for nurses to address food insecurity at the individual, community, and policy levels, a greater understanding of the day to day experience of living with food insecurity and the interaction of the forces influencing this social determinant of health is essential. A qualitative, exploratory, critical ethnographic design, in which participants were encouraged to share their stories through semi-structured interviews, provided rich data to help elucidate some of these hidden challenges, strengths, and multiple influences on the day-to-day experiences of the participants.

Critical Ethnography

Ethnography is a research method that makes explicit the "common sense knowledge" of a culture and what it means to be an insider in their social world (Wolf,

2007). The investigator using ethnography takes on a somewhat naïve position about the insiders and their world, applying a naturalistic, interpretive approach that relies on observation, interview, and description (Wolf, 2007). In applying a naturalistic approach, an effort was made to study the phenomenon of living with food insecurity in its natural state (Sandelowski, 2000), while an interpretive approach allowed for understanding and seeking meaning of the experience of food insecurity (Weaver & Olson, 2006).

Critical ethnography is a type of ethnography that addresses the political, historical, social, and economic dimensions of cultures, with a focus on raising consciousness and aiding emancipatory goals as a means of effecting social change (Polit & Beck, 2008). Using qualitative research techniques, critical ethnography can be used to seek participants' points of view and to understand their world, with an additional political purpose (Cook, 2005). Where conventional ethnography aims to speak for participants, critical ethnographers seek to empower participants and give authority to their voices by speaking on their behalf (Thomas, 1993). Rather than simply understanding and describing a culture, critical ethnographers seek to change it (Thomas, 1993). Cook (2005) has suggested that health promotion and critical ethnography share the goal of emancipation, in which participants become more knowledgeable about oppressive conditions and take action to address them, making critical ethnography an appropriate research method for health promotion.

When this research method was applied to the study of food insecurity, critical ethnography created an opportunity to understand the day-to-day experiences of families as well as uncover some of the underlying political, historical, social, and economic factors that contributed to families' food insecurity. While making visible some of these constraining factors, the ultimate goal was one of improving the everyday conditions that contribute to food insecurity and identifying strategies that create opportunities for social justice.

Critical Theories

Critical theory does not have a unified definition (Mohammed, 2006), but is a form of science and inquiry that seeks to liberate individuals from conscious and

unconscious constraints (Wilson-Thomas, 1995). These constraints may occur from physical surroundings, social relations, economic circumstances, and political situations, with oppressive, health damaging effects (Stevens & Hall, 1992). As the oppressive constraints are revealed, action can be taken to bring about change. Mill, Allen, and Morrow (2001) argue that critical theory is "necessary for nursing" (p. 123), and may be sufficient as a paradigmatic philosophical base for the discipline.

Critical theories have been applied at the family (Hartrick, 1998), community (Stevens & Hall, 1992), and policy level (Alvaro et al., 2010). In applying critical theory to families, the emphasis is on the social structures that constrain or enhance family health and healing experiences, while revealing underlying social conditions and belief systems, with the ultimate goal of transforming constraining conditions and liberating families from unacknowledged circumstances of domination (Hartrick, 1998). Stevens and Hall (1992) applied critical theory to community health, with the goal to "facilitate change in environmental conditions that threaten safety and well-being, inhibit health behaviours, and limit access to resources necessary for the pursuit of health" (p. 5). And Alvaro et al. (2010) used critical theory as a basis for explaining the continued emphasis of the Canadian government on individual and lifestyle factors, rather than socioeconomic and political forces, in health policy. All of these levels of family, community, and public policy, as described within the socio-environmental approach (See Glossary – Appendix A) to health promotion (Cohen, 2008), have potential to influence food insecurity, and were considered within the analysis of this study using critical theory to guide my interpretation. When the concepts of critical theory are applied using ethnography as a research method, an opportunity is created to understand the worldview and everyday experiences of participants with an underlying goal of revealing oppressive constraints and influences on their food insecurity so that they may be acted on.

Critical Caring Theory

The human science paradigm identifies humans as unitary wholes, and the focus of human science research is on understanding the lived experience, including the person's values, patterns, meanings, relations, and themes (Mitchell & Cody, 1992).

Several nursing scholars have developed theories under the umbrella of human science, including Jean Watson's theory of human science and human care (Mitchell & Cody, 1992). In order to "root public health nursing practice in an emerging caring science" (Falk-Rafael, 2005a, p. 47), Falk-Rafael developed a mid-range, critical caring theory as a combination of Watson's caring science and feminist critical theories. Critical caring theory's central concept is of empowered caring through advocating for those who have been silenced, challenging ideologies that contribute to power differentials, and influencing public policies that impact health (Falk-Rafael, 2005a). Falk-Rafael (2005a) suggested that public health nurses are at the "intersection where societal attitudes, government policies, and people's lives meet" (p. 219), creating a moral imperative for nurses to work toward changing societal conditions that contribute to poor health.

Critical caring theory and, more broadly, critical theories, were together a good fit to guide this research study as a lens for understanding the individual experience of food insecurity, but also to build on nurses' involvement in moving beyond understanding and interpretation of the phenomenon toward taking action to redress food insecurity as a health inequity (Falk-Rafael, 2005a). Falk-Rafael's (2005b) caring process of "Contributing to the creation of supportive and sustainable physical, social, political, and economic environments" (p. 45) involves nurses in upstream approaches to issues of social justice. This thesis contributes toward a body of knowledge about living with food insecurity by striving to understand the experience from an insider's perspective. Vulnerable individuals and families have shared their intimate knowledge and expertise, providing insight that can help inform nursing practice as we advocate on behalf of such families at the individual and family level, through community programming, and with public policy action on food insecurity.

Ontology and Epistemology

The knowledge gained from within this study is understood as co-constructed between myself and the participants, and is value-mediated, as the participants and I are interactively linked (Guba & Lincoln, 1994). This epistemological position is in keeping with the critical paradigm (Guba & Lincoln, 1994). Postmodernism is reflected in my

understanding of the nature of reality or ontology, in which positivism or a single reality has been rejected for the existence of multiple, socially constructed realities (Fontana, 2004; Hall, 1999).

The concept of marginalization is supported within postmodernism by the emphasis on complexities of power and subjective experience (Hall, 1999). The critical paradigm and postmodernist thought have informed my understanding of the complexities of the subjective experience and meaning of food insecurity, the differing contextual realities of participants, and the issues of power and marginalization that may exist between this low income population and other social groups, as well as between the participants and myself.

Application of Critical Theory Concepts

Throughout the design and later analysis of this study, there was a gradual shift from what began as my attempt to describe the phenomenon of food insecurity from the perspective of my participants, toward seeking a deeper understanding of the experience, and finally toward acknowledging the broader influences on food insecurity and what could be done to address them. This emphasis on the social, political, historical, and economic factors influencing food insecurity and how to address them is in keeping with the purpose from a critical perspective of moving beyond understanding and describing a phenomenon, to one of taking action toward changing that phenomenon (Berman, Ford-Gilboe, & Campbell, 1998). The combination of research and action, or research as praxis, in which the knowledge developed through research can create change, is a basic tenet of the critical approach (Berman et al., 1998).

According to Fontana (2004), there are several concepts consistently seen in critical studies, including critique, context, politics, emancipatory intent, democratic structure, dialectic analysis, and reflexivity. These concepts were applied within this study of the experience of food insecurity by:

- Critiquing the forces that lead to and sustain food insecurity, including economic and political policies, environment and community structures, gender, food aid programs, and the social and historical context of the family

- Recognizing that all knowledge acquisition is political and shedding light on the political forces that have shaped families' oppressive situations, with the fundamental goal of empowerment and emancipation
- Giving voice to those who are experiencing food insecurity and sharing with them the results of the research, so that this might promote confidence among families as their experiences and knowledge are valued, and create opportunities for action on the constraining factors as they see these factors in a new light
- Using a collaborative, non-hierarchical, and mutually educative process based on reciprocity, recognizing the participants as the experts of their own lives and on the topic of food insecurity, and reducing power imbalances between myself and participants
- Engaging in dialectic analysis in which contradictions of values, interests, and conditions are a focus
- Using reflexivity to analyze how the methods, conduction, and analysis of the study are influenced by my own feelings and biases about the participants' circumstances, and reflecting on the source of my own knowledge, personal beliefs, and values

Throughout the recruitment, participant interviews, analysis, and member checks, I have sought to reduce the power differential between the participants and myself, to give participants a voice, and uncover the participants' strengths and the multiple external influences on their food insecurity. I have examined the political, historical, social, and economic dimensions of their food insecurity, and shared with participants my emerging analysis during member checks so that they might confirm or deny my interpretation, add to the analysis as co-constructors of this knowledge, and ultimately so that they may understand their situations in a new light and be encouraged to address the conditions that serve to maintain their current status as food insecure. Further analysis took place as the data was worked with following member checks, and a copy of the results will be mailed to participants to share the final interpretation and insights gained from the study.

Insider/Outsider Membership

As the youngest child of a two-parent, well-educated, white, and privileged family, my understanding of the factors that lead to poverty and my assumptions about its causes rooted in personal free will versus oppressive external influences, has demanded ongoing contemplation. I have come to recognize the complexities of issues related to poverty, opportunity, power, and the multiple social, environmental, economic, political, and historical influences on family and community health and well-being. Within this ethnographic study, I identify as both an insider and outsider, recognizing the significance of researcher membership due to the direct and intimate role the researcher has with data collection and analysis (Corbin Dwyer & Buckle, 2009). I identify myself as an insider because I was raised and still reside in the rural area being studied and am therefore familiar with the culture, values, and social norms of the community. I identify as an outsider because of my privileged position within society and as a holder of knowledge and power, lacking first-hand understanding of the experience of food insecurity and poverty. This position within the research study may have provided benefits of more rapid acceptance by participants who perceived me as a member of the community or "one of us" (Corbin Dwyer & Buckle, 2009), or with some participants may have had the opposite effect, as I am not a member of their community with respect to the phenomena of interest.

Research Design

A qualitative, exploratory, critical ethnographic design was used to explore the experience of rural families with food insecurity. Data was collected during semi-structured interviews (see Appendix D) with participants, as well as from discussions with food bank directors and observation of clients and volunteers during hours of food bank operation.

Ethical Considerations

Ethics approval was received from the Human Participants Review Committee of the Office of Research Ethics at York University in March 2012. Confidentiality was carefully maintained throughout the recruitment, interviews, analysis, and member check

phases of the study. This is particularly important in small, rural communities where many families know each other, and particular attention has been paid to protecting the identity of participants through participants' selection of meeting areas and applying careful consideration to even subtle identifiers in the writing of my thesis. Pseudonyms were used within the thesis to maintain participant confidentiality. I declined to acknowledge which food bank participants had already participated in the study when asked for this information by the food bank staff, and have ensured I did not leave detailed phone messages about the purpose of my research when making contact with potential participants about the study or for member checks.

Participants were not recruited from my own community of residence, or from personal acquaintances, friends, or former clients. In the circumstance where the participant knew me on a personal level, she was aware of this prior to accepting the interview and at that point I was unaware of our mutual connection, which she disclosed at the end of the interview. This was not deemed a conflict of interest, as she willingly consented to be interviewed with this knowledge. Personal connections may have hindered another individual who initially expressed interest, but later declined to participate.

Written consent was verbally reviewed with all participants and signed at the beginning of the interview, and participants were informed that they could withdraw from the study at any time or choose not to answer some questions. All participants chose to answer questions, and no one withdrew during the interviews. Risks and benefits of participating in the study were discussed, encouraging them to consider whether the benefits of participation outweighed the costs (Polit & Beck, 2008). The risks addressed in the consent process included the emotional risks of being asked questions that elicit sensitive information or feelings, and intrusion into personal matters. Benefits identified to participants included gaining insight about social conditions and constraints that may be impeding their ability to overcome food insecurity, as well as developing knowledge and information about food insecurity that can inform policies and program development to benefit the larger community and society. A small honorarium of a $20 gift card for the

local grocery store was given to participants for their time, which was deemed small enough that it should not be considered coercive or to place undue pressure on individuals to participate.

An ethical issue that arose frequently during the interviews involved the sensitive nature of the content of discussion and the participants' disclosure of important health and emotional information. Families experiencing food insecurity more frequently rate their health as poor, and have increased odds of having a variety of health problems including major depression and distress (Vozoris & Tarasuk, 2003). This became apparent when several of the participants discussed the emotional impact that food insecurity has had on their lives, including ongoing depression and one recent suicide attempt. An effort was maintained throughout the study to ensure boundaries were not crossed between that of investigator and counselor, and when one participant spoke frequently of her history of trauma and abuse, an effort was made to redirect the conversation to the present while recognizing the relevance of her past to her current experience with food insecurity. A list of community health and social service resources was kept available so that appropriate follow-up contact information could be provided or referrals made, however this did not prove necessary as no participants became distressed during interviews and all of the participants who disclosed symptoms of depression were already receiving medical attention or appropriate counseling for their diagnosis.

Geographic Location of Study

The geographic location of this study included two rural communities and their surrounding areas in Southeastern Ontario. I chose this area for its limited access to grocery stores and public transportation, and its close proximity to my own area of residence due to convenience and familiarity with services and stakeholders. While there is no consensus on how to define rural within Canada, these communities met Statistics Canada's definition of "rural and small town", in which the population lives outside of the commuting zone of a larger urban centre with a population of 10,000 or more (Statistics Canada, 2001).

Sampling

The selection criteria for this study included: 1) self-identification as experiencing insecure access to food, or worry about having enough to eat, 2) caregiver of at least one child under the age of 18 living in the home, and 3) able to speak and read English. Recruitment took place through convenience and purposeful sampling. Convenience sampling, in which participants are recruited based on availability to the researcher (Polit & Beck, 2008), was used in order to recruit participants within the desired geographic location and to whom I had access through local service providers. This was combined with purposeful sampling to ensure the participants were a part of the culture of interest; a technique that is acceptable in qualitative research where manipulation, control, and generalization are not required in order to gain an understanding of a phenomenon (Streubert Speziale & Carpenter, 2007).

Recruitment Strategies

The assistance of key stakeholders was sought in recruitment of participants. I approached the directors of the food banks in each of the two communities, who were willing to help with posting and distributing the study flyers to food bank clients. Both directors also invited me to their food banks to talk about the study in person, and as an opportunity to show me around their food banks and discuss their policies and clientele. The initial meetings were during hours when the food banks were closed, and provided a great deal of information to increase my understanding of how the donations, purchases, and distribution of foods are carried out. This also gave me some insight into the challenges encountered by the food bank staff and volunteers, their policies, and the settings that participants would later describe during interviews.

Participant Selection

After the initial meeting with food bank directors to explain the study and distribute flyers, I arranged to help out at one of the food banks during their hours of operation. This provided an opportunity for clients to put a human face to the study by meeting me, and it allowed me to observe the interactions of participants and volunteers in the natural environment, providing a glimpse into the culture as per ethnographic study

methods. This also proved to be an effective recruitment strategy, as two clients expressed interest in participating during the food bank visit, and a third took the flyer home and called the next day to set up an interview.

Several other participants from both towns took the initiative to contact me after receiving flyers during their food bank visits over the course of three months, and one individual expressed interest indirectly via a food bank volunteer. When this strategy of recruiting with the assistance of the food banks was no longer generating additional participants, I made contact with the local Ontario Early Years Centre (OEYC), a drop-in centre for caregivers and their children aged 0-6. During a brief visit to the OEYC, I met a mother and her child who immediately volunteered to participate in the study, further reinforcing the success of face-to-face interactions in recruitment. This was the final participant recruited, although the OEYC staff person contacted me with two other interested participants who were not included in the study, demonstrating the value of this topic to local residents. Postings were also placed in the local grocery store, and I requested that participants share the information about the study with others they knew that might be interested, also known as snowball sampling (Streubert Speziale & Carpenter, 2007).

Interested participants either informed me in person during the visits to the food bank or OEYC, or phoned the number provided on the study posting (Appendix E). While an email address was provided as a potential contact method, no participants used this method to express their interest in volunteering for the study. Information about the study was provided verbally when the interview was scheduled, and the participants chose the date and site for the meeting.

Data Collection

Most interviews were conducted in the participants' homes, but one interview took place in a public outdoor space and another in a public indoor space with a private room. At the commencement of each interview, a consent form (Appendix B) was reviewed and signed, a demographics form (Appendix C) was completed, and then the semi-structured interview began. Participants received a copy of the consent form and

their honorarium $20 gift card to the local grocery stores at the beginning of the interview. Interviews were audiotaped and later transcribed verbatim. Identifiers were removed from the transcripts, audiotapes destroyed, and all data has been kept in a locked filing cabinet in my home where it will be destroyed after a maximum duration of 3 years, as per York University's ethics requirements.

Interviews

The interview questions from DeMarco's (2007) doctoral dissertation exploring the relationship between income, social support, and food insecurity, were used as an initial template in developing the interview guide. Interview questions (Appendix D) addressed practical aspects of food acquisition, indicators of food insecurity such as running out of food or worry about having enough food (Tarasuk, 2005), management strategies when food is low, supports, and the emotional impact of food insecurity. As literature was read throughout the study time frame, and new insights were gained both from the literature and the participant interviews, additional questions were added to the interview guide. Research by Yousefian, Leighton, Fox, and Hartley (2011) identified storing bulk foods in freezers as an important money-saving strategy for low income, rural families. Many of the early interviews in my own study named this strategy in helping make ends meet, and a question about freezers was therefore added to all interviews after this insight was gained. Similarly, an article by Smith and Miller (2011) suggested that alternative methods of food acquisition, such as hunting, fishing, and gardening, provided an important and often overlooked source of protein for many rural families. While the interview guide already included a question about gardening, an additional question about hunting and fishing was incorporated into interviews beginning with the third participant. This modification of study methods that occurred related to unexpected insights gained from the literature and participants is in keeping with the iterative research process to better support the focus and integrity of the analysis and final product (Carter & Little, 2007).

Following thematic analysis of the data, a second meeting was requested with all participants as a member check to ensure that my early interpretation of the data was

meaningful and accurately represented their stories (Hall, 2011). This provided an opportunity for participants to further reflect on their situations and constraints that contributed toward food insecurity, to gain an appreciation for the shared experience that might decrease feelings of isolation or move them toward action, and also recognized their expertise as co-constructors of this knowledge. During the member check, participants were invited to provide additional insight or details to expand on the themes, or suggest ways in which the analysis was in line with or contradicted their experience or their story shared during the initial interview. All participants were contacted for member checks via telephone, and five of the seven participants responded that they were interested in hearing about the results and providing feedback, while two participants did not return my voice mail messages and therefore did not participate in a second interview. Home visits were conducted with two participants, telephone conversations were used to share results with two others, and one participant requested that the information be provided in an email so that she could review it when she had time. This participant responded via email with only brief affirmation of the results, however the other four participants provided confirmation of themes and shared additional details or stories that expanded on themes and the questions that arose from the research.

Data Analysis

Data collection and analysis occurred concurrently, and the data from the interview transcripts, field notes, and my reflective journal were analyzed using the content analysis methods outlined by Wolf in Munhall's *Nursing Research: A Qualitative Perspective* (2007), as well as the constant comparative method (Polit & Beck, 2008).

Content analysis is frequently used in qualitative research to identify concepts or categories that present a condensed and broad description of a phenomenon (Elo & Kyngas, 2007). This method was combined with the constant comparative method of data analysis, in which data from one source is compared with another to develop conceptualizations of similarities and differences, and proceeding until the content of each new source has been compared with all other sources (Polit & Beck, 2008; Thorne, 2000). While content analysis and constant comparative methods are not commonly used

within ethnographic research, Sandelowski (2000) suggested that "pure" use of any one method is not necessary and "any one qualitative approach can have the look, sound, or feel of other approaches." (p. 337) Within this thesis analysis, content analysis and constant comparison were deemed a good fit, and several other studies were found within the nursing literature to have similarly combined ethnography with content analysis (De Graves & Aranda, 2008) or ethnography with both content analysis and constant comparative methods (Green, Meaux, Huett, & Ainley, 2009; Renaud, 2007).

Content analysis of transcripts was accomplished by coding, in which the material was read line by line, themes were attached in the margins, and then statements were extracted that corresponded to the listed themes (Wolf, 2007). NVivo 9 was used to help code or classify the data electronically, identifying themes as meanings emerged from the narratives (Wolf, 2007). This was in keeping with Elo and Kyngas' (2007) description of inductive content analysis, appropriate for when there is little known about a phenomenon. The themes were altered as each subsequent transcript was analyzed and compared to earlier transcripts. Over time, themes were merged with other similar themes, and were further adapted as the raw data was repeatedly returned to and contradictions between participant experiences were explored. Finally a number of common threads became apparent. For instance, the micro themes of *Kids Come First* and *Hardship* were gradually seen to represent the common experience of *Going Without*, while *Generosity Despite Hardship* was integrated into the larger theme of *Taking Action on Food Insecurity*: *Sharing Amongst Friends, Neighbours, and Community Members*.

A visual representation of themes was developed, which was shared with participants during the member checks, confirming the early interpretation and insights drawn. Throughout the writing of my thesis and further analysis of the data, additional models were created as tools to help in my analysis and to address some of the broader influences on participants' food insecurity, incorporating the family, community, and policy levels of influence as per the socio-environmental approach (Cohen, 2008). In consultation with my thesis faculty advisors, the analysis progressed from description of

the participant experience to seeking deeper understanding and uncovering the multiple layers of influence on food insecurity.

The socio-environmental model, with its emphasis on decreasing social and economic inequalities while increasing personal and community empowerment (Cohen, 2008), was chosen as a framework to help guide my interpretation and written analysis of the data. This model is frequently used within community health nursing (Canadian Public Health Association, 2010). I also considered the following social determinants of health in the study analysis: education, employment and working conditions, food insecurity, gender, housing, income, social exclusion, and social safety net (Mikkonen & Raphael, 2010). Rurality was considered alongside the other social determinants because of its relevance to health and the way many of the social determinants are influenced by geographic location within Canada (CIHI, 2006). As analysis proceeded, I returned to the critical theory literature and the purpose of my research study to help increase the focus in my analysis on issues like gender, contradictions within the data, and public policy.

Measures to Ensure Rigor

The goal of rigor in qualitative research is to accurately represent the experiences of participants (Streubert Speziale & Carpenter, 2007). The standards for reliability and validity in the conventional, empirical paradigm, with its focus on generalizability and repeatability, are an inadequate fit for understanding unique and contextualized human experiences (Hall & Stevens, 1991). Hall and Stevens identified alternative criteria for rigor that can be applied to postempiricist inquiries, useful for evaluating the whole process of inquiry through a standard they identify as adequacy. "Adequacy of inquiry implies that research processes and outcomes are well-grounded, cogent, justifiable, relevant, and meaningful" (Hall & Stevens, 1991, p. 20). The criteria proposed by Hall and Stevens that helped to achieve adequacy in this study included: reflexivity, credibility, rapport, coherence, complexity, consensus, relevance, honesty and mutuality, naming, and relationality.

Reflexivity

By examining and continually reflecting on my own values, assumptions, characteristics, and motivations, and how they influenced data collection and analysis, I attempted to make explicit my participation in the generation of knowledge, thereby increasing accuracy and relevance of the results (Hall & Stevens, 1991). This was accomplished through reflective journal entries on an ongoing basis, discussions with my faculty advisors, and identifying my thoughts, assumptions, and biases after each interview was completed.

Some of the issues that arose as I contemplated my biases or perspectives from a privileged outsider's point of view were described in my reflective journal. These included questions about initiative, for example contemplating what constituted a "good" job after a participant suggested that the only options locally were pumping gas. This presented an opportunity to consider issues of dignity and pride, and how I might respond if I were faced with similar circumstances, as well as how one's background and life experiences shape one's interpretation of what is socially acceptable. Similar to Canales' (2010) description of taking on the role of the "other" in order to see the world from their perspective, reflexivity helped me to understand and delve more deeply into the issues and day-to-day lives of participants. By using written reflective journals, this process helped to acknowledge and uncover my personal biases and how these might influence the research process (McCabe & Holmes, 2009).

Credibility

A credible study is one in which participants are able to recognize the researcher's interpretations in the report as reflecting their own experience (Hall & Stevens, 1991). Confirmation of my interpretations was sought by conducting member checks to determine whether the participants recognized, understood, and endorsed my emerging interpretations (Hall & Stevens, 1991). All of the participants confirmed that the findings rang true to their experience with food insecurity, and many expanded on the themes identified.

I also had my faculty advisors, who are nurse researchers, provide an impression of credibility based on the adequacy of the literature reviewed, data collection techniques, inclusiveness of samples, comprehensibility of descriptions, and logic of arguments (Hall & Stevens, 1991).

Rapport

Within a qualitative study seeking to understand the everyday experiences of families, engagement with participants is valued, and rapport is essential. By developing relationships of trust and openness with participants, there is increased confidence that the research accurately reflects their experience with food insecurity (Hall & Stevens, 1991).

The interviews conducted provided very rich data, much of which was sensitive, identified by some participants as embarrassing, and was occasionally accompanied by tears. Many participants acknowledged not disclosing this information with their friends or family, and stated that they wouldn't want others to know the information being shared. This degree of openness and willingness to share their experiences and feelings with me demonstrates a level of comfort, trust, and rapport developed during the interview. The willingness of five participants to take part in member checks confirmed an interest in being involved over time, and one participant gave me a hug after the second interview, which demonstrated the rapport developed between the two of us.

Despite the rapport that I perceived to have developed between the participants and myself, the participants did not seem inclined to recruit their friends or acquaintances for the study despite my suggestion at the end of each interview. It is possible that for some of the participants, this was related to not knowing others that they would willingly or openly talk to about their experience with food insecurity, perhaps related to feelings of embarrassment or shame.

Coherence

Coherence is said to exist when conclusions are well founded and consistent with the raw data, connected to a logical discourse, and faithful to the interests and experiences of the participants (Hall & Stevens, 1991). Member checks with participants and discussion with my faculty advisors increased coherence by examining plausibility of

findings, consistencies among data, cogency of interpretations, logic in light of a broader understanding of social, economic, and political realities, and the wholeness of the theoretical picture that emerged (Hall & Stevens, 1991). Thick descriptions were made in a reflective journal after each contact with community stakeholders or participant interviews to provide additional data for analysis. Additional notes were made about reflection and insights from new literature read on an ongoing basis, and I returned to the thesis proposal to ensure the original research question and critical approach were adhered to.

Complexity

With an emphasis on the complexity of the lived experience, an adequate study will capture the larger social, political, and economic influences in the everyday lives of participants, will provide historical background, and will avoid reducing human nature and experiences to isolated variables in a decontextualized format that has been common to empirical studies (Hall & Stevens, 1991). By using a critical approach, I attended to the social, political, economic, and historical influences on families' experiences by incorporating questions about barriers and solutions to food insecurity in the interview guide, and through analysis of how external factors may constrain families' opportunities for action. I provided a space for dialogue on the complexities of the challenges, and many participants gave detailed accounts of the cycles or interwoven obstacles that were difficult to break free from. The interview questions were also fine tuned as new insights emerged from the literature and early participant interviews, reflecting the complexities and multiple influences on the experience of food insecurity.

Consensus

Consensus is built through congruence among behavioural, verbal, and affective aspects of various forms of data (Hall & Stevens, 1991). As recurrent themes emerged between participants' experiences, and through searching for negative cases or divergent experiences, consensus was sought (Hall & Stevens, 1991). Yet, Hall and Stevens recognize the importance of honoring diversity of the participants in the search for consensus, and suggested that the social positions, experiential backgrounds,

environmental contexts, and loyalties of participants help gain perspective on both similarities and differences. This was apparent in the unique and varied stories shared by participants, and analysis into how their previous life experiences shaped their current struggles with food insecurity. Yet similar or overlapping themes emerged from these complex stories, and the data from alternative sources like discussions with food bank staff and observations during home and food bank visits contributed toward themes that were congruent between and within sources of data.

Relevance

An adequate study is one that is relevant, appropriate, and significant to the participants and population involved. Consideration of whose interests are being served by conducting the research study and how findings may be used by others are indicators of relevance (Hall & Stevens, 1991). The interest of participants in contributing toward this study, both through sharing their experience during the initial interview and by discussing results and requesting a copy of the findings, demonstrated that this is a topic of value and importance to participants. There is also interest in this topic from within the nursing community, as demonstrated by being accepted as an oral presenter to highlight the study findings at an upcoming Community Health Nurses' conference. An effort will be made to ensure that key stakeholders also have a copy of the study findings to inform their practice, programs, and policies developed.

Honesty and Mutuality

Honesty and shared control with participants increases the dependability of the data (Hall & Stevens, 1991). Conscious monitoring of power dynamics and reduction of power inequalities was attempted throughout this study, providing a stronger base from which to draw conclusions about findings (Hall & Stevens, 1991). Mutuality was demonstrated by conveying a genuine interest in participants' unique experiences, trusting their ability to convey relevant information, and showing a grateful attitude for their time and effort (Hall & Stevens, 1991). This mutuality allowed for rich data to emerge during interviews and interest in participating in member checks.

Naming

Naming is defined as "learning to see beyond and behind what one has been socialized to believe is there" (Hall & Stevens, 1991, p.26). Naming power may be shared with families by using their language and verbatim stories to describe and analyze the experience of food insecurity, ensuring adequacy if the participants' voices can be heard in the research account (Hall & Stevens, 1991). By using thick description and direct quotes within the thesis results and analysis sections, and returning regularly to the raw data to ensure that participants' stories are being reflected in the written thesis, I have provided insight into the phenomenon of food insecurity as the participants have described it.

Relationality

Modes of inquiry that are participatory, non-hierarchical, and action oriented contribute to relational knowledge construction (Hall & Stevens, 1991). Within this study, collaboration with faculty advisors and participants provided opportunities for critical reflection and questioning, and member checks with participants helped ensure the participants' voices were being fully taken into account and that knowledge construction was relational (Hall & Stevens, 1991).

Dissemination of Research Findings

In keeping with the purpose of conducting critical research, in which individuals, families, and communities are empowered to take action against oppressive structures, these same groups must have the research results returned to them (Berman et al., 1998). Early thematic analysis was discussed with participants during member checks, and a final report will be mailed to participants with a summary of findings in layperson language. This may create opportunities for participants to contemplate the constraining factors or influences on their food insecurity and create opportunities for action as they see these factors in a new light. I will also disseminate the findings to local stakeholders involved in food security initiatives and public health program and policy development, and will submit the findings for publication to reach the broader audience of nurses and other health care providers.

Limitations

There are several limitations with this ethnographic study design and sampling methods. The first involved the small sample size of 7 participants. The interviews provided insight about unique and complex personal histories and factors affecting the experience of participants with food insecurity, and new stories and details would undoubtedly have continued to unfold if a larger sample was used. However, rather than seeking data saturation or generalizability of findings to other groups, qualitative research seeks a deep understanding that provides "new and richly textured understanding of experience" (Sandelowski, 1995, p.183). Despite the small sample size, the rich data from participant interviews in this study allowed for the development of themes that represented the many common experiences of participants, which was confirmed using member checks.

Due to the convenience and purposeful sampling strategies used, the participants who chose to take part in this study may not be representative of others who experience food insecurity in these communities, which could narrow the range of experiences shared and knowledge gained. The sample of mothers with children living at home also lacked diversity with respect to race or ethnic background and gender, providing results that may differ from the experiences in other groups or populations. It is possible that the resourcefulness and skills of the participants are representative of the type of family who would take the initiative to volunteer for a study, or who felt the incentive of a $20 gift card was one further method to help make ends meet. It is therefore possible that the experience of food insecurity for other low income families is quite different. In addition, because the food banks were used as one of the primary settings for recruitment, this study does not represent those families experiencing food insecurity but who are not seeking the assistance of formal supports.

There were also challenges in carrying out an ethnographic study with this population and setting, as it was difficult to immerse myself in the culture through method of observation, when the setting where most people experience food insecurity is within their homes. Most participants chose to have interviews in their homes, which

gave some glimpse into their personal living situations, and the visits to the food banks during hours of operation gave some insight into that environment as well. My access to the local environment, including the OEYC, was facilitated by already being a member of the larger rural community, as well as through earlier employment as a Public Health Nurse. However, the total number of fieldwork opportunities for observation and immersion within the culture was limited.

Summary

The critical ethnographic research design and theoretical underpinnings of critical theory and critical caring theory, combined with the procedures and measures that enhanced rigor within this study, have contributed toward very rich data that provide insight into the everyday challenges, skills, and unique experiences of families with food insecurity. Study limitations included a small sample size, recruitment strategies that led to a sample that may not be representative of the larger community of food insecure individuals, and challenges with gaining opportunities for long term observation of participants. Despite these limitations, the rich and contextualized data that participants shared during interviews afforded a meaningful glimpse into the experience of food insecurity. Next, the results section will describe the common themes and insights that were gained from these interviews and observations about the day-to-day experience of living with food insecurity.

Chapter 4

Results

This chapter will summarize the themes that emerged as I sought to understand the experience of food insecurity and uncover the influences and constraints related to the participants' day-to-day experiences. Seven semi-structured interviews were conducted with rural families experiencing food insecurity, followed by additional interviews with four of the participants to share and seek feedback on the emerging findings during member checks. This made a total of eleven interviews for analysis. First, I will describe the socio-demographic characteristics and diverse backgrounds of the families interviewed, which helped shape the participants' experiences with food insecurity. All participants are identified by pseudonyms to maintain confidentiality. Participant socio-demographics will be followed by a description of some of the experiences that emerged, experiences that were common to many participants, and the influences on their food insecurity from an individual, family, community, and public policy perspective.

Participant Socio-demographics

All seven participants were females, ranging in ages from 30 to over 50, with one or more children living in the home. Six of the participants lived with a spouse or partner, and one participant was a single parent. The number of children in the home varied between one and five. One family had one child, two families had two children, three families had three children, and one family had five children living at home. The children's ages ranged from 2 to 18 years.

The incomes of families came primarily from paid work, with four of the female participants employed (two full-time and two part-time), and one receiving income from a combination of Ontario Student Assistance Program (OSAP) and her partner's employment. Two participants received Ontario Works, one as the family's sole source of income and the other as a top-up to her paid work, and the final participant received a small amount from Ontario Disability Support Services (ODSP) and the remainder of her income from a pension. The total household incomes ranged as follows: two families

with $10,000-19,999, three families with $20,000-29,999, and two families with $30,000-$39,999 per year.

Other socio-demographic characteristics collected included participants' level of education, home ownership, and ethnic background. Three participants had completed a college diploma or university degree, three participants had some college or university education, and one participant had less than a high school diploma. Two of the participants owned their homes, two were in a rent-to-own arrangement, and three participants rented their houses or apartments. The sample was homogeneous with respect to ethnic background, with all participants describing themselves as Caucasian Canadians.

This sample provided an opportunity to hear a range of perspectives from participants with varied ages, educational backgrounds, and experiences within the social welfare system. One of the participants described earlier life experiences of trauma and poverty, while two other participants had led relatively privileged lives during their childhoods, all of which created diverse experiences and helped to contextualize the stories of their current challenges. Another participant and her husband had been earning a comfortable income to support their three children and pay their mortgage, but due to a recent job loss they had plummeted into debt, lost their home, and were new to poverty and food insecurity. Some families had lived with poverty and food insecurity for many years, and several family members had been raised in poverty during their own childhoods.

The themes described next will identify the common threads running throughout the participants' stories, while appreciating the unique and diverse nature of their experiences. The multiple influences on food insecurity will also be described from the individual, community, and public policy levels, which will provide insight for practice and policy recommendations for community health nurses.

The Experience of Food Insecurity for Individuals and Families

Participants opened up about their experiences with food insecurity and shared intimate details about the emotional impact, daily challenges, and some historic context that provided rich data for analysis. Many participants described the emotional

consequences that food insecurity had on their families, their relationships, and their mental health. Some participants also spoke of the stereotypes they perceived others to have about low income individuals or those on social assistance, and the perseverance required to go on in the face of these stereotypes and emotional challenges associated with food insecurity.

The Emotional Impact of Food Insecurity

Participants openly discussed the emotional impact of living with food insecurity during interviews, and some of the participants cried at various points throughout our visits. Participants identified depression, stress, and relationship strain associated with their food insecurity, provided examples of the stereotypes that they faced in their daily lives, and a determination and perseverance that helped them to go on in the face of hardship.

Stress, depression, and emotional strain. The experiences described by participants ranged from stress about what to feed the family or how make ends meet, to constant worry that kept them from sleeping at night, to clinical depression and self-harming behaviour. Every participant identified stress that resulted from the worry about paying bills, feeding their families, and making ends meet. One participant described this as having a negative impact on her confidence level and two participants talked about it in terms of putting a strain on their relationships.

> Oh yeah, we snap all the time. We didn't used to ever fight. We come from, like...there used to be more money and near the city sometimes it's easier to find work, let's be honest. So, he used to always have work. And I always had money...Definitely our relationship is strained. (Toni)

Two participants described their stress keeping them awake at night, "...there has been times, and I'm an emotional person...where I have laid awake at night and wondered what am I going to feed them the next day." This same participant talked about the stress in relation to having three children in the house to provide for:

> And it all goes hand in hand with feeling like a failure, because they're your kids and you need to provide for them. And so that goes hand in hand with self-esteem, depression, and this household has had its fair share. (Sharon)

Some participants described an exceptional amount of stress that they felt led to depression and contributed toward one participant's self-harming behaviour: "...this winter was bad, it was really bad. I ended up having a breakdown over it by the time it was finished...I cut myself and they ended up taking me to the hospital." (Janet) When asked to clarify whether the source of this stress was related to the recent separation with her husband, she suggested it was solely based on the financial stress.

In total, four participants acknowledged experiencing depression. "Well let's say I've been taking Prozac for many years. The stress is just phenomenal." (Susan) One participant regarded her depression as a result of not being able to find a solution to the problems relating to unemployment, poverty, and food insecurity. "It's like a tornado. It just doesn't end." (Danica) This tornado was her way of describing the complexities involved in trying to navigate a way out of her cycle of poverty and daily challenges. In addition to stress, depression, and relationship strain, participants discussed the stereotypes that they dealt with as low income families or as recipients of social assistance.

Facing stereotypes. Feelings of poor self-worth were described by some of the participants in relation to feeling marginalized against or the object of others' negative stereotypes. This was particularly prominent in relation to accessing social assistance or Ontario Works (OW). Some participants described their feelings of shame related to both having to resort to using social support and stemming from their interactions with staff at the OW office:

> And we have been on welfare before, not by choice. That was one of the hardest things we ever had to do. That was really embarrassing. And that was another place, they treat you like the scum of the earth in there. You feel like it when you go in, and when you go out you feel like shooting yourself. It's just horrible. Absolutely horrible. (Susan)

Two other participants described the negative stereotypes of their friends or acquaintances on Facebook, where there were derogatory comments posted about people on social assistance:

> ...quite a few people on my friends list were putting on there that people should be cut off of OW, there shouldn't be OW, all they do is spend it on drugs, and

> they're too lazy to work and stuff like that. And I will admit, that's kind of my prejudice too before I had to go on it. And now that I've been on it...you know, we just don't have a choice. (Siobhan)

This marginalization or perceived negative attitude toward participants contributed toward feelings of shame and embarrassment about accessing services or disclosing their food insecurity to others. "...a lot of it, you don't want to discuss with people because it's embarrassing...you know, you feel ashamed." (Susan) This sense of shame delayed participants from accessing services: "Um, yeah...it took me a long time to access any of these organizations that I've went to for help, because of the judgment thing." (Sharon) The perceived judgment contributed toward feelings of shame, but also may have been integrated into the participants' expectations that they held of themselves. "I just feel like I'm letting a lot of people down, and myself down." (Danica)

Two participants used the word "lazy" when describing the stereotypes that they perceived others had of them or about people using social assistance in general. Despite these internalized stereotypes and feelings of shame, many participants also demonstrated an attitude of perseverance and strength that helped them to move forward and achieve day-to-day successes in managing their challenges with food insecurity.

Perseverance despite the hardship. Families living with food insecurity experienced many challenges in making ends meet, but several participants expressed an attitude of perseverance that allowed them to keep going in the face of hardship. This was often discussed in terms of personal strength and a hard working approach to life. "You work with what you've got...every once in awhile I have my meltdowns, but...it's like pick yourself up and get back at it." (Susan) Another participant described her desire to contribute and work hard to overcome her challenges with unemployment and poverty: "I can still work, like I want to work...I need to work and be, you know, part of the system...I do whatever I can find to do." (Christie) One participant demonstrated similar ambition when discussing how hard she worked at her full-time job, taking on small jobs on her days off to clean homes when she could.

This ability to "survive" and succeed in making ends meet with minimal assistance from formal or informal supports was identified as a source of pride by some

participants. "We might scrimp, but at least we're doing our own thing and we're not depending on somebody else..." (Susan) Another employed participant stated, "...you can work hard and feel good about that...that food on the table – I put it there." (Toni) Participants also expressed confidence in their choices and abilities to make ends meet beyond solely earning an income, including this participant's rationalization for accessing services like the food bank: "...in my own mind, I know I'm doing everything I can. It's not like I'm out drinking or spending my grocery money, I'm actually buying groceries and spreading them..." (Janet)

Participants further demonstrated a positive attitude by expressions of gratitude for what they did have. While explaining the difficulty with accessing fresh produce, one participant stated, "fresh stuff is nice...but at the same time you've just got to say, it is what it is, and be thankful and happy too, right?" (Danica) Another participant talked about searching for the positives despite her struggles with recent bankruptcy and major family disruption: "And then the reminder all the time of you know what...we are together, we're a family, and we're healthy and happy and that sort of thing." (Sharon) One participant similarly used the word "lucky" when describing her love for her family and good fortune to be surrounded by children and grandchildren. This positive attitude, ability to persevere when faced with hardship, and hard working nature of participants contradicted the perceived stereotype of low income families as lazy.

The participants described a significant toll that living with food insecurity had on their social and emotional health, yet many provided examples of positive attitudes and perseverance in their approach to their daily challenges. Factors that seemed to influence how participants experienced food insecurity included rural living and gendered expectations about their roles within the family.

Factors Influencing the Experience of Food Insecurity

The experience of food insecurity is unique to each individual and family, although all participants expressed some degree of emotional strain that was a consequence of their food insecurity. Some of the common factors that seemed to influence how participants experienced food insecurity included gender as it shaped their

expectations of their roles within the family, and participants' status as members of a rural community.

Gendered Expectations Influenced Experience

All participants within this study were women and mothers. The women discussed their roles within the family, and the division of household tasks directly related to food insecurity like cooking, shopping, and paying the bills. The experience of food insecurity among these participants may have been influenced by gendered expectations of their roles within the family, as evidenced by the division of labour and the language used around mothering, as well as the perceived increased burden carried by mothers compared to fathers.

Women in this study reported doing the majority of the cooking, shopping, childcare, paying of bills, and other housekeeping duties. While two of the participants stated that their husbands liked to cook and were the better cooks in the home, the husbands mostly did the cooking only on weekends. One participant described that while her husband helped out with diapers and got up in the middle of the night with the children, she still did the "majority of everything. It's my job - I'm the mom. It's what we're supposed to do, right?" (Toni) These gendered stereotypes were not as clearly articulated by all participants, yet the roles of women in this sample frequently fit with what is deemed traditional women's work of household chores and childcare.

The gender differences in division of household labour meant that women made the bulk of the decisions about what foods to purchase and feed the family. This may have contributed to the higher emotional burden that was described by many participants when discussing the toll of food insecurity in relation to the emotional impact they perceived food insecurity had on their partners. Some women stated that their partners were less worried or stressed when resources were low: "I'll say to my husband: Are you not concerned about this? But I guess because I'm so concerned about it, you know, you're worrying about it for both of us." (Sharon) Another participant stated, "Like he just fluffs it off, like oh, don't worry…" (Susan).

Within this sample consisting of only women, it is not known what the experience of food insecurity was from the perspective of men or partners. However, two participants talked about their male partners going without food so that either the children or the pregnant participant could eat first, demonstrating a conscious concern and effort to protect their loved ones from food insecurity. These strategies will be further discussed within the Taking Action on Food Insecurity theme.

In addition to the experience of food insecurity being influenced by gendered expectations and the unequal division of labour, living in a rural environment seemed to impact the experience of participants, serving to either protect and support families and/or contributing toward participant isolation.

Rurality

Families within this study described both positive and negative aspects of living in a rural community. There were several experiences and opportunities that were deemed unique to rural living, often discussed within the context of community belonging and social support networks. While many participants enjoyed a strong social support network and a culture of trust within their rural communities, there was also the potential for isolation that related to rural geography, being an outsider amongst locals, and difficulties in maintaining privacy. The role of food banks in both promoting community and contributing toward poor diet quality also impacted the experience of participants.

Rural cohesion versus geographic isolation. Participants in this study lived either inside one of two small rural towns of less than 1500 residents, or in the country outside of these towns. Specifically, four families lived outside of town where they had to drive their car to reach local amenities like school, grocery, or convenience stores, and three participants lived within walking distance to these amenities. Only one participant lived in an apartment, while the other families lived in houses with large yards.

The larger of the two towns had one grocery store and a weekly farmer's market, while the other town had no access to food within the town other than what could be found at the convenience store and a small bakery. The next largest town where participants from both areas frequently traveled for grocery shopping was approximately

15 minutes by car, and while this larger town had two grocery stores, one of which was a discount grocery store, the population of that nearby town was still less than 5000 and lacked many amenities that would be found in larger urban areas. It took a minimum of 40 minutes to travel by car to big box or discount stores where participants occasionally shopped if they required a trip to the city for appointments or other reasons.

Participants talked about their reasons for choosing to live in their rural communities, including safety, the friendly people, and the quiet and beauty of the country. Two participants wanted to raise their children here because they had local roots, extended family nearby, and felt that their own happiness growing up in the area meant it was a safe place to raise their children. Other participants came to visit or were searching for an area to settle in, and "fell in love with the place" (Siobhan). All participants talked in both positive and negative terms about their experience with living in rural communities, but no one talked about leaving their current area in favour of a larger centre, and many participants had developed strong social networks within their rural communities.

Despite the perceived beauty and peace of the country, living rurally did create the potential for geographic isolation due to challenges with requiring a reliable method of transportation to access employment, supports and services, and basic necessities like groceries. Public transit was not available in the areas of this study. One participant lived in the country outside of town and did not have a driver's license, forcing her to rely on her husband to drive her places. Another participant also lived outside of walking distance to town or any amenities, and shared her experience about the family car breaking down on a number of occasions. At one time this family was unable to have the car fixed for a period of five weeks. They had no transportation beyond what several different friends would provide when they asked them for help, and so were isolated within their home. This five-week period occurred over Christmas, which impacted their ability to purchase any Christmas presents and caused a great deal of stress for the family.

The expense of car maintenance and gasoline was identified as a challenge for most participants, and several families did not have reliable cars and worried about what

they would do when their cars eventually stopped working. Those who lived where they could walk to local amenities appreciated this aspect of their location and the small town convenience where they "can be anywhere in 15 minutes" (Janet). One factor that affected families' ability to cope with geographic isolation related to their social support networks in these rural communities.

Social support networks versus potential for social isolation. The families in this study had lived in their rural communities anywhere from two to more than twenty years. Many had developed social networks that included family, friends, neighbours, community members, and more formal supports and services within their communities. Most participants were able to name some strong support persons that they could ask for help in the way of someone to drive them somewhere or to pick their children up from school if needed, and a few participants stated they could also borrow money from these supports if they felt they had no other option.

Culture of Trust. In addition to the strong rural support networks identified by many participants, another benefit of rural living involved a culture of trust. This was described as flexibility and trust that was extended to those who struggled to pay upfront for necessities like prescription medications and auto mechanic bills. Two participants stated that the local pharmacist dispensed their drugs and allowed them to provide postdated cheques or come back in on payday to provide the remainder owing. Another participant had an arrangement with her mechanic that allowed her to provide postdated cheques, despite her not knowing the mechanic personally and not being from the area.

> I just had to pay out like $360 with my mechanic; I gave him $120 cash and that's all I have...I gave him a cheque postdated for my next pay cheque...He doesn't know me, I'm nobody. I'm not from here...he knows where I work and he knows I've been there steady. So he relies on that I think. (Toni)

These participants agreed this opportunity to pay for prescription drugs or car repairs would likely not be possible in a larger urban area, but rather was related to the small town or rural culture of trust. This flexibility of service providers in the rural community was an important part of a social support network for some participants, and may have contributed toward a sense of community belonging.

Being an Outsider. Despite the positive influence on social supports that some participants attributed to living in rural communities, two of the seven participants were not able to identify strong social supports. This highlights the contradiction within rural communities between those who feel a sense of community belonging and those who may be isolated. Both of these participants were newer to the area (lived there for three years or less) and had no family in the vicinity. One participant had developed a strong support network within her place of work however, and identified her community as the workplace itself.

The second participant experienced geographic isolation due to not having a driver's license, compounded by isolation due to being new to the area. At the time of the initial interview, she did not have a lot of supports in the area, and did not know others with similar challenges to her own beyond those she met briefly at the food bank. By the time the second interview took place as part of a member check six months later, this participant's circumstances had changed in that her partner had found work, she had acquired her driver's license, and she was talking about a friend in town that she was exchanging children's clothing with. This suggested that being new to the community did not preclude her from being able to overcome the isolation related to being an outsider, although transportation played a significant role in her ability to develop local supports.

Being an outsider, or new to the area, may have increased the potential for isolation for some participants, but other participants within this sample also demonstrated the ability to overcome this challenge. In the words of one participant, it "took a little while for them to figure out that I wasn't a renter and just going to be running away..." (Christie) This participant, while not having local roots, had settled in the area several years previously and had developed a strong attachment to the people and area. Another participant had lived in the area for only two years, but identified strongly with the community already. This participant knew where to access many resources, attended children's programs in town regularly, and talked about knowing others within the area who had similar challenges with food insecurity. These examples support the notion that being new to a small rural community can create isolation due to being an

outsider, but within this sample, these challenges were overcome within a short time, and a sense of community developed.

Lack of Privacy. Finally, due to small town dynamics in which many local families know each other, there were concerns expressed by two of the participants about others knowing their "personal business". One participant was hesitant to apply for jobs or volunteer opportunities because of a criminal record which she attempted to keep hidden from the current community, where she had worked hard to establish a good reputation and move past these earlier mistakes in her life. While this particular participant did not identify herself as feeling isolated by this experience, there was the potential that someone may restrict their engagement within a small community in order to maintain some privacy or hide some aspect about their personal lives. Another participant talked about her house being foreclosed and most of the small town becoming aware of her family's personal hardship when the "for sale" sign went up. It was difficult to maintain privacy in a small town, and the attempt to do so may have contributed toward isolation.

There was a potential for isolation identified within this study related to being newer to the area, geographically isolated, and through an attempt to maintain privacy. However, most participants described some degree of social support or community belonging within their rural communities, or demonstrated an ability to overcome these challenges that arose from being new to the area. Food banks were an additional source of support within the rural communities, which served both to promote community and contribute toward challenges and stress with the experience of food insecurity.

Rural food banks: A source of support and stress. Participants in this study were accessing one of two separate food banks based on their geographic location of residence. Policies at one of the food banks allowed participants to attend once per month for a large box of foods, and on the other weeks of the month they could return for staples such as bread, milk, and eggs. At the other food bank, participants were allowed to attend only once per month.

All participants reported feeling as though the atmosphere at the food banks was welcoming and nonjudgmental, despite some clients' initial feelings of shame or being "self-conscious" about having to attend. One participant described her experience as this:

> The very first time I went...last year...I hadn't even gotten in the door and I was at home and I was freaking out and I was crying, and my husband's like What's wrong? I'd never used a food bank before, so I felt shameful...but when I got there, like they were so welcoming that you know, you don't feel ashamed to walk in the door. (Siobhan)

Other participants also commented on not feeling good about having to attend the food bank, "cause you think there's always that stigma attached to it" (Sharon). This same participant stated that she didn't feel judged when she was there by either the volunteers or the other food bank recipients, and had even brought her children to the food bank with her on occasion, so "it's never been a bad experience".

The food bank that allowed for weekly visits had a lobby area in which clients could have a coffee and wait for their turn based on the order in which they took a number. Many of the clients knew each other, with some greeting each other by name and with hugs, chatting, and sharing recipes according to one participant. Providing identification at each visit was not required, as everyone already knew each other, stated another participant. The other food bank had a very small space where participants were required to wait outside in line, although only one participant complained about this being "embarrassing". Another participant stated that there was usually someone in line that they knew and could talk to while they waited outside at the food bank; "they all seem to know each other too, a lot of them sit around and talk outside so, it's almost like a group meeting place..." (Janet). The perception of being among friends and acquaintances with similar life circumstances was expressed by another participant who described her experience at the food bank in the context of being among a variety of people all "in a similar boat" (Sharon).

The welcoming environment and perceived lack of judgment while attending the food bank was supported by my own observations during food bank visits and from conversations with the directors of the two food banks. The food bank director of the

smaller facility where participants had to wait outside expressed regret about their small building size and inability to welcome participants with coffee and a private space while they waited in line. The director was actively seeking an alternate location to better serve the participants. She also spoke in a respectful way about participants, although I was not present during regular food bank hours to observe the interactions or atmosphere within this facility.

The other food bank, which served coffee in the larger lobby area while clients waited for their food, was a busy place on the two days that I was present during their hours of operation. In the back, a private room allowed individual clients to go behind a closed door with a volunteer to fill out a form about specific foods or other items that were needed. In a separate room at the back, two volunteers filled bags or boxes with the items from the completed forms. In the front lobby area, there was socializing between clients of all ages, as well as with two additional volunteers who were mingling with clients. Fresh produce was spread on the counter in the front area for clients to choose from, some of which participants did not recognize, and there were discussions about unusual foods, recipes, and a variety of other topics.

This experience of food banks as welcoming, nonjudgmental centres in which participants socialized with others who were "in a similar boat", provided an opportunity for community development and social support. This contradicted the stereotypes that participants had prior to attending food banks about stigma and shame, and within this sample of rural families, food banks served as an important piece of the local social support network.

While participants enjoyed the welcoming environment and expressed gratitude when discussing the food received from the food bank, many participants reported they had received foods that were expired and frequently received foods of low nutritional value. One participant said she believed she brought home some products from the food bank that were infested, and "just had to throw out and burn so much flour and oatmeal yesterday." (Toni) Another participant had received expired ready-to-feed infant formula, and gave her child 3 tins before she noticed it was one month past the expiry date. When

discussing the expired, sometimes dented cans of goods received from the food bank, another participant stated: "just cause we can't afford to buy food doesn't mean you can give us something you picked out of the garbage can." (Susan) This seems to indicate an emotional component to receiving damaged or expired goods, as participants may see the donations as a sign of their status as "lesser than", adding to the feelings of shame and emotional distress.

The problems of receiving expired or damaged goods were in addition to the more general, ongoing challenges of receiving processed foods of low nutritional value. Participants acknowledged this as part of a broader issue with the food bank's process of acquiring and distributing foods, since "the food bank does their best, but that's what's out there to give to people right?" (Sharon) Another participant identified the contradiction of accepting and being grateful for food received, while wanting to provide better for her children: "I want my kids to know how to eat properly…I don't want them raised on spaghetti, wieners, you know…" (Susan)

The welcoming environment and positive impact that the food banks had in promoting community for many participants is contrasted by the challenges due to the receipt of damaged and often unhealthy foods. Food banks were one of the formal supports within the rural support networks of participants, which combined with a culture of trust to provide benefits deemed unique to rural living. Challenges that were common to rural living included the cost of transportation and the potential for isolation due to being new to the area or due to geography and unreliable transportation. The gendered expectations of participants and rural influences on food insecurity shaped the experience for participants, and created opportunities for action.

Taking Action on Food Insecurity

Individuals and families within this study described the multiple ways in which they were active participants in addressing the issue of food insecurity, going to great lengths to manage their resources and using personal skills to feed their families. Participants demonstrated great skill and resourcefulness in juggling their bills with family needs, and providing food for their families through traditional cooking and

canning methods, gardening, hunting, fishing, and harvesting wild foods. They also made efforts to protect one another and their children from food insecurity by going without food, medications, and self-care. Yet even with this skill, knowledge, and caring that participants demonstrated to manage their food insecurity and provide for their families, the food insecurity persisted.

Making Ends Meet

Participants regularly looked for ways to stretch out their foods and get the most value for their grocery spending, while using alternative methods to secure food like gardening, hunting, and fishing. All of the participants within this study knew how to cook from scratch, and many did this regularly. They described making foods like spaghetti, chili, soups, and stews that can be stretched out and transformed from one meal into the next using leftovers. "A roast for me, I could cook the roast, we can have dinner, we have sandwich meat, I'll take the bone and make soup off the bone…I've got like 3, 4 meals by the time I'm done." (Janet) Another participant described a similar process involving skilled cooking: "We're going to have chicken tonight, chicken salad tomorrow, chicken soup and then you can even throw in a 4th day and make it a stew. You can stretch it out." (Toni) Two of the participants identified their cooking skills as being related to the rural culture, in which they had learned from their farming families of origin how to stretch foods and cook from scratch. Many of the participants also acknowledged that cooking from scratch was healthier for their families.

The rural environment also created more opportunity for growing their own vegetables, as the participants frequently lived on properties that had plenty of space for gardens. Three of the participants were growing a wide variety of vegetables during the summers, and freezing the produce when they were able to. Two of the participants had used gardens in the past, but hadn't this year because one had developed a health problem and another had recently moved to a new location that did not have space for a garden. Only two of the seven participants had not used gardening as a strategy for procuring food.

Several participants were canning or freezing their home-grown produce, making items like salsa to stretch their foods out, or preparing large quantities of a meal to freeze some for later. In addition, harvesting wild fruit and vegetables was used by some families, as one family described having recently discovered an area of wild raspberries near her property: "So I put in, a little bit scratched up, couple hours of labour but I'm getting raspberries for free. I'm getting food." (Toni) Another participant acknowledged picking berries on the side of the road whenever possible, confirming the theme of Making Ends Meet, during the second interview when it arose as part of the member check.

Some participants stocked up on items that were on sale to put in their deep freezers, for example "if bread's on for less than $2 I'll buy it - 20 boxes (laughs). We have lots of freezers." While most participants acknowledged this strategy of freezing bulk items as desirable, it required enough money to buy the items when they were on sale. One participant had a deep freezer which was sitting empty, and two participants had sold their deep freezers; one to make some money by selling off household items, and another because it was always empty.

Participants also talked about ensuring no food was wasted as a strategy to make ends meet. "I hate to throw food out, so I always try to do something with it, whether it be them (children) eating a wholly different meal and I'm eating leftovers at the table..." (Sharon)

There were several families that relied on hunting and fishing as a food procurement strategy. One family fished regularly in a stream close to their home, with fish in their diet once a week. Two other families fished regularly, but weren't always successful in catching enough to feed their family: "So if we do happen to get something decent enough, then we would keep it and clean it and put it in the freezer. I grew up here...I can fillet a fish in 30 seconds or less." (Janet) Two families hunted deer and wildfowl, and if they weren't successful in shooting anything they would often receive game from other hunters for their freezers.

These strategies demonstrate the skill and knowledge of the rural families in this study with respect to feeding their families, which were further enhanced by their creativity and resourcefulness with their financial resources, described as juggling. All families described the juggling required to make ends meet, a result of balancing family needs with bills and a limited income. Many families were living pay cheque to pay cheque:

> If he doesn't work, like for some reason if he can't get work every day, then...we can't pay the mortgage and the bills and buy groceries every month. Something has to let go. Like this bill doesn't get paid...we don't get to eat meat every night or whatever. (Susan)

Participants were required to put off paying certain bills or paid only half bills, trying to prioritize between rent, utilities, debt, food, and other family needs. Some participants talked about the frequent phone calls from debt collectors and services being shut off for unpaid utilities. One participant had her power turned off on three separate occasions in the past, including for a period of five weeks in the cold of November. Another participant described her current circumstances with bills:

> I'm behind on everything. I'm officially one month behind on my mortgage payment, 2 months behind on my Hydro payment, a month behind on my phone, probably a month behind on my internet because they just turned us on and they haven't taken the money out yet. Almost $25,000 behind on student loans. And I have one collection agency that just will not leave me alone. (Toni)

Another participant described choosing to use the little money she had on Christmas presents for her children and grandchildren, and the repercussions that followed in which she would try to "catch up" and her utilities would be cut off. During a home visit for a member check with a different participant, the phone rang and a message was left on the answering machine from a debt collector who had clearly been trying to get in touch with the participant. This led to obvious embarrassment in the participant who ran to turn the volume down and tried to laugh it off, and confirmed this daily challenge described by several of the participants.

In addition to balancing their income with bills, families worked hard to balance their grocery purchases and feed their families on their limited budget.

> I shop about once a week or once every two weeks, and I'm trying to really keep a good mind on what's in the cupboard, what I need, and what money I have. Really...it's almost a point to where it can become an obsession because you're so worried about having the food there. (Sharon)

When all of this juggling still produced a shortage of food, families worked to protect one another by going without food, without medications, and without self-care.

Protecting Each Other by Going Without

One of the most commonly described phenomena among families with food insecurity was deprivation from going without. This was frequently described in the context of ensuring the children's needs were met first, resulting in caregivers going without food, without self-care, and sometimes without prescription medications.

Six of the seven participants interviewed described the experience or coping strategy of going without food. This ranged from going without the foods they would like to eat as part of a healthy diet, to going without food altogether. Several families had experienced times in which they had completely run out of foods in their cupboard, and in order to make ends meet they either went without or stretched the foods they had, for example "we've eaten rice for days, and stuff like that." (Susan) Many participants described inconsistent eating habits, in which they did not eat regularly scheduled meals. One participant stated, "I just don't eat. I drink protein water, and I just don't eat...I drink powdered milk...just eat soup." (Christie) Another participant described only eating one meal per day most of the time, and when it was really difficult financially during the previous winter, "I missed a couple meals then, just...it happens." (Janet)

Many participants talked about both themselves and their partners going without food to ensure the children had enough, described here: "You have to keep that in your mind, like I can't eat very much because there's 3 other kids that are going to...they have to eat that food...(husband) won't eat sometimes either...both of us will just have like coffee." (Toni) Similarly, one participant described her husband protecting her in the same way: "my husband would do the whole 'I'm not hungry, I'm not hungry' so that I ate, because I was pregnant." (Siobhan)

In addition to going without food, many participants identified their own care or needs as going unmet, clearly articulated by this participant:

> There's no hair, there's no make up, there's no lovin'. No me at all. It's just go to work, be a mom, clean the house, go to bed, go to work, do it again. Make sure that there's something there, make sure that there's always something there. (Toni)

Another participant commented on a desire to look after herself better by achieving a healthier weight, and while she had success in the past with a weight loss program, she stated "something even like Weight Watchers - there's no way I could afford something like that." (Danica) While self-care itself was not identified by all participants during the initial interview and was not asked about specifically in the interview guide, many participants identified with this theme during member checks.

A less commonly described strategy to ensure the family had enough food was to go without prescription medications. Lack of drug benefits was a problem for several families, related to being self-employed or at a company that did not provide a benefit package. In an effort to make ends meet, this participant described her choice to go without medications.

> We go without a lot ourselves...I usually am on medications for, I suffer from depression since I had my first son. When there's been benefits there, it's been perfect because you can get your medication. When it hasn't been there, which is recent, I've slowly weaned myself off medication. But that's what we've given up so I can have food in the house and have what they need. (Sharon)

During member checks when this theme was identified, two additional participants agreed that they had gone without medications in the past when they did not have benefits. Since being able to purchase medications was not directly addressed within the interview guide, it is possible that there were other participants who went without prescription drugs so that they could afford other necessities. Going without food, self-care, and medications were some of the many ways that food insecurity impacted the participants' emotional and physical wellbeing described earlier. This was also a strategy that allowed participants to meet their families' needs and helped make ends meet.

Sharing Amongst Neighbours, Friends, and Community Members

Five of the seven participants discussed how they perceived that the surrounding community influenced their own experience of food insecurity. Several participants knew others who were food insecure, or felt that poverty and its associated challenges were a common experience within their town or the surrounding area because of the economic recession or high levels of rural unemployment. Participants were very cognizant of others' struggles, and frequently demonstrated their generosity toward friends, neighbours, or other community members either through practical support like taking children into their homes for meals or driving each other places, or through direct sharing of their own resources.

One way in which participants demonstrated their generosity was through their hesitation to accept formal supports or resources for their families, in case other families were more in need. In discussing the other recipients at the food bank, one participant stated the following:

> I've seen the families in that food bank that look like they're not doing as great as what I'm doing. It's like, I have a vehicle, you have holes in your shoes. It's like, yeah I've been wearing the same shoes for like 4 years, but mine don't have holes in them, so...those people need to go more often. (Toni)

Similarly, another participant had not sent her daughter to the free breakfast program at her elementary school because she was concerned about taking a spot from another child.

> I know some people have, we've been there where we have had no food and we needed to rely on those things, so...I'm very uncomfortable sending her to that if she doesn't *need* to be there. In case some other kid does need to be there. (Janet)

Other families provided examples of sharing their limited resources directly with others in need. One participant described having shared food with neighbours in her apartment building, because the neighbour was pregnant and they had a young child, were on OW, and had less money for food than the participant and her husband did, so "we were splitting what little we had with them, just so that they had food." (Siobhan) Another participant regularly shared any extra food that she had with a neighbour: "...if I have extra I'll make a plate for her and I'll take it down to her." (Christie) Neither of

these participants who shared their food had secure access to food for their own families, but many participants talked about understanding where the others in need were coming from, and having a strong desire to help out despite their own personal hardship. These were reciprocal practices that would also benefit participants, as one participant described with examples of a neighbour providing her family with a chicken each Christmas, or a friend dropping off a couple of squash on her doorstep when she had them.

The strategies that participants described as they took action to address their food insecurity involved individual practices like cooking and gardening that stretched participants' resources, interpersonal strategies like protecting loved ones by going without food, self-care, and medications, and community level sharing of resources with family, friends, and neighbours. These actions demonstrate resourcefulness, creativity, and perseverance, however on their own were not sufficient to help families overcome their food insecurity. Further influences on the experience of food insecurity came from the public programming and policy level, including social supports from within and beyond the boundaries of the rural community.

Program Use and Public Policies

There are several federal and provincial government funded social welfare programs within Canada that provide financial supports and services to families who meet specific criteria. In addition, local programs are offered through provincial and municipal governments, non-governmental organizations, and charities. The supports available from these programs are often targeted toward low income families, or based on perceived needs within a community. All of the participants within this study were accessing some types of support programs, and all participants were influenced by public policies that impacted their daily lives, their experience with food insecurity, and the food system around them. Despite the benefits received from these programs and policies, many participants discussed the challenges involved in navigating or qualifying for these services, the inadequate income supports received that made it difficult to make ends meet, and the policies that made healthy choices nearly impossible.

Programs Accessed and Barriers Encountered

Within this sample of low income, rural families, several participants had benefited from the financial support of Ontario Works (OW) or Ontario Disability Support Programs (ODSP) either now or at some point in the past. Many participants also spoke about their Child Tax Benefit, a monthly income-based supplement for families with children under the age of 18, within the context of waiting until the date they received this benefit each month so that they could pay bills or purchase food or other essentials.

At the more local level, all seven participants were using a food bank, which was the primary method of recruitment for this study. In addition to the food banks, four participants either currently or had previously purchased the Good Food Box, a discounted box of fruits and vegetables available once per month through a collaboration between the Salvation Army and other social service organizations. Some participants also sought support with winter snowsuits or other programs through the Salvation Army, one family received subsidy through Canadian Tire's Jump Start charity so that their children could participate in sports, one participant had received financial support from a local church in the past to turn her utilities back on, and that same participant had received support from the Trillium drug plan to help offset prescription drug costs.

Despite the clear benefits of income supports, drug and dental benefits received from OW and ODSP, support for recreational activities, clothing and food donations, and other items received through these social support programs, many of the participants talked about the challenges of qualifying for services and their hesitation to access supports because they did not want to always be "begging".

Difficulty navigating support programs. While many participants were actively using social support programs, four participants identified the difficulties they had experienced in navigating the rigid rules of these programs. One participant described the challenge in qualifying for childcare subsidy so that her husband could get a job:

> If we had daycare, he could get a job. To get the job, he has to have the daycare. To get the daycare you have to have the subsidy. To get the subsidy he's got to

> have the job. So where is the line? Where do you start, where's the starting line there? (Toni)

Another example of rigid rules that made it difficult to access services involved the re-education program qualifications in which a participant's husband did not fit the program criteria after his recent lay-off, because of his age.

One participant described the process of seeking coverage from ODSP for a special diet supplement required for her health condition. The participant reported having finally succeeded in getting the paperwork filled out by her doctor and sent in to her caseworker, which was then sent back from ODSP requesting further paperwork from her pharmacist. "It's all another process...it's just ridiculous, I could die by the time they get this done." (Christie) Similarly, it took one participant a full year to qualify for drug coverage under the Trillium Drug Plan, a provincial government plan intended to support people with high prescription drug costs relative to income. After the lengthy wait to qualify, the participant was shortly thereafter cut off and had to reapply because of a clerical error, resulting in the family being owed almost $1000 by Trillium. Two participants described these types of challenges regarding navigation of programs and the options available to them as cyclical, in which breaking free of the cycle was very difficult. In addition, many participants described their decision to go without services rather than to ask for help.

Going without rather than asking for help. Many participants talked about the difficulties in asking for help from friends, family, community programs, or government funded income supports. Some participants chose to suffer without, rather than ask for help. "Mainly, I just, I hate borrowing money too, so normally I just kind of suffer through it and make do..." (Janet) Another participant expressed this in terms of pride:

> Sometimes I'm too proud to ask...I just always think that something's going to work out. Something will come in, like somebody will call me, and it does...cause I don't want to always be begging...So, you try to be good, you try to hold out. (Toni)

Another participant used similar language about not wanting to feel as though she was always begging, and a desire to do things all on her own. Two of the participants who had

accessed OW support in the past talked about their reluctance to accept this help, and one expressed the experience as "absolutely horrible...because I can't provide for my own family." (Susan)

The reluctance to ask for help from supports also translated into stress for some of the participants with children in school.

Schools: A Source of Support or Stress for Parents

Another community support for these families was their children's schools, which had the potential to support families with their food insecurity through programs like free breakfasts or to help offset the cost of school activities or trips. Instead, no participants talked about using the breakfast program or asking for subsidies, and many participants found schools to be a source of stress.

Participants described a pressure associated with being asked for money for hot lunch programs, milk programs, school activities, or requests from their children who wish to participate in special events at school by supplying baked goods for classmates. One mother commented on the tension created during holiday festivities when her daughter asked if she could bring in treats like the other kids were doing: "Well, I can't do that, and that's very traumatic for her...but I don't have enough to send like 30 cookies or whatever." (Janet) Many participants described the stress of school lunch programs, "they have pizza and they have hotdogs and...all kinds of stuff...but you have to pay for them all...you're paying it all the time, you just don't have another $3." (Janet)

The perceived pressure often resulted from a child's desire to participate in school activities, combined with a parent's desire to ensure their child fits in. Some participants had a strong desire to "hold it all together" or maintain some sense of normalcy for their children, despite their personal struggles with providing the opportunities they deemed important for their children's wellbeing. For participants who had not always struggled with poverty, this pressure seemed particularly pronounced. "I just think to my childhood, like I had nothing ever to worry about. And I just wish, sometimes that's what bothers me the most. Is I can't always do what I had, for her." (Danica) Another participant, whose

husband had recently lost stable, well-paid employment, discussed the difficult transition for the family:

> When you go from...we just wrote cheques for doing sporting stuff...and then, you know, me saying you have to choose between this sport and that sport or, we can't do this sport at all, I'm sure it's had an impact on them. And there's struggles too where you know, if kids are offered things through school but you have to pay for it. I really hate saying no to my kids, because their friends are doing it. So there's that pressure... (Sharon)

While two participants acknowledged that their children had simply been unable to participate in school trips or hot lunch programs, this parent described how she had gone to great lengths to ensure her children could participate in field trips.

> And what I do, is when it comes time for school trips, I plan everything. So I start months in advance, gathering little things, if I have to fundraise, then by the time I'm ready to fundraise I have my fundraising materials that I can bake with...(Christie)

Other participants talked about the start-up costs associated with school, including outdoor shoes, indoor shoes, a backpack, a lunch bag, in addition to the ongoing expenses of school lunch programs. None of the participants talked about approaching their schools to discuss ways that they might have the cost of trips subsidized, or how to access free breakfast programs. And one participant had intentionally not enrolled her child in the breakfast program, over concern that other children may need the program more. Overall, the perception of many of the participants in this study was that schools created a great deal of stress.

While participants in this sample did access some supports and services, it was a very difficult experience for many families, contributing to feelings of shame and stress. Some chose to go without, or had their children go without, rather than accessing support. In addition, when participants did access formal supports, they often found inadequate resources were available to support their families to make ends meet, as noted in the following section.

Inadequate Income Supports and High Rural Unemployment

Participants who were accessing income support from OW or ODSP, or who had used these services in the past, experienced difficulty supporting their families and having secure access to food with the limited amount of income received. This was also evident by the detailed accounts provided by many participants of the great lengths taken to try to make ends meet on their low incomes.

One participant suggested, "I think the government should kind of overhaul the whole thing and just, you know, take a look at different people's circumstances." (Siobhan) This participant felt that when she had been working for $11 an hour and traveling 45 minutes each way to work, there should have been some income support available to her family. Instead of returning to work after her second maternity leave, paying for gas to and from her job and for two children in childcare, she felt the only alternative available to her was to receive OW. "Once I pay for a sitter for both (children) and pay for the gas, I'd be bringing home like $21 a week." (Siobhan) This participant perceived few reasonable choices available to her, with minimal job opportunities locally, children to care for, and the high price of gas to commute for a low paying job. However, she had recently qualified for Ontario Student Assistance Program (OSAP) and was completing a college program via distance education so that she could improve her employment prospects, taking action to address her economic situation.

For working, self-employed individuals, the ineligibility for Employment Insurance and drug benefits was identified by one participant as contributing toward a cycle of poverty and occasional reliance on Ontario Works, despite the participant's strong desire to be self-sufficient. She described her frustration regarding economic and social welfare policies:

> The people making the decisions absolutely have no idea what it's like for us. They're the ones making the cutbacks, but they're not cutting back are they? They're getting the bigger pay cheque, we're getting the same, but the food costs, the hydro, the oil, all that's going up. (Susan)

An additional challenge identified by participants involved the high rural unemployment. The job opportunities that were available to participants were not for

well-paid jobs. "Minimum wage is basically all you're going to get in this area unless you're willing to commute. And you see my car, it's an old beater, there's no way that's going to make it to (larger urban centre) every day." (Susan) One participant talked about the difficulty her teenaged daughter had in trying to find part-time work locally, and two other participants discussed their husband's difficulty in finding stable employment, which one described as "utter nonsense" trying to find work in the area. (Toni)

The challenges with food insecurity were directly related to families' descriptions of having inadequate income from either paid employment or social support programs to manage their bills, food, and other essentials for their families. This was compounded by what they considered to be the high cost of healthy living.

High Cost of Healthy Living

All participants identified one of the major barriers to a secure and healthy diet as the high price of healthy foods. Some participants made choices to settle for less nutritious and more filling foods, based on what they could afford or what was on sale, despite their knowledge about a healthy diet and their desire to eat well. This challenge was related to what many deemed the inappropriately high price of fresh produce, dairy, and quality meats.

Other participants reported purchasing fresh produce and quality foods despite their high price, but couldn't buy the quantities they desired and had to stretch the food further through practices like eating half portions of meat. Some participants tried to eat local produce by picking their own from local farmers, but this was also a challenge as local foods were often more expensive than imported foods. One participant identified that this past year it had been more expensive to pick your own strawberries locally than it was to buy a flat at Giant Tiger. Another participant stated that she didn't buy "foreign food", yet this same participant often found herself eating "rice and oatmeal" because that was all that she could afford. Some participants talked about wanting to purchase healthy, local foods but found it too expensive to shop at the farmer's market. These everyday challenges with trying to eat healthy and locally, in an environment dominated by cheap,

processed convenience foods and inexpensive imported goods, demonstrated an appreciation by some participants for the role of policy in creating a healthy food system.

Participants described several supports or services that they had accessed, many of which provided important financial support or opportunities for food, clothing, drug benefits, and recreational programs that helped participants make ends meet. There were emotional challenges involved in accepting services, and when participants did ask for help, many described difficulties in navigating the services or in making ends meet due to inadequacies of income supports. When combined with the demands perceived to be placed on participants from their children's schools, and the high cost of maintaining a healthy diet, participants struggled with the day-to-day management of their food insecurity despite these public programs and policies that are intended to support families in need.

Summary

The sample within this study of food insecurity was comprised of women with children, living primarily within two parent households, and with most families having at least one adult working outside of the home. All of the participants described the emotional strain and stress associated with living with food insecurity, and many participants were experiencing depression. Some of the factors that shaped their experience with food insecurity were the gendered expectations of the women, and rural living in which community supports and a culture of trust were deemed as benefits unique to the rural environment. Rurality also conferred disadvantages, including the potential for isolation, challenges with requiring reliable transportation, and high unemployment. Participants went to great lengths to manage their food insecurity, and demonstrated skills and resourcefulness in their daily approach to making ends meet. Participants also sought formal supports to help manage their resources, including a variety of local programs, with some participants accessing income supports. These support programs and actions taken by participants were not adequate to address the food insecurity in this sample. The insights gained from these findings, how the results relate to the literature, and the

implications for community health nurses, researchers, and policy makers will be discussed in the next sections.

Chapter 5

Discussion

The results of this critical ethnography provide a picture of the day-to-day struggles of rural families with food insecurity, and are situated within the larger context of social, economic, political, and historical influences that make breaking free from food insecurity a near impossibility. The stories of rural families demonstrate the significant skills, creativity, and perseverance required to survive in the face of hardship, thus challenging the dominant notions about families in poverty (Herbert & Reid, 2005; Reutter et al., 2009), and leading to questions about what it takes to escape food insecurity and its associated challenges in the current environment. What is it about the broader circumstances these families find themselves in that make hard work, education, cooking and budgeting skills, and strong social supports inadequate to resolve their food insecurity? How is it that $27 billion worth of food is wasted each year in Canada (Value Chain Management Centre, 2012) while members of our communities skip meals so their children can eat? And how can we, as nurses, work toward developing healthy communities that support families to achieve the independence and social equality that they seek?

Despite the skills and resources of families in this study, there were broader forces at work that influenced families' ability to make ends meet. Changes in tax structures that redistribute wealth in Canada have led to significant increases in poverty and income inequality in the past 30 years (Bryant et al., 2011). The influence of these neo-liberal policies, combined with dominant societal stereotypes about poverty, has impacted the social determinants of health and equality of opportunity for families. Canadian society tends to perceive health as a product of individual dispositions and actions (Raphael et al., 2008), and social class or poverty as something that can be overcome through hard work (Williams, 2009). These individualistic attributions for health and welfare fail to adequately account for the experiences of families like those in the current study, and create an environment where low income individuals may experience social exclusion and perceive others to view them as burdens to society (Reutter et al., 2009).

In order to challenge these societal stereotypes about poverty and begin to promote social equality, the voices of those living with poverty and food insecurity need to be heard. This ethnography provides a glimpse into the strengths, resources, and challenges of families with children living in rural Ontario, and provides an alternative view to the construction of the poor as dependent, deviant, and undeserving (Herbert & Reid, 2005). In seeking a deeper understanding of this phenomenon, I have considered the multiple and broad influences on food insecurity, and how public policy is both implicated in contributing toward this phenomenon, while it also has the potential to pull families out of food insecurity.

This analysis will provide insight into the experience of food insecurity for rural families, with practice and policy implications for community health nurses. The social determinants of health will serve as a framework to examine the many factors influencing food insecurity within this ethnography, and a critical lens is used to guide my analysis of the broad political, social, economic, and historical influences on food insecurity.

Social Determinants of Health

The social determinants of health are deemed central to advancing health equity (Falk-Rafael, 2005a), and the standards and principles guiding community health nurse practice are based on the social determinants and primary health care theory (Community Health Nurses Association of Canada, 2008; CPHA, 2010). While all social determinants are interrelated, this analysis will focus on the key determinants of health that emerged from the narratives of this rural sample, including income, education, employment, gender, housing, social support network, and social exclusion. These determinants will be discussed as I examine the relationship between each social determinant and the experience of food insecurity, as well as how the related public policies affected families and provide impetus for nursing action.

Income

It comes as no surprise that families with low income are at increased risk of being food insecure, with research demonstrating that a declining income corresponds to a decrease in quality and quantity of food as other needs take precedence (Partyka,

Whiting, Grunerud, Archibald, & Quennell, 2010; De Marco, Thorburn, & Kue, 2009). Among the participants who received social assistance as a source of income, the meager living allowance provided by OW and ODSP is a well known factor associated with food insecurity (Kirkpatrick & Tarasuk, 2010; McIntyre, 2003; Tarasuk & Vogt, 2009; Vozoris & Tarasuk, 2003).

While most participants struggled with financial constraints that contributed to their food insecurity, not all participants had low incomes. Two of the seven participants in this study did not fall below Statistics Canada's (2011) threshold for low income. This is consistent with research suggesting food insecurity within Canada does not occur only among low income families (Health Canada, a, n.d.), and that 14.4% of middle income Ontarians were food insecure in 2004 (Vogt & Tarasuk, 2007).

From personal experience, I have witnessed a similar phenomenon among some of my middle income peers with young children who creatively juggle resources or purchase food on credit cards. Household debt is at record levels within Canada, and indebtedness tends to peak between the ages of 31 to 35 years (Bank of Canada, 2012). At this stage in their lives, many individuals have taken on large amounts of debt as they completed post-secondary education, purchased a home, and started a family. In rural areas, the cost of transportation is added to this debt load, where two parent families often require two vehicles to commute to work or shuttle children to school or activities. Given the high debt load of many middle income families, including the two participants within this study, an event like a job loss or birth of a child can create a situation in which families can no longer make ends meet.

While the level of deprivation and experience of food insecurity is unique to each individual, the common struggles described by families from various levels of income within the current study highlights the need to appreciate the larger context of family circumstances and the assumptions made about who is at risk for food insecurity. When social and income support programs target low income families, it is possible that this middle income segment of the community is missed. Factors like student loans and other household debt, recent changes to employment circumstances like a job loss or maternity

leave, cost of transportation, and having no employment benefits must be considered as potential risk factors that can tip someone with a middle income toward food insecurity.

Education

Statistics show that the population within the rural area of this study has lower levels of education compared to the provincial average (Statistics Canada, 2012), and there is some evidence to suggest low education is associated with food insecurity (Olson et al., 2004). Yet, the majority of participants in this study had either partially completed or graduated from postsecondary education. Clearly education alone was not enough to secure families well paying jobs with benefits, or to protect them from food insecurity. In fact, exorbitant student loans may have contributed to the food insecurity of one participant, making this participant's post-secondary education more of a burden than a benefit. When job opportunities are limited in rural areas, the costs of transportation to larger towns or cities are prohibitive, and when childcare costs are factored into the mix, some participants are left with few choices for supporting their families.

Employment

Employment provides a secure income, and income determines access to other determinants of health like food security (Mikkonen & Raphael, 2010). Having limited opportunities for employment was raised by several participants when discussing the disadvantages of rural living, and Statistics Canada (2012) confirmed that this study's geographic setting has higher rates of unemployment than the average for Ontario. Five of the seven participants in this study were currently employed, although many identified their low wages, transportation expenses of getting to their work, or lack of benefits as factors contributing to food insecurity. Many participants discussed their desire to stay off social assistance and to be able to support their families independently and were seeking better employment opportunities, jobs closer to home, or higher paid jobs on an ongoing basis. The slow recovery from the recession of 2008 and a weak labour market in Canada (Stanford, 2012) further compounded the challenges created by the limited employment opportunities of a rural environment. However, participants strove to overcome these barriers, demonstrating perseverance and a hard working nature that challenged the notion

of poor women as "cheaters, lazy, and choosing not to work" (Herbert & Reid, 2005, p. 167).

Gender

Gender plays a role in the health of Canadians due to the inequity of workforce opportunities, the gap in earnings between men and women even when employed in similar jobs, the burden of responsibility for childcare and housework that falls more heavily on women, and the lack of affordable and high quality day care (Mikkonen & Raphael, 2010). These factors contribute to higher poverty rates for women (Herbert & Reid, 2005), increase the risk of women becoming food insecure, and impact the experience of women who may struggle to meet their personal expectations of what makes a "good mother".

Many participants in this sample discussed the impact of gendered norms and role expectations on both their experience of food insecurity and the strategies used to make ends meet. These rural women identified as the primary caregivers, undertaking most of the tasks associated with housekeeping and feeding the family. This is consistent with research that showed women in Canada spend more hours than men on domestic work like cooking, cleaning, and caring for family (Organization for Economic Cooperation and Development [OECD], n.d.), and fits with the dominant discourse about what constitutes women's work and social roles within the family (Olson, 2005). The common strategy described of reducing or missing meals to make ends meet and feeding the children first adds to the growing body of research on this topic (Stevens, 2010; McIntyre, Walsh, & Connor, 2001; Hamelin et al., 2002; Hoisington et al., 2002). While skipping meals was also identified as common to some male partners in this study, there were multiple other ways that women described going without in relation to their role as mother. This is similar to the findings of McIntyre, Officer, and Robinson (2003) in which mothers in Atlantic Canada commonly accepted self-sacrifice as part of their mothering role, going without clothing and small luxuries. These gendered ideas about the role of mother likely increased the emotional burden of food insecurity for women as they sought to fulfill multiple roles within the family.

Gender and emotional impact of food insecurity. Many participants perceived that their partners worried less when resources were low, whereas the women in this study described an enormous personal strain resulting from their food insecurity. A majority of study participants had been diagnosed with depression. This is consistent with a study by Carter et al. (2011) that demonstrated women suffer more frequently from psychological distress connected to their food insecurity than men (Carter et al., 2011).

Several studies have identified that individuals, primarily women, with depressive symptoms are significantly more likely to experience food insecurity (Hanson & Olson, 2012; Melchior et al., 2009; Okechukwu, El Ayadi, Tamers, Sabbath, & Berkman, 2012). Several participants within the current study suggested that their depression was directly linked to their experience of food insecurity, and that the stresses of trying to make ends meet were a major contributing factor to their depression. This description is similar to the findings from other research, in which food insecurity increased the likelihood of developing depressive symptoms (Carter, Kruse, Blakely, & Collings, 2011; Siefert, Heflin, Corcoran, & Williams, 2004).

The women's descriptions and interpretation of the impact of food insecurity on their wellbeing suggest that the experience may be different for women in this study than their male partners. This may be related to the women's expectations of themselves as mothers, trying to care for the family and provide opportunities for their children, while many were also working outside of the home. These role expectations contribute to the emotional strain on women, and are further compounded by an environment with fewer workforce opportunities, lower wages for women, and limited affordable, quality childcare spaces. Within the rural environment, the challenges for women may be even more pronounced.

Gender and the rural environment. The number of women participating in the workforce is lower in rural than urban areas of Canada, and the rural gender gap in employment participation is larger with 11.6% fewer women employed than men (Status of Women Canada, 2012). In addition, a higher percentage of women in rural areas spend time on unpaid work compared to women in urban areas, and the gender gap in hours of

unpaid work is greater in rural areas as well (Status of Women Canada, 2012). These trends were visible within the rural setting of the current study, in which women had limited opportunities for well-paid employment, and described the burden of unpaid work falling primarily within their domain. The rural environment further added to the challenges for women in accessing jobs because of the concerns about reliable transportation to get to employment opportunities, and the limited affordable childcare options to support their employment outside of the home.

Housing

Housing is identified as a social determinant of health, in which increasing numbers of Canadians struggling with issues of affordable housing find themselves with limited resources remaining for food, recreation, and other needs (Bryant et al., 2011). Owning a home has been identified as a factor protecting individuals from food insecurity (Olson et al., 2004), while the proportion of income spent on rent, rent in arrears, and borrowing money for rent have all been associated with increased risk of food insecurity (Kirkpatrick & Tarasuk, 2011).

Within this rural sample, four of the participants rented their homes and three either owned or were in a rent-to-own situation. Not owning their home is consistent with the risk factors identified by Olson et al. (2004). In contrast to the literature however, none of the participants identified the cost of housing as contributing toward their food insecurity. This may be a unique feature and clear advantage of rural living, where housing and rental prices are lower than in urban centres where much of the food insecurity research has been conducted. This further highlights the need to consider rurality as a social determinant of health, in which the rural environment can impact health in both positive and negative ways.

Social Exclusion

Social exclusion relates to a group's limited opportunities for participation in Canadian life, through reduced access to social, political, cultural, and economic resources (Mikkonen & Raphael, 2010). This social determinant of health may disproportionately affect certain groups, including women, people with disabilities, recent

immigrants, Aboriginals, and Canadians of colour (Mikkonen & Raphael, 2010). Within this sample, the participants were racially homogeneous as white Canadian born females, and while some participants disclosed health information that may be categorized as a disability, none of the participants openly discussed their disability in relation to their poverty, food insecurity, or social exclusion.

A variety of factors increased the risk of social exclusion within this sample, including gender, the potential for geographic isolation, limited financial means to access resources, and the stigma and discrimination toward those in poverty (Herbert & Reid, 2005; Reutter et al., 2009). There were some examples provided of children being excluded from school trips and women who were unable to afford participation in social life, yet overall the results of this study suggest participants were engaged in their communities and local social support networks. This may have been unique to their rural communities, in which high levels of community belonging, social supports, and resilience served to reduce social exclusion.

Rural social capital. The study findings suggest that one of the benefits of living in a rural community was the high level of social capital (See Glossary – Appendix A) among many participants. Social capital is the opportunity or ability to access resources by virtue of belonging to a social network (Ramadurai, Sharf, & Sharkey, 2012). Social capital was not formally measured or addressed within this study, however the topics of rural living and access to community and personal supports were common threads within the narratives. Many participants identified being well connected in knowing where to access formal supports, regularly sharing resources with community members, experienced benefits of flexible payment arrangements with local service providers, and several participants knew others who were experiencing similar challenges with poverty and food insecurity. While these indicators suggest participants had a high level of social capital, there were limits to their accessing of supports or resources, demonstrated by not seeking support to offset the cost of school trips.

The seemingly high degree of social capital within this study is consistent with Statistics Canada (2005) data showing higher rates of community belonging in rural

compared to urban Canada, with 71.6% of the population in the geographical setting of this study reporting a very strong or somewhat strong sense of community belonging in 2012, higher than the provincial average of 67.4% (Statistics Canada, 2012). Community belonging in this sample may have also been enhanced by the perception of poverty as a common experience within their local communities, decreasing the stigma attached to their poverty.

While there have been few studies on the topic of social capital in relation to food insecurity, the results from this research have been mixed. A study by Ramadurai et al. (2012) found that individuals with food insecurity in rural Texas had a strong sense of commitment and responsibility toward their communities, perceived by the authors as a high degree of social capital. This social capital seemed to improve nutritional and information access, while building morale and social support among rural residents (Ramadurai et al., 2012). Dean and Sharkey (2011) found that low levels of perceived social capital were associated with food insecurity, while Kirkpatrick and Tarasuk (2010) found no association between social capital and food insecurity in an urban environment. Other research has suggested that social support and high levels of community belonging are associated with fewer depressive symptoms (Turner & McLaren, 2011), while both neighbourhood and individual social capital are associated with improved health and lower rates of mortality (OECD, 2010).

Given the high levels of social support, the culture of trust, and community belonging described by many of the participants in this study, it is possible that this had a positive effect on their experience with food insecurity and led to lower levels of social exclusion than one might expect within a group of low income women with food insecurity. The low level of social exclusion may also be related to the level of resilience described by participants. Some of the participants' descriptions of being survivors, hard working, and able to pick themselves up and "get back at it" provided examples of resilience in managing their food insecurity. This resilience may have contributed toward social capital within this sample, as an attitude of perseverance helped participants access resources and support one another within their social networks. Other strategies that

participants used to manage their resources and food insecurity were impacted by strong social support networks, including sharing of resources and protecting each other by going without.

Strategies to manage resources. Many of the participants described sharing amongst family, friends, neighbours, and community members as a strategy to make ends meet. This finding was particularly striking given the limited resources of the participants, who were sharing what little food or other resources that they had with others. Garasky et al. (2006) revealed a similar finding, in which rural families in poverty often shared resources with others experiencing hardship, to the point of their own detriment. The families who were the recipients of the food did not benefit with respect to their level of food insecurity, however the more groups that a family was sharing their own food with increased their likelihood of being food insecure (Garasky et al., 2006). The authors suggested that despite this unexpected finding related to food sharing, having an informal network of support served to reduce the likelihood of rural families experiencing food insecurity (Garasky et al., 2006).

Participants within this study also identified sacrifices made to protect one another from food insecurity; when combined with the sharing of resources, this may have had a detrimental effect on participants whose resources are already low. However, the strong connections and supportive networks within the rural communities also helped participants access local social and cultural resources, thereby lowering the level of social exclusion, and possibly leading to lower levels of emotional strain or depressive symptoms (Turner & McLaren, 2011). It is possible that these examples of families, neighbours, and communities coming together to support each other are a product of a failed social safety net, in which communities have had no choice but to fend for themselves in the face of economic adversity.

Social Safety Net

Participants within this study were benefitting from a variety of charitable and government level support programs, although they described some challenges with navigating the rigid rules of these programs and the difficulties making ends meet despite

the supports received. At the local level, some unexpected results emerged from the study findings regarding the participants' experiences with food banks and their children's schools. These community resources must be understood within the broader policy context, and applying a critical lens allowed for deeper analysis of the impact of the social safety net on food insecurity of this sample.

Schools: A missed opportunity. Within this sample, participants with school-aged children perceived the financial demands placed on their families by the schools to cause a great deal of stress, and no families were accessing school breakfast programs (See Glossary – Appendix A) or subsidies. This was a surprising finding, as school had not been addressed as part of the interview guide, nor had this potential source of stress come up in the literature during my review.

School nutrition programs have been found to benefit families by reducing the risk of marginal food insecurity among at-risk families (Bartfeld & Ahn, 2011), and increasing vegetable consumption and frequency of breakfast eaten among food insecure children (Grutzmacher & Gross, 2011). However, a study of low income Toronto families using various community food programs found no association between participation in school nutrition programs and food security status (Kirkpatrick & Tarasuk, 2009), and research by Raine, McIntyre, and Dayle (2011) suggested that school nutrition programs are not meeting the needs of the target group. Raine et al. (2011) suggested that the reason for low attendance of children in poverty at school nutrition programs related to parental resistance due to fear of stigmatization. This rationale for failure to reach families in need was based on comments from program operators and volunteers rather than the parents themselves (Raine et al., 2011). The findings from the current study support Raine et al.'s assertion that food programs are missing their target audience, and add insight into why some parents may hesitate to accept program support: parents may be concerned about taking the food or program spots from others who are more in need.

Canada is the only G8 country without a nationally funded school meal program (People's Food Policy Project, 2011), and the current territorial and provincial school nutrition policies and programs vary widely (McKenna, 2010). The Centre for Science in

the Public Interest (2007) urged federal, provincial, and territorial governments to establish pan-Canadian school meal programs, policies and surveillance, which would go a long way toward supporting children from food insecure families whose children are not accessing the current breakfast programs. Raine et al. (2011) recommended that children's nutrition programs be seen from a social justice perspective, in which families should have adequate financial resources to support their needs, viable child care options to support their workforce participation, and affordable access to food staples such as milk, eggs, and meat. In keeping with Raine et al.'s recommendations, while schools are an important piece of the social safety net and there is an opportunity for improved targeting of current programs and development of universal meal programs and policies, none of these solutions address the underlying poverty of families.

Rural food banks as community centres. An additional unexpected finding from this study was the welcoming environment and sense of community belonging that most participants described regarding their experience with the local food banks. This is in stark contrast to much of the literature about urban food banks (Smith & Morton, 2009; Tarasuk & Beaton, 1999) and the stigma of poverty (Herbert & Reid, 2005; Reutter et al., 2009). Tarasuk and Beaton (1999) described urban women's feelings of shame, embarrassment, and humiliation during their first visit to the food bank, and an ongoing attempt to hide their food bank usage from their children. This seemed to be the expectation of some participants in this study who described similar feelings of shame prior to attending the food bank for the first time, although participants described a welcoming and nonjudgmental response of staff and volunteers that put them at ease once they arrived. Participants in this study also acknowledged having brought their children with them to the local food banks on occasion, contrasting with the literature.

In a rural setting, Smith and Morton (2009) identified stigma attached to attending food pantries in rural Minnesota and Iowa that prevented some participants from using this resource. The participants in the current study were recruited primarily from food banks and therefore do not represent those who may have avoided using the local food banks due to concerns about stigma. However, the experiences described by the

participants of feeling welcomed and among a group of community members with similar life circumstances, allowed them to feel comfortable returning to the food banks for subsequent visits and seems to contradict the findings of Smith and Morton (2009).

According to research by Tarasuk and Eakin (2003), urban food banks often had strictly enforced policies about a client's income, expenditures, and the frequency of access to assistance that was allowed, based on a limited supply of donated items. This contrasts with one of the food banks within this study that allowed participants to attend as often as once per week, and the director from the second food bank who stated that despite suggesting clients may not attend more than once per month, she would not turn a client away who was in need. The food bank experience described in this study may in fact have promoted a sense of community belonging and served to reduce the stigma often attached to poverty and food insecurity, quite the opposite effect to what is found in the literature.

Food banks as community hubs. The findings from this study suggest that participants felt comfortable attending the local food banks, and often socialized with volunteers and other clients using this service while they waited in line. This raises questions about the potential for food banks to achieve an expanded community development role, in which the food bank becomes a hub for other services or activities within the community and involves the local members in addressing the root causes of poverty and issues of social justice. An example of this approach is the newly named Table Community Food Centre in a small town of eastern Ontario, formerly the Perth and District Food Bank. The Table Community Food Centre has recently expanded to incorporate after school programs, cooking classes for fathers/male guardians and their children, a community garden, and a social justice club, among other initiatives (Perth and District Food Bank, 2013). Involving participants in developing local solutions to their unique needs and challenges helps to overcome the limitations of the current charitable food assistance programs, in which food banks do little to address the underlying causes of food insecurity and "giving food is more a symbolic gesture than a response to need" (Tarasuk & Eakin, 2003).

Food banks' role in addressing underlying poverty. Charitable food programs were developed as a temporary solution to address the needs of a growing number of food insecure Canadians (Tarasuk, 2001). The motives of food bank directors and volunteers are undoubtedly honorable, seeking to meet a need they perceive within their communities. However, Dachner, Gaetz, Poland, and Tarasuk (2009) suggested that planning and delivery of charitable meal programs are disconnected from the food and nutrient needs of clients, with a coordinated and sustainable program only achievable through the commitment of federal and provincial governments. Engler-Stringer and Berenbaum (2007) and Kirkpatrick and Tarasuk (2009) agreed that food programs are not the answer to long-term food security, and that more effective strategies that include policy reforms are essential to ensure Canadian families have adequate resources for food. Tarasuk and Eakin (2003) expressed further concern about the effect that food banks have in rendering the needs of clients invisible. By giving the illusion of addressing hunger, food banks can reduce the impetus for community groups and government to develop solutions to food insecurity (Tarasuk & Eakin, 2003).

Within the current study, there appeared to be a lack of organized initiatives or involvement of clients in addressing the root causes of poverty. This demonstrates that despite the welcoming environment and natural community development occurring within these settings, there is great potential to expand services and client involvement in a policy or activism role, much like the Table Community Food Centre's initiatives focused on issues of social justice (Perth and District Food Bank, 2013).

Food banks' role in diet quality. The challenges that participants encountered with the questionable quality of foods offered by the food bank, and food of low nutritional value, has been previously identified within the literature. Tarasuk and Eakin (2003) explained this as an attempt by food bank workers to salvage food through cleaning up, repackaging, and sorting through damaged foods in order to meet the demand for food with their limited supplies. This practice is similar to that described by both local food bank directors within this study, in which produce being discarded from grocery stores was sorted through, washed, and redistributed. Similar to experiences of

participants in this study who received expired goods or an infested product from the food bank, in a study of collective kitchen users within three Canadian cities, some individuals were concerned about the safety of food bank donations after having fallen ill from consuming them (Engel-Stringer & Berenbaum, 2007).

The additional concerns expressed by many participants in this study regarding the nutritional quality of foods from the food bank were also identified in the research. A predominance of crackers, cereals, and bread products received from food banks (Rush, Ng, Irwin, Stitt, & He, 2007) combined with the challenges of affording the high price of quality fruits, vegetables, and meats from the grocery stores may have contributed toward the poorer quality diets (Breuning et al., 2012; Glanville & McIntyre, 2006) and higher levels of nutrient deficiencies among the food insecure (Kirkpatrick & Tarasuk, 2008).

The challenges faced by participants regarding the quality and safety of foods received from the food banks are a legitimate and often hidden concern among participants. Some families felt they had no choice but to use food bank resources that eroded their health and sense of dignity, and yet they were hesitant to criticize this food and support that they felt grateful for. The food bank collection and distribution practices demonstrate how the combination of local policies and lack of broader government policies intersect to play an important role in the health of low income families. These challenges are troublesome given the research suggesting that the foods received from the food bank are doing little to address the food security status of participants and underlying issues of poverty (Tarasuk & Eakin, 2003). According to McIntyre (2003), food banks are "a poor policy alternative to the family purchase of health foods" (p. 51).

Using a critical lens provides a look at the broader political, historical, and social influences on the problems relating to food insecurity. From this perspective, it becomes apparent that food banks and charitable food programs like school breakfasts are part of a short-term response by well-meaning community members, and may have an important role in promoting community. However, this charitable model does little to address the underlying causes of poverty, and instead, upstream approaches to food insecurity are necessary.

Public policies and government support programs. Some of the participants within this study identified the inadequacy of social assistance rates to meet their family needs, supported by many authors within the literature (Kirkpatrick & Tarasuk, 2008; Raphael, 2007; Tarasuk & Vogt, 2009) and in position statements of key nursing and other organizations (Dietitians of Canada, 2007; Food Banks Canada, 2012; RNAO, 2010). Rideout et al. (2007) suggested that the climbing food bank usage statistics provide evidence of 20 years of breakdown of the social safety net in Canada.

Social assistance income is intended to support families while they seek employment and, in this population, also raise their young children. Yet the income received is well below the poverty levels and the lowest paid employment, as incentive to get people off the welfare system (Food Banks Canada, 2012). Keeping families in poverty, without addressing the underlying issues that contribute toward their difficulties in securing work, is a policy that causes more harm than benefit. The narratives of participants in this study demonstrate that going on social assistance was considered a last resort or act of desperation, and families would prefer to work and independently support their families. This pride, hard work, and perseverance of participants challenges the dominant notions about families on social assistance as lazy and "choosing" not to work (Herbert & Reid, 2005).

Within this sample, many of the participants were not receiving social assistance or had only received it for a short time in the past. This demonstrates the need for a multi-pronged approach to address poverty and food insecurity, including rural employment and childcare initiatives, a reasonable minimum wage, improved access to drug benefits, and a streamlined application process for existing programs that many participants found difficult to navigate. The high degree of participant knowledge and skill within this sample should also help to inform program development targeting low income rural families.

Participant resources should guide program development. The literature suggests that high levels of food and financial skills (Olson et al., 2004) and more complex food preparation skills (Engel-Stringer, Stringer, & Haines, 2011) were

associated with higher levels of food security. While these measures were not directly assessed within the current study, the examples provided by participants of how they made ends meet through cooking from scratch, gardening, and juggling bills, suggested that they have high levels of complex cooking and financial skills. The strategies described by participants were similar to the samples in the rural United States who gardened, hunted, fished, and drove long distances to purchase foods using coupons, flyers, and sale items (Smith & Miller, 2011; Yousefian et al., 2011).

Additional research has suggested that food insecure families already have good nutrition knowledge and cooking skills, yet lack the income to make healthy choices (Atkinson, Billing, Desmond, Gold, & Tournas-Hardt, 2007; Yousefian et al., 2011). This is consistent with the sample of families in this study, who all seemed aware of healthy food choices and how to prepare a healthy meal. Despite the participants' nutrition knowledge and desire to eat well, some families felt it necessary to make choices based on cost and sustenance. This is similar to research by Ramadurai et al. (2012) that found rural families were forced to eat nonrecommended foods or "fillers" in order to feel satisfied.

Considering the nutrition knowledge and skills of this sample, it is probable that the solutions to their food insecurity do not relate to food and nutrition knowledge, cooking skills, or personal financial management, but rather must be addressed through relief of economic constraints (Tarasuk, 2001). This insight should help inform program development for rural families with food insecurity, with the critical lens offering an alternative view to that of food insecurity as an individual or family problem, and rather integrating the larger influences of social, economic, and political policies on food insecurity. This adds to the body of literature suggesting that the social determinants of health must be addressed in order to improve population health and wellbeing, with a reduced focus on individual and behavioural interventions (Falk-Rafael, 2005a; Mikkonen & Raphael, 2010; Raphael, Curry-Stevens, & Bryant, 2008).

Access to healthy foods. Food supply problems are not the cause of food insecurity within wealthy nation states like Canada where surplus food exists and

significant amounts of food is wasted annually; rather Riches (2011) suggested that poverty, social inequality, and failed public policy are to blame. Neoliberal policies have created an environment in which government's role is limited to food supply and safety, and food prices and availability are largely set by the market (Dowler & O'Connor, 2012). The acquisition of food by consumers is based on the "individual choice model", where food purchases are considered a sign of competency with respect to budgeting and nutritional knowledge (Dowler & O'Connor, 2012). Yet, the analysis of narratives from the rural participants in this study provide a clear message that food choices are about more than budgeting and nutrition knowledge. The inability of families to make the healthy choices they would like, particularly in the face of surplus food all around them, is a testament to the problems with our public policies in Canada.

The OPHA (2002) suggested that food supply issues must be incorporated into a systemic approach to community food security, where environmental, economic, and social policies of government dictate the access and affordability of foods available to individuals. A food staple program has been suggested as one component of a strategy to address food security, protecting the affordability of healthy foods like dairy, eggs, and meat (McIntyre, 2003; Raine et al., 2003). Monitoring of the affordability of a nutritious food basket is currently done through annual surveys of local grocery stores by public health units (Ministry of Health and Long Term Care, 2008), the results of which are intended to inform policy and program development at the local level.

The literature and analysis of the social safety net indicate a strong need for healthy public policy to address the many levels of influence on food insecurity, including adequate income supports and an affordable, healthy, and accessible food supply. This reveals opportunities for nurses to respond through the "creation of supportive and sustainable physical, social, political, and economic environments" (Falk-Rafael, 2005b, p. 45). Nurses must continue their work in poverty reduction and promoting social justice through the creation of healthy public policy, addressing food insecurity from an upstream approach.

Implications for Nursing Practice, Policy, and Research

This study has provided insight into the everyday experiences of rural families with food insecurity. Critical ethnography helped give voice to families and seek an understanding of their worlds, while uncovering the social, political, historical, and economic factors influencing families' food insecurity. I will now identify the implications for community health nurses who can use these findings to support their work in advocating for families who have been silenced, challenging dominant ideologies about poverty that have contributed to power differentials, and influencing public policies that impact health (Falk-Rafael, 2005a).

Practice

Nurses working in the areas of family and community health have the opportunity to work with low income families who may be struggling with food insecurity. It is important for nurses to have an appreciation for the emotional toll that food insecurity has on families, and more importantly the strengths, skills, and knowledge that families employ on a day-to-day basis to make ends meet. When professionals have negative stereotypes and low expectations of vulnerable or disadvantaged clients, it undermines their competence and successes with everyday challenges (Canvin et al., 2009). Acknowledging the strengths and resources of families allows for nurses to help maximize these strengths and work together with families toward overcoming barriers to food security. This approach considers the contextualized nature of lived experience, and should seek to move beyond simply recognizing this context toward challenging and disrupting the external constraints that maintain food insecurity (Falk-Rafael, 2005a).

Given the skills and knowledge around healthy eating, cooking, and budgeting within this rural sample, it is likely that the solutions to food insecurity are not through programs that promote education or skill building, but rather those that relate to the social determinants of health like poverty, rural employment opportunities, childcare, transportation, and access to low cost healthy foods. This is a more upstream approach to influencing societal structures and relations that are contributing to the poor health of disadvantaged groups (Falk-Rafael, 2005). As community health nurses, the social

determinants of health and principles of social justice are woven into nurses' practice through activities like advocacy, building capacity, community development, and policy development and implementation (CPHA, 2010). These strategies must be incorporated into a comprehensive approach that builds on community strengths and capacities while addressing the overarching conditions that maintain food insecurity, promoting equity and the fundamental right of all Canadians to the determinants of health (CHNAC, 2008).

In putting these tenets of primary health care into practice, engagement with local community members is essential to gain an understanding of the strengths and areas of concern for each unique community. Once the factors influencing food insecurity have been identified and the community's priorities are developed in a collaborative way, community health nurses can take action to advocate for partnerships, programs, or policies that help to address the root causes of food insecurity and achieve social and economic equality in health (Cohen, 2008).

This study also has implications for nurses and nurse practitioners working within primary care settings. While the current study did not directly assess the number of participants who disclosed their food insecurity or difficulty affording prescription medications to their primary care providers, the strategy of going without food to stretch resources has been well documented (Stevens, 2010; McIntyre, Walsh, & Connor, 2001; Hamelin et al., 2002; Hoisington et al., 2002). Some literature has also identified going without or limiting prescription drug use as a method of juggling food and other resources (Bengle et al., 2010; Ma, Gee, & Kushel, 2008). This literature has primarily focused on low income families however, and it is possible that health care practitioners would overlook these important social determinants of health in the two parent, employed, middle income families similar to some of the participants within this study. It is also unlikely that participants in this study would have disclosed this information without being asked, given the commonly expressed feelings of shame about seeking formal support and sense of pride in maintaining their independence. With the significant health consequences associated with food insecurity (Alaimo, Olson & Frongilo, 2001; Rose-Jacobs et al., 2008; Vozoris & Tarasuk, 2003; Zaslow et al., 2009), and obvious

consequences of not taking prescriptions drugs as recommended, it is important that access to healthy foods and ability to purchase prescription drugs be assessed by primary care providers routinely during health care visits.

Community health nurses working within the Healthy Babies, Healthy Children program in Ontario also have an opportunity to assess important social determinants of health during routine postpartum phone calls and home visits to families with young children (Ministry of Children and Youth Services, 2010). Access to sufficient, safe, and nutritious food (FAO, 2003) should be incorporated into all postpartum assessments regardless of whether families are perceived to be "at risk".

Finally, community health nurses are already working with local organizations to collaborate and develop programs and policies relevant to each community's needs. The insight gained from this study about school nutrition programs failing to reach children most in need should inform the current Comprehensive School Health programs under the pillar of *Partnerships and Services* (PHAC, 2008) so that improved access can be facilitated. Similarly, the findings of this study suggest a need to strengthen partnerships and coordinate services with local rural food banks where families with young children seemed to feel comfortable and welcomed.

Policy

There are several important implications for policy development regarding the constraining conditions that lead to food insecurity for low income, rural families. The first is from a local perspective, in coordinating services with the food banks. Participants in this study felt comfortable attending their food banks, which seemed to provide a place for meeting and fostered a sense of community for some participants. Providing access to other services in a central hub within the local food bank would serve to maximize the social, emotional and practical support provided to food bank clients within rural communities. Similar to the Table Community Food Centre (Perth and District Food Bank, 2013), this could include services to support employment, transportation, mental health, and any other services relevant to the local community that address the social determinants of health. The food banks could also be an access point for resources that

meet the short-term needs of clients like snowsuits and backpacks for children, fruit and vegetable boxes, or programs like collective kitchens. In order to move toward longer-term solutions to food insecurity, engaging food bank clients in initiatives that address the underlying causes of poverty and issues of social justice may empower them to make changes within their communities that work toward eliminating food insecurity, as was recently initiated at the Table Community Food Centre (Perth and District Food Bank, 2013).

In developing programs and policies from a public health perspective, it is important to recognize the inherent skills, knowledge, and resourcefulness that are already possessed by many rural families. This calls into question the strategy of education campaigns about healthy eating, or skill building workshops to teach cooking skills or budgeting. Many rural families are already making the most of the resources they have, by stretching their foods, gardening, canning, freezing, and cooking from scratch. The solutions to their food insecurity do not lie in lifestyle approaches, so prevalent within the current public health documents with their emphasis on healthy "choices" (Raphael, 2008). Within this sample, a social determinants of health approach that promotes a higher and more secure income, access to rural employment opportunities, drug benefits for the working poor, and better access to healthy foods would help create supportive and sustainable environments (Falk-Rafael, 2005b) in which participants could fulfill their goals of self-sufficiency and social equality.

The social determinants of health, including income, employment, food security, and a social safety net, must be addressed from a broad policy perspective. Policy initiatives should include instituting appropriate levels of income support through Ontario Works and Ontario Disability Support Programs, and Tarasuk and Vogt (2009) suggested that restructuring of the full spectrum of income security systems is needed. This level of policy intervention requires commitment from the provincial and federal governments. The RNAO (2013) is one organization encouraging the members of provincial parliament to address poverty in their report entitled *Why Your Health Matters*; the strategies recommended by the RNAO include improving access to affordable housing, increasing

social assistance rates, and increasing minimum wage. In a similar approach, the findings from this study support the role of community health nurses in education and lobbying to government officials about the needs of rural, low income families.

In 2011, Public Health Units were provided funding by the Ministry of Health and Long Term Care in Ontario to hire two new nurses per each board of health area whose role was specifically to address the social determinants of health (Peroff-Johnston & Chan, 2012). Public Health Nurses identified priority populations in their geographic areas that were negatively impacted by the social determinants, and one of the common determinants affecting these populations was identified as food insecurity (Peroff-Johnston & Chan, 2012). This initiative is encouraging, as it demonstrates a growing appreciation by the provincial government for the direction that public and community health nurses must pursue in order to create positive change in prevention of issues like food insecurity.

Improving access to fresh produce and healthy meats is another important area for public health involvement, given the challenges identified by participants in affording quality produce and meat from grocery stores and the less healthy options often received from food banks. This may be accomplished through work with local farmers, businesses, food banks, community gardens, and partnering with other community members and social service providers, in keeping with a systemic approach to community food security promoted by the Ontario Public Health Agency (2002). At the federal government level, The People's Food Policy Project (2011) urged Canada to develop a national food policy. The People's Food Policy Project was a collaborative effort to produce a food policy that was "developed by the food movement itself" (p. 1) to articulate a vision for a healthy, ecological, and just food system within Canada. This document included recommendations that serve as an example of a systemic approach to food security that considers the broader context, including food production, poverty elimination, the need for a nationally funded school food strategy, and community member involvement in decision making about the food system (People's Food Policy Project, 2011).

Research

This study identified some elements of living with food insecurity that have received little attention in the nursing literature. It is important for nurses to understand the lived experiences of rural families with food insecurity, in addition to the predictors of food insecurity, physiological consequences like obesity, and the neighbourhood food environment that have predominated in the food insecurity research thus far (Rose, 2010). In order to effectively address food insecurity, nurses must have some knowledge of the experiences, strengths and strategies used by individuals and families to make ends meet, and the factors that influence food insecurity. While this study has provided some insight into the topic of the everyday experience of food insecurity, there are areas that should be further explored.

The sample of rural families with children was recruited primarily from the local food banks, and was homogeneous for many characteristics like gender and ethnic background. Further research should examine the experience of diversely situated families within rural settings, and how rurality impacts their experience. Additional research can also provide some understanding of how an individual's sense of community belonging or social capital impacts the stigma associated with food insecurity and poverty. While no association was found between social capital and food insecurity in Toronto, Ontario (Kirkpatrick & Tarasuk, 2010), it is possible that social capital within rural communities and the higher level of community belonging has a different effect on the experience of food insecurity for rural families. This effect may be mediated by the potential for reduced stigma related to knowing others in a similar state of food insecurity or poverty, or through strategies families used to stretch their resources like sharing of food, welcoming neighbourhood children over for meals, or paying for local services or medications through flexible payment plans.

As food banks were found within this study to be a meeting place with the potential to foster community development, further research is needed to understand this aspect of the rural social safety net. Investigating the experience of using rural food banks and how some food banks succeeded in promoting community and reducing the feelings

of shame in participants would provide insight for best practices within these organizations. In addition, examining the food acquisition and distribution strategies of food banks with the goal of increasing the quality and nutritional value of foods provided to families is an important area for further research. The findings about schools as a source of stress for parents with food insecurity also needs further exploration, so that barriers to access can be better understood and supports like breakfast programs or school subsidies for trips can be targeted toward the families who need them most while reducing any potential stigma associated with using these services. Finally, research that engages clients and communities in developing collaborative solutions to food insecurity, for example participatory action research, would provide insight into the range of supports and sociopolitical involvement of nurses that can effectively address this social determinant of health and inform community nursing practice.

Summary

This critical ethnography has provided valuable insight into the experience of rural families living with food insecurity, including the strengths and resourcefulness required to make ends meet and the daily challenges that created significant emotional distress. This knowledge creates opportunities for nurses to build on families' strengths, to address the constraining conditions that maintain food insecurity, and develop policies that help reduce the social inequities that lead to poor physical and emotional wellbeing. Several gaps in the nursing literature have been identified, and implications for practice, policy, and research were reviewed. By giving voice to rural families about their experience with food insecurity, I have sought to challenge the societal stereotypes about poverty, and inform our practice as nurses so that we may improve our care of clients and communities in the future.

Chapter 6

Conclusion

Canada is a wealthy nation that identifies itself as a leading producer of high quality, nutritious food (Dept. of Agriculture & Agri-Food Canada, 2006). As a successful welfare state, Canada has signed on to numerous international commitments that recognize the right to food (Rideout et al., 2007). Yet more Canadians are accessing food banks now than ever before (Food Banks Canada, 2012), and almost 1 in 10 Canadians are considered food insecure (Tarasuk & Vogt, 2009). Despite the growing public awareness about food insecurity, and the attempts by the charitable sector and some government-funded organizations to address this social determinant of health, food insecurity has become entrenched in Canadian society. The predominant cause of food insecurity is low income (Kirkpatrick & Tarasuk, 2010; Tarasuk, 2005), although this study adds to the body of research (Health Canada, a, n.d.; Vogt & Tarasuk, 2007) that demonstrates not only low income families suffer from insecure access to food, and the problems of food insecurity are far more complex and multi-faceted than related to income alone.

This ethnography on the experience of food insecurity in rural Ontario has helped create understanding about this phenomenon from a critical nursing perspective, which addresses a gap in the literature. Community health nurses, by virtue of their role as "leaders of changes to systems in society that support health" (CPHA, 2010, p.6), are in a unique and privileged position to help relieve families of the constraints that create and maintain food insecurity through advocacy for families and communities, public health programming, and policy development. Peer reviewed literature is lacking to inform nurses about the experience of living with food insecurity in rural Canada, and the complex factors that influence that experience. Despite the small number of participants, this study has provided meaningful insight into the challenges rural families face in juggling resources with their family needs, and the great skill and knowledge that allows families to stretch their food dollars and make ends meet on a limited budget. These

strengths of rural families should be acknowledged and incorporated into the supports and programs nurses develop to target food insecurity.

Given the remarkable ongoing efforts and strategies employed by participants to feed their families, and their limited success in overcoming their food insecurity, it is essential that the broader, external conditions that maintain families' poverty and food insecurity be addressed. The critical lens served to guide my inquiry and analysis of the role of social, political, historical, and cultural influences on food insecurity, as this larger context is deemed essential in both understanding and developing solutions to food insecurity. The recommendations that resulted from the knowledge gained within this study identify the need for appropriate social and economic supports and reforms that provide opportunities for rural families to address the complex social determinants of health and underlying constraining conditions that maintain their food insecurity An emphasis on upstream approaches, the foundation of healthy public policy (RNAO, 2010), will help families reach their goals of self-sufficiency and ensure that equal opportunities and a strong social safety net are in place to support their success.

Nurses' involvement in upstream approaches to issues of social justice requires sociopolitical action, where nurses are actively engaged (MacDonnell, 2010) and have a proud tradition of advocacy (CNA, 2000). At the same time, some nurses may feel powerless and unsupported in this role (Cohen & McKay, 2010), despite our collective moral obligation to help change the societal conditions that contribute to poor health (Falk-Rafael, 2005b). This study has attempted to translate knowledge of rural food insecurity and the associated social determinants of health into recommendations for nursing practice, but recognizes the importance of organizational supports as nurses take on a political advocacy role (Cohen & McKay, 2010). Professional nursing organizations, coalitions, and action groups are supporting nurses to mobilize around several important social determinants of health like poverty (Health Providers Against Poverty, n.d.), housing (RNAO, n.d.), and quality mental health services (CNA, 2012), while individual nurses are also speaking out to advocate for vulnerable individuals and populations (Cathy Crowe, n.d.). The current study provides some insight into how these advocacy

efforts and the everyday practice of nurses might target the issue of rural food insecurity in Canada.

The results of the study also provide insight into how nurses can help address rural food insecurity at an individual and community level. First, there is an opportunity for greater partnerships within rural communities, including enhancing the programming within food banks where families already attend and feel welcomed, and improving access to programs at schools that target low income families. Second, with the knowledge about the common strategy of going without food and self-care, there is a need for primary care practitioners and nurses who have access to families with young children to incorporate assessment of food insecurity and ability to afford prescription medications into their routine practice. It is clear that factors like post-secondary education, dual-income or two parent households, and home ownership are not predictable indicators of food security in this sample and perhaps in other similar rural communities. While screening for food insecurity and improving local access to community and school meal programs do not address the underlying contributors to poverty and food insecurity, these are short-term recommendations that may help alleviate some of the stress on families and improve access to food.

Critical theory has informed this study, with its underlying purpose to liberate individuals from conscious and unconscious constraints (Wilson-Thomas, 1995). By providing a space for marginalized families to be heard and co-create knowledge about food insecurity, an aim of this study was that participants would have an opportunity to address some of the constraints that contribute toward their food insecurity, conducting research as praxis (Berman et al., 1998). This is a difficult outcome to measure, and while participants contemplated their situations and oppressive external factors leading to food insecurity, whether this resulted in enlightenment that contributes toward long term positive outcomes is unknown. By disseminating the findings of the study during member checks and within a short report in layperson language to participants, this may have created further opportunities for action on the constraining factors. It is hoped that by disseminating the study findings to local service providers, stakeholders, and the

broader nursing community, this may help enlighten others on this important topic and reduce the stigma or misperceptions about low income or food insecure families. By shedding light on this understudied phenomenon, I hope to inspire further investigation into the area of food insecurity from a nursing perspective, and influence the development of policy regarding this social determinant of health.

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Appendix A

Glossary of Terms

Collective kitchen:	Participants meet regularly to pool resources and cook large quantities of food to take home (Engler-Stringer & Berenbaum, 2007)
Food bank:	Non-profit organizations that provide about one week's worth of food to individuals or families to take home and prepare (Food Banks Canada, 2012)
Food justice activist:	No consistent definition found; relates to an individual who advocates for safe, healthy, sustainable food for all
Food insecurity:	Experience of having inadequate access to sufficient, safe and nutritious food (FAO, 2003)
Food pantry:	Non-profit organizations that provide emergency food and grocery items to clients in the United States (Hoisington et al., 2011), similar to food banks in Canada
Human capital:	Investment in training and education that increases productivity of individuals or groups (OECD, 2010)
Low income:	Below the Low Income Cut Off threshold established by Statistics Canada, calculated based on income, family size, and community population (Statistics Canada, 2011)
Primary health care:	"Emphasizes locally appropriate action across the range of social determinants, where prevention and promotion are in balance with investment in curative interventions" (WHO, 2008, p. 8)
Resilience:	A characteristic that allows individuals to overcome adversity and become stronger or better equipped to deal with crises in the future (West, Buettner, Stewart, Foster & Usher, 2012)
Rural:	Statistics Canada's definition of Rural and Small Town – live outside main commuting zone of urban area with population of 10,000 or more (Statistics Canada, 2001)
School breakfast program:	Volunteer-driven breakfast program served to children each day prior to school (Williams, McIntyre, Dayle, & Raine, 2003)
Social capital:	Opportunity or ability to access resources by virtue of belonging to a social network (Ramadurai et al., 2012)

Socio-environmental model: Defines health determinants in psychological, social, environmental, and political terms, with health promotion strategies focused on the *Ottawa Charter* including: strengthening community action, creating supportive environments, developing healthy public policy, developing personal skills, and reorienting health systems (Cohen, 2008). Model is commonly used by community health nurses in Canada (CPHA, 2010).

Appendix B

Consent Form

Study Name: What is the Experience of Food Insecurity for Rural, Low Income Families in Southern Ontario?

Researcher: Ellen Buck-McFadyen
Master of Science in Nursing student, School of Nursing, York University
emcfadye@yorku.ca

Purpose of the Research: The purpose of this study is to understand the diverse experiences of rural families who have difficulty getting enough food to eat, or who worry about having enough food to feed their families. The information learned from interviews will be written in a report for my student research project and also shared with the public and health and social service providers to help improve community services and develop policies to prevent food insecurity.

Selection Criteria: 1) self-identification as experiencing insecure access to food, or worry about having enough to eat, 2) caregiver of at least one child under the age of 18 living in your home, and 3) able to speak and read English.

What You Will Be Asked to Do in the Research: You will be asked to meet with me, at a place and time that is convenient for you, to talk about your experience of food insecurity. I will ask questions about what it's like to worry about having enough food to feed your family, and ways that you manage when food or money is running low. This interview will take about 60-90 minutes, and I will tape record our conversation with your permission. After I have looked at the interviews (yours and other families) and found common themes or ideas, I would like to meet with you again to see if you agree with the themes or have more to add. You will receive a $20 gift card to the local grocery store as a thank-you for your time at the first interview.

Risks and Discomforts: Some of the questions that I will ask are personal. If you participate, some of you may feel uncomfortable because of these personal questions. You do not have to answer any questions that you don't want to, and you may stop participating at any time during the study.

Benefits of the Research and Benefits to You: The study is meant to help nurses and other health and social service providers to understand what life is like when families don't have regular access to food, or when families are worried about having enough to eat. This is a common problem in Canada, with about 1 in 10 families having trouble getting enough food. By sharing your experience and making others aware of the problem of food insecurity, I hope that better supports and policies can be developed to prevent this serious problem.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will have no influence on the nature of your relationship with the researcher or York University either now, or in the future.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason. If you decide to stop participating, you will still receive the $20 gift card for agreeing to be in the project. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: All information you supply during the research will be held in confidence and your name will not appear in any report or publication of the research. The audiotape used to record your interview will be destroyed after the information is typed into a computer to make a transcript, and your name will not be used on that transcript. Your data will be safely stored in a locked filing cabinet in my home, and only research staff will have access to this information. When the study is complete, the transcripts will be destroyed. Confidentiality will be provided to the fullest extent possible by law.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact me or my Graduate Supervisor - Dr. Judith MacDonnell either by telephone at 416-736-2100 Ext. 77515, or by e-mail (jmacdonn@yorku.ca). You may also contact my Graduate Program – School of Nursing, HNES Building, 4700 Keele Street, Toronto, ON M3J 1P3, (416)-736-5271. This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I _____, consent to participate in *The Experience of Food Insecurity* study conducted by Ellen Buck-McFadyen. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature_____ **Date**_____

Participant

Signature _____ **Date** _____

Principal Investigator

Appendix C

Demographics Form

1. Are you: Male ____ Female ____ Other ____

2. What is your age?

18 – 19 yrs.	_____	30 – 39 yrs.	_____
20 – 22 yrs.	_____	40 – 49 yrs.	_____
23 – 29 yrs.	_____	50 or older	_____

3. How would you identify your ethnic background? _____

4. How many children live in your home? ____

   What are their ages?

Child 1: ____	Child 4: ____
Child 2: ____	Child 5: ____
Child 3: ____	Child 6: ____

5. How many other adults live in your home? ____

   What is your relationship to each other adult?

   Adult 1: _____
   Adult 2: _____
   Adult 3: _____
   Adult 4: _____

6. Do you rent or own your home? Rent ____ Own ____ Other ____

7. Which category best describes your total household income (before taxes)?

Less than $5000	____	$30,000 - $39,999	____
$5000 – $9,999	____	$40,000 - $49,999	____
$10,000 – $19,999	___	$50,000 - $74,999	____
$20,000 – $29,999	___	$75,000 and over	____

8. Where does your income come from? (check all that apply)

Paid work	____
Ontario Works	____
ODSP (disability)	____

Employment Insurance (EI) ____

Other ____

9. What is your highest level of education?

Less than high school ____

High school or GED ____

Some college or university ____

College or university degree ____

Appendix D

Interview Guide

Thank you for meeting with me to talk about your experience with food insecurity. I am going to ask you some questions about topics like: your community and supports, how you get your groceries, how you manage when food or money is running low, and what it's like to have difficulty getting enough food to eat or to worry about having enough food to feed your family.

At any point in our interview, please let me know if you are feeling uncomfortable, would like to skip a question, or if you change your mind about participating and would like to stop the interview. With your permission, I will record the interview so that I can type out the interview on a computer, at which time your name will be removed from the typed transcript and the audiotape will be destroyed. All information that you share with me will remain confidential.

Community

Tell me about where you live.

Prompts: In town vs. rural, how long have you lived here?

What is the best thing about living in (your community)?

What is the worst thing about living in (your community)?

Eating Patterns and Access to Food

Tell me about how you get your food.

Where do you buy your food?

How do you get to the store?

How do you find the prices at the grocery store? High, low, average?

Does your access to food change at different times during the month? The year?

Can you tell me about how you divide up the cooking and grocery shopping responsibilities in your home?

Do you ever worry about having enough food?

Do you ever run out of food or go hungry? What do you think leads to this?

Are you able to buy and cook the foods you like or prefer?

Do you eat differently than the others in your family? How so? Are there any family members who eat differently than others in the family?

What do you think are some of the barriers to having enough food? (Either yourself or others you know of that have trouble getting enough to eat.)

Management Strategies

What are some of the things you do to help have enough food for your family?

Do you change the foods you eat when you are running low on money?

Do you grow any of your own food?

Have you ever had to choose between paying for food and paying for other household expenses? What did you do? Who makes decisions about money in your family?

Do you go to the food bank or other community agencies to get food?

Do your children often eat outside of the home? Where?

Is there anything you think might help with having enough food?

Transportation

How do you get around?

If you have a car, is it reliable? Tell me about how you manage when your car needs to be fixed?

If you do not have a car, is there one that you can borrow when you really need it? What do you do when you need to get somewhere that you can't walk to?

Supports

Tell me about your supports.

Prompts: Do you have family in the area? How often do you see them? Do you have neighbours or friends that you see regularly?

Is there someone that can help you out when you need it? (Ex. Give you a ride somewhere, pick your kids up from school, etc.). Are you comfortable asking them for food or money if you were running out?

Do you use any community services? Ex. Drop-ins, food banks, school breakfast programs, others. If not, what prevents you from accessing these services?

Do you know others who struggle to get enough to eat?

Does anyone know that you sometimes have a hard time getting enough to eat? (Do you hide your food insecurity?)

Emotional

Can you share with me what it's like to be worried about running out of food?

How often do you think about having enough food to eat?

What impact do you think food insecurity has on your children?

Solutions

We've talked a lot about how you manage with food insecurity, and some of the services that help families who don't have enough to eat. What do you think the solutions are to *prevent* families from experiencing food insecurity in the first place? (Reword – how do we prevent the problem of families not getting enough to eat?)

Is there anything else that you would like to share about your experience?

Thank you for participating in this interview. I will be in touch with you again to share the information that I have gathered from the study and to see if you agree with the ideas and themes that I have identified. You may also add more information at that time.

Appendix E

Study Posting

Do You Worry About Having Enough Food to Feed Your Family?

Interviews are being done to help understand what it is like to have difficulty feeding your family, and how you manage when food is low.

I would like to talk with you if:

1) You are 16 years or older
2) You are the parent or caregiver of at least one child under 18 living in your home
3) You have a hard time getting enough food to eat, or you worry about having enough to eat

You will be asked to meet with me for 60 – 90 minutes to talk about your experience. All information will be kept confidential. You'll receive a $20 gift card to the local grocery store to thank you for your time.

For more information about this study or to set up an interview, please contact:

Ellen Buck-McFadyen
Master of Science in Nursing student
School of Nursing, York University

emcfadye@yorku.ca (XXX) XXX-XXXX