

Individual and Household Food Insecurity in Canada: Position of Dietitians of Canada

EXECUTIVE SUMMARY (1)

Position Statement

The position of Dietitians of Canada (DC) is that all Canadians must have food security. Recognizing food security as a social determinant of health, DC recommends a population health approach to food security: that is, an approach that seeks to reduce health inequities through the pursuit of social justice. A population health approach addresses the root cause of individual and household food insecurity – poverty – through improvements to the social safety net.

DC strongly encourages dietitians to educate themselves about the issues and processes to achieve food security through social change, to use empowering strategies in community-based food programming, to conduct and apply research, and to participate in coalitions that advocate to create the conditions in which all Canadians can achieve food security.

(Can J Diet Prac Res 2005;66:43-46)

Énoncé de position

Les Diététistes du Canada (DC) soutiennent que tous les Canadiens doivent bénéficier de la sécurité alimentaire. Reconnaissant la sécurité alimentaire comme déterminant social de la santé, les DC recommandent de traiter cette question par une approche axée sur la santé de la population, c'est-à-dire ayant pour but de réduire les inégalités en matière de santé par la recherche de la justice sociale. Cette approche s'attaque à la cause première de l'insécurité individuelle et familiale – la pauvreté – en améliorant le filet de sécurité sociale.

Les DC encouragent fortement les diététistes à s'informer sur ces problèmes et sur les processus visant à assurer la sécurité alimentaire par le changement social, à utiliser des stratégies d'habilitation dans la planification des programmes communautaires portant sur l'alimentation, à mener des recherches, à appliquer les résultats de recherches et à participer à des coalitions qui préconisent la création de conditions permettant à tous les Canadiens d'atteindre la sécurité alimentaire.

(Rev can prat rech diétét 2005;66:43-46)

INTRODUCTION

Dietitians have a history of involvement in food security activities, both as part of their employment mandate and in a volunteer capacity. Despite their efforts, and those of many other Canadians, disturbing numbers of households report food insecurity; many of these include children. While food security can be defined in many ways, the following definition is used in this paper:

Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life (2).

The opposite situation, in which food security is limited or uncertain, commonly is called “food insecurity.”

Components of food security

Food security can be viewed from a variety of perspectives and at multiple levels: individual, household, community, regional, national, or world. This paper focuses on food security at the individual and household levels in Canada, to promote solutions that will address the particular concerns of low-income citizens, who suffer the greatest burden of food insecurity and health inequities. This analysis situates the problem of individual and household food insecurity within the political context of systemic socioeconomic inequities. These result from social policies that affect income distribution and have an impact on both household income levels and population health. From this perspective, social justice is seen as the solution to individual and household food insecurity, and to the need for improved population health.

The political context

Many government policy changes during the 1990s had a negative impact on Canadians' economic and food security. These changes included the 1995 restructuring of unemployment insurance (now known as employment insurance), the replacement of the Canada Assistance Plan with the Canada Health and Social Transfer, restricted eligibility for social assistance and a decline in benefit levels in most provinces, the recovery (commonly called “claw back”) of the National Child Benefit Supplement from families living on social assistance in some provinces, federal taxation policy changes that have disproportionately increased lower-income Canadians' tax burden, and the federal government's cancellation of social housing programs. In addition, minimum wages and social assistance rates are well below poverty levels in all provinces. The only social program to receive significant increases in benefit levels was child benefits, through the program known as the Canada Child Tax Benefit.

During the 1990s, poverty rates fluctuated between a low of 15.3% and a high of 18.6%. In 2001, the overall poverty rate was 14.4%. Poverty rates are higher among particular groups: children, single mothers, and Aboriginal peoples have rates more than double those of other Canadian men, women, and children. Not only is poverty a barrier to the protection of and respect for human dignity and harmful to economic and social development, but it is a significant public health concern. Income is one of the most important determinants of health: the poor live shorter, sicker lives than those who are wealthier, irrespective of lifestyle risk factors. While several provinces have recognized the role of income in determining health,

Quebec is the only province addressing poverty as a health issue and food security as part of the solution.

The current situation, in which large numbers of Canadians live in poverty, is unjustifiable under national and international Canadian commitments and obligations. Canadians continue to value equality, justice, compassion leading to collective responsibility, and social solidarity. Of late, however, we have seldom had success in ensuring that our governments put these values into policy and action to improve economically marginalized citizens' lives.

The extent of food insecurity

Canada lacks a coordinated, systematic plan for monitoring food insecurity, either nationally or provincially. The prevalence of food insecurity and hunger has been estimated using data collected from the 1998-99 National Population Health Survey (NPHS) and the 2000-01 Canadian Community Health Survey. Of the 10.2% of Canadians (approximately three million people) who reported food insecurity in 1998-99, 80% lived in households with a standardized pretax income of \$20,000 or less, and 50% in households with an income of \$11,000 or less.

Other analyses of Canadian data show that the risk of food insecurity or food insufficiency increases with declining income. While the relationship between income and food security measures is not linear, data clearly indicate that household food insecurity is a product of poverty. Furthermore, data analyses show that the attainment of basic needs, including a healthy diet, is not affordable for low-income household members living on social assistance or minimum wage employment. Households most at risk for food insecurity include one-parent families (especially with one or more children under the age of 13 years), those receiving social assistance, those who rent their dwelling, and Aboriginal people living off reserves. Households with seniors' benefits have a decreased risk of food insecurity, a finding that suggests deliberate federal social policies to reduce poverty among Canadian seniors also have had a positive impact on seniors' food security. The prevalence and risk estimates calculated from the NPHS almost certainly do not represent the true nature of food insecurity among Canadians because the survey did not include the most marginalized groups in our population, including the homeless, Aboriginal people living on reserves, and those without telephones.

The nature of food insecurity

In research studies primarily focused on low-income families in southern Canada, investigators have examined the components and dimensions of individual and household food security. At the household level, these have been summarized as issues related to food supply management and acquisition. At the individual level, food insecurity is characterized as inappropriate and inadequate food consumption, including the physiological sensation of hunger. Different levels of food security exist: the least severe is characterized by anxiety about having enough food. As food insecurity worsens, individuals make qualitative compromises in food selection and consumption. Finally, as resources become more depleted, individuals cut back in food quantity to the point where they may not

eat at all because of lack of food. Individuals within families experience food insecurity differently: mothers compromise their own food quality and quantity to protect their children from hunger. Food insecurity is dynamic in nature: it may be chronic or transitory, and can be characterized by frequency, duration, and periodicity.

In remote northern Canadian communities, the Aboriginal population faces unique food security challenges. Food is expensive and often unavailable, of poor quality, and typically of poorer nutritional value than traditional country food harvested from the local environment. While traditional country food is more economical and offers nutritional benefits, there are barriers to its consumption. These include lack of equipment and/or skills to harvest it, changes in food preference patterns, decreasing supplies due to global climate changes and migratory patterns, inaccessibility, and environmental contaminants that make the food unsuitable for consumption.

Food-insecurity management strategies

Food expenses are one of the more elastic components of household budgets. As a consequence, money that would normally be allocated for food is further eroded to pay for less flexible expenses, such as shelter and household utilities. Individuals and families faced with food insecurity use many strategies to augment their resources so that they can feed themselves and family members. These include using coupons and/or returning bottles, postponing bill payments, borrowing money and/or food, selling possessions, and buying food on credit. Many try to eat less expensive food, skip meals or eat less, obtain food from charitable outlets such as food banks, join community kitchens or food-buying clubs, or plant gardens.

Many low-income families have a cyclical flow of resources that allows them to acquire food supplies at periodic intervals and gradually and systematically deplete them. The homeless, and those whose income flow is more unpredictable, have a much more precarious experience of food insecurity.

Health consequences

Research consistently demonstrates that individuals in food-insecure households are at increased nutritional risk and have poorer health. However, disentangling the specific effects of food insecurity on health is difficult because food insecurity necessarily occurs within the context of poverty, and poverty has well-documented, independent, adverse effects on health. Given the dietary compromises associated with food insecurity, those who are food insecure can be expected to have difficulty managing chronic medical conditions requiring dietary intervention. Consequently, there are negative repercussions for morbidity and mortality.

Responses to food insecurity

The volunteer sector, public health and education professionals, and government have responded to food insecurity in various ways. All these approaches have inherent limitations, and none has demonstrated success as a solution to food insecurity. The approaches include the following:

1. Charitable food distribution in the form of food banks.
2. Community-based responses to food security (e.g., community kitchens, food skills workshops on making

- food from scratch, self-provisioning activities such as community gardens, food-buying cooperatives).
3. School- and community-based feeding programs.
 4. Federal policy responses (e.g., the National Child Benefit [NCB] and the Canada Prenatal Nutrition Program [CPNP]).

Food banks, as well as other food-distribution charities such as soup kitchens, depend upon volunteer labour and donations of food and goodwill, which are almost always inadequate to meet the demand. Moreover, food banks are not necessarily located where need is highest, packages of food may be of poor quality and questionable safety, food selection and quantities are limited, and the variety available may not meet nutritional needs or suit dietary modifications required because of health concerns or ethnic preferences. Food banks were never intended as a permanent response to the contemporary problem of food insecurity in Canada, and clearly they have remained an inadequate “Band-Aid” response to a systemic problem of poverty.

Community-based approaches foster self-help, mutual support, and community development. Such approaches also provide social, psychological, and community benefits. To date, however, the effectiveness of such programming in reducing individual and household food insecurity remains to be demonstrated. Ironically, these community-based responses share some of the same problems as food banks: they are small-scale, geographically fragmented, and *ad hoc*. Such programs likely would meet their health promotion goals more effectively if participants already had other basic resources, such as a decent income, good quality housing, and child care. These resources would provide security and stability in their lives and facilitate participation in community-based food programming.

The rationale for school-based feeding programs rests on the conviction that properly nourished children behave and learn better than those who are hungry; however, there is little scientific literature about the short- and long-term cognitive effects of hunger in children in industrialized countries, particularly in relation to breakfast skipping. Furthermore, to date only one study has focused on the potential contribution of school- and community-based feeding programs to household food security, and the results showed only a modest impact. Nonetheless, those involved in these programs perceive multiple other benefits, such as positive socialization, promotion of school attendance, nutrition and health education, and a strong satisfaction from feeding hungry children.

The federal NCB, implemented to address low-income families' needs, had the potential to make a substantial difference to the incomes of those on social assistance, and, in turn, to families' food security status. However, many provinces and territories have responded by reducing household welfare payments by the amount of the supplement, thereby penalizing the poorest families, many of which are single-parent households headed by women.

In 1994, the federal government initiated the CPNP to develop or enhance programs for vulnerable, low-income pregnant women. The program gives community-based funding to reduce the incidence of low birth weight, improve mothers' and infants' health, and encourage breastfeeding

through provision of food and food vouchers, health education, social support, and assistance with access to health and social services. While this program has successfully increased breastfeeding initiation rates and provided needed social supports to marginalized groups of women, on its own it does not solve income-related food insecurity.

Dietitians' role

Poverty levels must be reduced to improve food security of individuals and households and overall population health. This certainly is not a task that dietitians can accomplish alone. Nevertheless, we can contribute to the solution in a personal and professional capacity, working toward the big goal of social change. This issue is pertinent not only to dietitians practicing public health or community nutrition: it has implications for dietitians working in broader scopes of practice. These implications range from the health problems likely in food-insecure clients, to the recommendations one can reasonably expect clients to follow, to health care system sustainability. Moreover, as professional health care workers who have benefited from Canada's social security programs, with good education and often publicly funded positions, we have a responsibility to ensure that social policies and conditions promote the health and well-being of all. The following are recommended actions for DC members:

1. Work in coalitions with others, including community-based organizations and antipoverty advocates, to advocate for policies to reduce poverty. This is a key strategy to improve food security, social justice, and population health. As has been indicated in this document and supported by numerous organizations, such policies include improving social assistance and minimum wage rates, establishing affordable housing policies, eliminating the NCB claw back for families receiving social assistance, improving employment insurance coverage and benefits, and providing accessible and affordable child care. These policies would strengthen the Canadian social safety net, and thus address social determinants of health and promote population health.
2. Conduct and publicize research supporting such policies to strengthen the social safety net. This research might include comparisons of healthy diet costs, housing, and other living expenses with social assistance rates and minimum wage rates. Use this research in advocacy campaigns. For example, Montreal Public Health Unit research on social inequalities in health contributed to the advocacy campaign leading to the adoption of Quebec's antipoverty bill.
3. Vote, and vote wisely. Political parties espousing policies to cut taxes and privatize services invariably cut the social programs on which food-insecure people depend. Evidence from Europe indicates that political parties committed to policies of income redistribution and full employment successfully improve the health of populations. Ask electoral candidates in your riding where they stand on key issues.
4. Use empowering strategies in community-based food programming (such as community kitchens and community gardens), and structure these programs to include the most

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marginalized (e.g., subsidize program costs, transportation, and child care). Listen to and respect program clients' diverse knowledge and experiences. Expect the most important benefits to be social and psychological, especially for the most marginalized participants, and structure programs to maximize opportunities to achieve these important outcomes. Create and take advantage of opportunities to address larger structural issues related to poverty, and thus population health.

5. Be reflexive in your professional practice. Understand how your social position (a product of income, education, gender, profession, etc.) and the power and privilege that accompany being a health professional affect your opinions, everyday practices, and perspective on the world. Recognize, too, how your clients' social positions affect theirs, and the reasons that your perspective and theirs may differ. Essentially, reflexivity involves understanding another's point of view and "walking in his or her shoes." It is key to successful coalition building.
6. Educate yourself and others on the issues and processes to achieve food security through social change.
7. Look for ways that DC can promote food security for all Canadians. Work within your professional association to make these initiatives successful.

References

1. Dietitians of Canada. Individual and household food insecurity in Canada. Position of Dietitians of Canada. *Can J Diet Prac Res* 2005;66(1):43-46. The complete position paper, along with references and a copy of the Executive Summary, can also be accessed at www.dietitians.ca/news/highlights_positions.html.
2. Canada's action plan for food security: a response to the World Food Summit. Ottawa: Agriculture and Agri-Food Canada; 1998.

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