

**THE EXPERIENCES OF PEOPLE WITH DISABILITIES  
WHO ARE ON PERSONS WITH DISABILITY BENEFITS  
WITH REGARD TO FOOD SECURITY**

by

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## **ABSTRACT**

Adequate food security is achieved when “food is obtained in a manner that upholds human dignity; food is safe, nutritionally adequate, personally and culturally acceptable; food is sufficient in quality and quantity to sustain healthy growth and development and to prevent illness and disease” (Community Nutritionists Council of BC, 2004, p. 3). Many adults with disabilities are unemployed due to their chronic condition and require the receipt of government sponsored disability benefits. They face unique challenges in sustaining their health and are at higher risk for food insecurity. The purpose of this research was to describe the experiences of people on Persons with Disability (PWD) benefits with regard to attaining adequate food security.

Qualitative inquiry was the central defining methodological feature of this research. The data were derived from 16 face-to-face semi-structured interviews. All participants were adults who were currently receiving PWD benefits and living alone (non-institutionalized) in Vancouver, British Columbia. The interviews were tape-recorded, transcribed and analyzed using constant comparative analysis.

The three major factors that affected the food security of the participants were 1) living with a low income, 2) living with a disability and 3) living with psychosocial issues. These three factors prevented most of the participants from attaining adequate food security at some level. Those without subsidized housing and with disabilities that affected mobility and energy were worse off in terms of attaining adequate food security. The results of this study will help decision makers and service providers to understand the multiplicity and complexity of factors that are pertinent in addressing food security issues for people on PWD.

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# 1 INTRODUCTION

In Canada, the United States, Australia, New Zealand and Europe, food security has been recognized as a major quality of life and public health issue (Dietitians of Canada, 2005; Olson & Holben, 2002; Robertson et al, 2005; Uttley, 1997; Wilson, 1997). The United Nations declared adequate access to food as a basic human right (Amnesty International USA, 2008). In Canada, food security has been identified as an important social determinant of health (Raphael, 2004). A lack of food security, also known as food insecurity, has been shown to have a negative effect on a person's physical, emotional, and mental health status (Alaimo, Olson & Frongillo, 2002; Campbell, 1991; Che & Chen, 2001; Lee & Frongillo, 2001; McIntyre, Conner & Warren, 2000; Vozoris & Tarasuk, 2003)) and has also been associated with poor nutritional intakes (Kleges, Parlor, Shorr, & Wang, 2001; Rose & Oliviera, 1997). A proper healthy diet has been identified as a key intervention point in preventing and managing many diseases and as an important aspect of any healthy lifestyle (Coulston & Boushey, 2008).

Living with a disability is the reality for approximately 15% of British Columbians (Human Resources and Skills Development Canada [HRSDC], 2008). Many adults with disabilities are unemployed or under-employed due to their chronic condition and require the receipt of government sponsored disability benefits (Statistics Canada, 1997). In British Columbia, to be eligible for persons with disabilities benefits (PWD), the person must go through an exhaustive application process. They must prove that the disability is severe and expected to last for at least two years and that it directly and significantly restricts their ability to perform daily living activities (such as preparing meals, shopping,

making decisions about personal care, etc.) (Ministry of Housing and Social Development, 2008). The person must also require help from an assistive device (e.g. a wheelchair) or assistance animal or need significant help from another person (Ministry of Housing and Social Development, 2008). In 2006, a single person with the PWD designation was eligible for: monthly support (\$531.42/month) and shelter assistance (\$325/month); medical coverage which includes Medical Services Plan (MSP) and Pharmacare coverage with no deductible, as well as other health services such as dental and optical coverage; a \$400 earnings exemption per family unit per month; a low cost annual bus pass; and, exemptions from time limits for receiving assistance (BC Coalition of People with Disabilities [BCCPD], 2008). However, the benefits are inadequate as people on PWD are provided incomes far below the low income cut-offs (LICO's) (BCCPD, 2007; Statistics Canada, 1997). Because of this fact, people with disabilities are more likely to live with a low income than the general population (Dunn, 2003). Living with a low income is a key risk factor for food insecurity and the primary cause of hunger (Che & Chen, 2001; Heart Health Coalition, 1997; Ledrou & Gervais, 2005).

## **1.1 Research purpose and questions**

The primary purpose of this research was to describe the experiences of people with disabilities who are on Persons with Disability (PWD) benefits with regard to accessing adequate food security. The following questions were used to guide the focus of the research:

- 1) What are the experiences of people on PWD when attempting to acquire food in a manner that upholds human dignity?

- 2) What are the experiences of people on PWD when attempting to acquire food that is safe?
- 3) What are the experiences of people on PWD when attempting to acquire food that is nutritionally adequate?
- 4) What are the experiences of people on PWD when attempting to acquire food that is personally and culturally acceptable?
- 5) What are the experiences of people on PWD when attempting to acquire food that is sufficient in quality?
- 6) What are the experiences of people on PWD when attempting to acquire food that is sufficient in quantity?

## **1.2 Background of researcher**

In qualitative research, our research questions and methods are strongly related to our identities (Denzin & Lincoln, 1994). I am aware that my “personal history, biography, gender, social class, race, and ethnicity, and those of the people in the setting” matter (Denzin & Lincoln, 1994, p.3). Accordingly, the first phase of the research process is to define the researcher’s conception of self and the other (Denzin & Lincoln, 1994).

I am an educated, middle-class, Hispanic female. I have been involved in health promotion research since graduating with a Bachelor of Science degree in Nutritional Sciences from the University of British Columbia in 2002. My interest in the area of food security was birthed from my nutrition background and involvement in health promotion

research which highlights the importance of food security as a social determinant of health. Although I am not classified as having a disability, I have experienced it indirectly through my father's experience. In 2001, my father was involved in two motor vehicle accidents where he sustained injuries that left him in chronic pain and with a brain injury. In 2004, after struggling for years to return to work, he lost his job as an accountant due to his memory problems and chronic pain. I lived with my father until 2005 and was witness to the dramatic changes and challenges he endured following the accident. Finally in 2008, after an exhaustive process, my father began to receive PWD benefits. This personal experience further confirmed to me the importance and relevance of this research topic in the community. I have extreme empathy for people with disabilities who are on PWD as I have been witness to my father's struggles and the effect it has had on his physical and mental health. It is my hope that the research presented here shines a spotlight on this issue and subsequently leads to increased understanding of the challenges people on PWD face when attempting to acquire sufficient food security.

### **1.3 Thesis overview**

The present document addresses a gap in the knowledge surrounding people with disabilities on PWD specifically as it relates to information around their experiences with regard to food security. This chapter included a brief discussion of the research issue; the research purpose and objectives; and the background of the researcher. The remaining chapters of this thesis include a literature review (chapter 2); study design and methods (chapter 3); results (chapter 4); and a discussion (chapter 5).

Chapter 2 includes a discussion of major definitions related to the research; food security, low income and disability and how they are related. It also highlights research gaps on pertinent issues regarding food security and people on PWD.

Chapter 3 characterizes the research paradigm and research design. It also includes a discussion of the community partner and research site selection and population sampling, data collection methods, data analysis, mechanisms employed to assess the trustworthiness of the results and ethical considerations.

Chapter 4 provides the results of this research project's investigation of the experiences of people on PWD with regard to food security. It is organized around six major sections: 1) participant profiles and results of the food security survey question, 2) living on a limited income, 3) living with a disability, 4) living with psychosocial issues, 5) the triple burden and 6) the relationship between the factors and the components of the food security definition. The chapter ends with a brief summary.

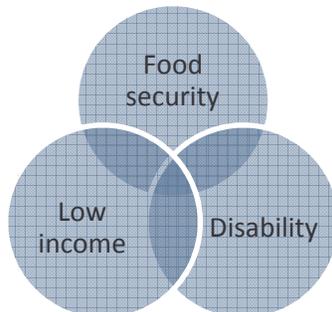
Finally, chapter 5 discusses my reflections on the major themes of chapter 4 and how it compares to the current literature. This chapter also includes a discussion on the limitations and challenges of the study, as well as the impetus for future research and suggestions for improving services and policies for people on PWD.

## 2 LITERATURE REVIEW

The literature review is an important component as it provides background information for the topic and gives justification for the research project (Bruce, 1993). Bourner (1996) explains how the literature review has several purposes. First, it demonstrates the underlying assumptions behind the general research questions. Second, it shows that the researcher is knowledgeable about related research. Lastly, it demonstrates that the researcher has identified gaps in previous research and that the proposed study will fill a demonstrated need.

A systematic review of literature was conducted using appropriate keywords and computer databases. It included published, peer-reviewed literature, and attention was also made to find non-peer reviewed publications on the internet. These publications included reports by several local, national and international governments, organizations and groups. The relationships between food security, disability and low income were examined, as well as, literature regarding food security within the context of people with disabilities. The following figure demonstrates the interactions between the main areas of focus for the research.

**Figure 2.1 The three main areas of focus for the present research**



There are eleven topics addressed in this chapter: 1) defining food security 2) food security: is it a national priority? 3) measuring food security in Canada 4) measuring low income in Canada 5) affordable housing in British Columbia 6) low income and food insecurity 7) prevalence of disability in Canada 8) disability and health 9) disability and low income 10) disability and food security and 11) a summary of the literature review.

## 2.1 Food security

### 2.1.1 Defining food security

The concept of food security is broad and includes six major levels: individual, household, community, regional, national, and global (Dietitians of Canada, 2005). There are two types of food insecurity within families: individual and household (Radimer, Olson, Greene, Campbell & Habicht, 1992; Tarasuk, 2001). The focus of this investigation was on household and individual level food security and their corresponding characteristics. Table 1 lists four dimensions for both of these types of food security elucidated from qualitative research by Radimer et al (1992): quantitative, qualitative, psychological and social.

**Table 2.1 Dimensions of food security**

<b>Dimension</b>	<b>Individual level</b>	<b>Household level</b>
<b>Qualitative</b>	Insufficient intake	Food depletion
<b>Quantitative</b>	Nutritional inadequacy	Unsuitable food
<b>Psychological</b>	Lack of choice, feelings of deprivation	Food anxiety
<b>Social</b>	Disrupted eating patterns	Food acquisition in socially unacceptable ways

Radimer et al (1992) found that individual food security differs from household food security because it acknowledges variations between family members and takes into account the personal experience of food security. Insufficient intake for individual food security is characterized by the quantity of food being ingested by the individual and relates strongly with hunger. Nutritional inadequacy alludes to insufficient variety of food in the diet to obtain all the necessary micro and macronutrients in required amounts. Lack of choice and feelings of deprivation correspond to the individual's feelings of anxiety and stress associated with inability to eat what the person desires. Disrupted eating patterns are related to the lack of ability to eat regular meals and the need to skip meals in order to save money or due to the inability to obtain food or cook meals. Household food insecurity relates to the situation of all household members as one unit. Food depletion is the absence of enough food in the home to sustain all members. Unsuitable food is the presence of food that does not meet the nutritional needs of the household such as highly processed, high sodium, low nutrient meals from a can. Food anxiety is the overall feelings of powerlessness, frustration and shame associated with not having sufficient food in the home. Food acquisition in socially unacceptable ways is concerned with household members having to use unfavourable means of acquiring food such as the use of charitable sources or begging.

Food security first became an important subject in the 1970's and since then over 200 definitions for it have been described in the literature (Maxwell & Smith, 1992). The original definition of food security was first introduced at the World Food Summit of 1974 (United Nations, 1975). It stated that food security is achieved when there is "availability at all times of adequate world food supplies of basic foodstuffs to sustain a

steady expansion of food consumption and to offset fluctuations in production and prices” (United Nations, 1975). Since then the definition has evolved from being primarily concerned with production and prices to being more individual focused. The most widely used definition in Canada was derived from the 1996 World Food Summit in Ottawa, which states: “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” (Agricultural and Agri-Food Canada, 1998). Although this definition is inclusive of many important aspects of food security such as quantity, accessibility and safety, it does not explicitly incorporate psychosocial issues. Therefore, for the purpose of this study, I am focusing on the definition offered by the Community Nutritionists Council of BC (2004) which states that food security is achieved when “food is obtained in a manner that upholds human dignity; food is safe, nutritionally adequate, personally and culturally acceptable; food is sufficient in quality and quantity to sustain healthy growth and development and to prevent illness and disease” (p. 3). Food insecurity exists when people do not have access to food in accordance with the above definition.

The lack of safe and nutritious food can have severe consequences, not only for those experiencing food insecurity, but for their communities as well (Atlantic Health Promotion Research Centre & Nova Scotia Nutrition Council, 2006). Female single parent households, seniors, aboriginal people, children, new immigrants, people on welfare and people with disabilities are more likely to be food insecure than the general population (Vancouver Coastal Health, 2008). People in food insecure households are more likely to report poor or fair self-rated health, physical limitations, mental health

problems, and multiple chronic conditions including obesity, diabetes, heart disease and hypertension (Alaimo, Olson & Frongillo, 2002; Campbell, 1991; Che & Chen, 2001; Lee & Frongillo, 2001; McIntyre et al, 2000; Vozoris & Tarasuk, 2003). Alaimo, Olson & Frongillo, (2002) found that adolescents in food-insufficient households (not low-income households) were significantly more likely to have had thoughts of death, a desire to die and have attempted suicide than those in food sufficient households. Other studies have shown that elderly persons who are food insecure have worse dietary intake, nutritional status and health status than do food-secure elderly persons (Lee & Frongillo, 2001). In Canada, it has been acknowledged that food security is an important health issue (Dietitians of Canada, 2005).

### **2.1.2 Food security: is it a national priority?**

Food security has been recognized as a major quality of life and public health issue in several countries such as Canada, The United States, Australia, New Zealand, and Europe (Dietitians of Canada, 2005; Olson & Holben, 2002; Robertson et al, 2005; Uttley, 1997; Wilson, 1997). In 1998, The World Food Summit took place in Ottawa, Canada at which 187 countries were represented (Agriculture and Agri-Food Canada, 2004). As a response to this summit, the Canadian government issued an international commitment to ensure the human right to food as outlined in *Canada's Action Plan to Food Security* (Agriculture and Agri-Food Canada, 1998). This action plan incorporated ten priorities: 1) the right to food, 2) the reduction of poverty, 3) promotion of access to safe and nutritious food, 4) food safety, 5) traditional food acquisition methods of Aboriginal and coastal communities, 6) food production, 7) emphasis on environmentally sustainable practices, 8) fair trade, 9) acknowledgement of peace as a precursor to food security, and

10) a monitoring system for food insecurity. The Canadian government has since undertaken several strategies to address these priorities (Agriculture and Agri-Food Canada, 2004). These strategies include raising public awareness of food security issues, tracking changes in the low income status of the population and supporting isolated northern communities with *Food Mail*, a program that subsidizes the air transportation of nutritious perishable food and other essential items (Agriculture and Agri-Food Canada, 2004). However, despite these efforts not enough is being accomplished to address the root causes of food insecurity issues in Canada (Rideout et al, 2007; Riches, 1999). These root causes such as low income, unemployment and inadequate social assistance are still being neglected by federal and provincial governments (Riches, 1999). The issue is exacerbated by the fact that there is still no official national or provincial surveillance system in place to monitor change in the food security of the population (Kirkpatrick & Tarasuk, 2008a). The data on food insecurity collected in Canada have provided inconsistent measurement across surveys which make it difficult to develop a deeper understanding of the issues (Kirkpatrick & Tarasuk, 2008a).

### **2.1.3 Measuring food security in Canada**

#### **2.1.3.1 National surveys**

The most recent data estimating food insecurity in Canada come from the National Population Health Survey 1998-99 (NPHS) (Rainville & Brink, 2001; Che & Chen, 2001) and three Canadian Community Health Surveys (CCHS) (2000-2001, 2004 and 2005) (Health Canada, 2007). According to the NPHS, in BC, 11.6 percent of the population was food insecure and 11 percent of food insecure households in Canada

indicated long-term disability as a problem related to food acquisition (Rainville & Brink, 2001). Twenty-two percent of food insecure Canadians sought food from charitable sources; almost half reduced the quality of their foods, and about one-quarter skipped meals or ate less (Rainville & Brink, 2001). People with poor health or disability seem particularly vulnerable to problems acquiring food (Rainville & Brink, 2001). More recent data was taken by the CCHS in 2000/2001, 2004 and 2005. However, the CCHS used different survey items than those used in the NPHS.

The CCHS provided Canada for the first time with national and provincial estimates of income-related food security at the household, adult and child level (Health Canada, 2007). According to the CCHS, in 2000/2001, 14.7 percent of the population lived in households reporting food insecurity (3.7 million people) (Health Canada, 2007). However, in the 2004 CCHS, this number changed to 6.8 percent of the population reporting food insecurity (2.1 million Canadians) (Health Canada, 2007). In British Columbia, the rate of households reporting food insecurity was 8.4 percent in 2004 and 5.4 percent in 2005 (Kerstter & Goldberg, 2007). The reason for these dramatic decreases was changes in survey methods (Kirkpatrick & Tarasuk, 2008a). They were changed in 2000/2001, 2004 and 2005. In 2005, the rate of food insecurity of people considered permanently unable to work was 19.6 percent; nearly four times the BC average (Kerstter & Goldberg, 2007). Unfortunately, the 2000/2001 and 2004 CCHS did not specifically report on the food insecurity of people with disabilities and/or people who are on PWD. As a result of all the changes to the survey instrument, we have no consistent data to indicate whether or not the prevalence of food insecurity of the

population, including people with disabilities, has changed over time (Kirkpatrick & Tarasuk, 2008a). We do, however, have consistent data on food bank use in Canada.

### **2.1.3.2 Food bank use**

A common indirect measure of food security in Canada is food bank use. However, according to the NPHS, in 1998, only 22 percent of food insecure Canadians sought food from charitable sources (Che & Chen, 2001). This indicates that food bank use as a measure of food security is most likely severely underestimating the problem. Nevertheless, food bank use can still provide us with a traceable current source of data indirectly related to food insecurity (Davis & Tarasuk, 1994). Tarasuk & Beaton (1999a) surveyed women accessing charitable food sources in Toronto and found that 94 percent reported some degree of food insecurity over the previous 12 months and 70 percent reported some level of absolute food deprivation. Therefore, the assumption is that the majority of food bank clients experience some level of food insecurity. Every year, Food Banks Canada (2008) (formerly The Canadian Association of Food Banks), a national charitable organization representing food banks, provides a comprehensive report on food bank use in Canada titled *HungerCount*. In 2008, the national *HungerCount* reported that 704,414 people used food banks in March 2008. This number has increased 6 percent since 1997, the first year for which data is available. In British Columbia, 78,101 people used food banks in March 2008 making it the province with the third highest food bank usage after Ontario and Quebec. This was an increase of 2.1 percent from the previous year. Of those who use food banks in BC, 22.5 percent indicated that disability-related income benefit was their source of income. Unfortunately, food banks cannot meet all the nutritional needs of their clients because their supply is dependent on donations;

therefore, they have no control over the amount and nutritional quality of the food they provide (Tarasuk & Beaton, 1999; Tarasuk & Eakin, 2003, Teron & Tarasuk, 1999). Teron & Tarasuk (1999) analyzed the content of food bank hampers given to clients. They found that 78.8 percent of hampers contained at least one damaged or outdated item and over half of those surveyed indicated they had at least one time received food that was unsafe to eat. A study by Jacobs Starkey, Gray-Donald and Kuhnlein (1999) found that in Montreal, Quebec, those who were less mobile, such as the frail elderly, were underrepresented in terms of who was accessing food banks. This indicates that food banks cannot reach all of the food insecure individuals such as those who cannot physically access them. Therefore, food banks only alleviate hunger on a short term basis for some of the food insecure population and therefore, are not by any means a complete solution to food insecurity problems in Canada (Davis & Tarasuk, 1994; Tarasuk & Beaton, 1999; Tarasuk & Eakin, 2003).

## **2.2 Low income**

### **2.2.1 Measuring low income in Canada**

Unlike the United States, Canada has no official poverty line (Fellegi, 1997). The absence of detailed information on the economic circumstances of households in Canada makes it difficult to estimate the problem (Kirkpatrick & Tarasuk, 2008a). The closest measurement available is Statistics Canada's Low Income Cut-offs (LICO) (Statistics Canada, 1999). The LICOs are based on the proportion of households that spend at least 20 percentage points more of their income than the average household on food, clothing and shelter, and are dependent on family and community size (Statistics Canada, 1999).

However, Statistics Canada has been consistent in reminding the public that the LICO lines are not poverty lines (Fellegi, 1997). Chief Statistician of Statistics Canada, Ivan Fellegi (1997) issued this warning on the use of LICO lines, “Statistics Canada does not and cannot measure the level of poverty in Canada”. Nevertheless, in the absence of true poverty lines, the LICO lines provide some measure of low income; therefore, alternative to being a direct measure of poverty they can be considered a reflection of poverty-level incomes (CCSD, 2007). The most recent LICO’s were calculated in 2006. A few of them are outlined in Table 2.3 below.

**Table 2.2 Low income cut-offs for 2006 after taxes (Income Statistics Division, 2007)**

Family Size	Community Size (Number of people)				
	Rural Areas	Less than 30,000	30,000-99,999	100,000 – 499,999	500,000 and over
1 person	\$11,494	\$13,154	\$14,674	\$14,859	\$17,570
2 persons	\$13,989	\$16,010	\$17,860	\$18,085	\$21,384
3 persons	\$17,420	\$19,934	\$22,239	\$22,519	\$26,628
4 persons	\$21,731	\$24,871	\$27,745	\$28,095	\$33,221

In 2005, an estimated 655,000 Canadian families were below the LICO after taxes, representing 7.4 percent of all families in Canada (Statistics Canada, 2007a). Thirty-three percent of individuals living alone between the ages of 18-65 were surviving on incomes below the LICO’s (Feng, Dubey & Brooks, 2007). Of those individuals, 52.9 percent reported experiencing activity limitations (Feng, Dubey & Brooks, 2007). Housing is a major issue for those living in British Columbia with low incomes, as most are spending the majority of their monthly income on housing costs (Canadian Centre for Policy Alternatives, 2008). Low income households have difficulty affording both housing and nutritious food (Dietitians of Canada & Community Nutritionist Council of

BC, 2007). The situation is worsened by the fact that providing sufficient affordable housing in British Columbia is an on-going challenge (BC Housing, 2007).

### **2.2.2 Affordable housing in British Columbia**

A household is considered to be in core housing need when it is spending more than 30 percent of the gross household income on rent (McClanaghan and Associates, 2006). BC Housing is a provincial crown agency under the Ministry of Housing and Social Development. According to BC Housing (2007), 16 percent of households in BC are in core housing need. There are two types of subsidized housing options in Vancouver, BC: independent social housing (BC Housing units, co-operative housing units) and rental assistance in the private market (portable subsidized rent). In independent social housing, the tenant resides in government owned or government subsidized buildings at reduced rent cost. With rent assistance, the tenant is able to live anywhere they choose and the rental assistance follows. To be eligible for subsidized housing, the applicant's gross household income must be below certain income limits set by the Canada Mortgage and Housing Corporation (BC Housing, 2009). These Core Need Income Thresholds (CNITs) represent the income required to pay the average market rent for an appropriate sized unit in the private market. The CNIT for a Bachelor's suite in Vancouver is \$29,000 (BC Housing, 2009). In spite of the provincial government's efforts, the demand is higher than availability and government-assisted social housing currently has a waiting list of approximately 14,000 people (BC Housing, 2007). There are also long waiting times (3 years or more) for Co-operative housing units, especially for those seeking subsidized housing or disability outfitted units (Co-operative Housing Federation of BC, 2009). SROs are Single Room Occupancy hotels that provide short-term or long-term

accommodation in single rooms, typically without private bathrooms or kitchens. As part of the Province's housing strategy, BC Housing has purchased 25 SRO hotels (BC Housing, 2007). However, SRO hotels in Vancouver are most often associated with people who are intensive illicit drug users, who have been incarcerated and who have been the victim of a physical assault (Shannon et al, 2006). Therefore, it is not a desirable housing option for people with disabilities. This means those who are unable to access subsidized housing have no choice but to seek shelter through the private market.

In Vancouver, in 2007, the average rental cost for a bachelor suite and a one-bedroom apartment were \$735 and \$846 respectively (Canada Mortgage and Housing Corporation [CMHC], 2007). The percentage of bachelor units in metro Vancouver with the rent at or near the maximum shelter allowance (\$375-399) was 0.7 percent (CMHC, 2007). Therefore, it would be very difficult for a person on PWD to find housing at the amount shelter allowance provides (\$375). If the average cost of a bachelor suite is \$735 then a single person on PWD would be paying more than 80 percent of their income towards rent. In the United States, people with disabilities are experiencing a housing crisis as their disability benefits are far below what is needed (O'Hara et al, 2007). Low income families often sacrifice food and nutrition to pay for rent and other necessities which are not as flexible (McIntyre et al, 2002). However, there is currently no research showing this type of strategy in people with disabilities living in Canada.

### 2.2.3 Low income and food insecurity

Low income is a key risk factor for food insecurity and the primary cause of hunger (Che & Chen, 2001; Heart Health Coalition, 1997; Ledrou & Gervais, 2005). Tarasuk & Beaton (1999b) found that 90 percent of single mothers using charitable food sources (e.g. food banks) in Toronto reported household incomes which were less than two thirds of the LICO line. The 2005 CCHS indicated a strong correlation between low income and food insecurity in British Columbia (Kerstter & Goldberg, 2007). Table 2.4 shows the relationship between income group and the rate of food insecurity. The source of the data is the 2005 CCHS (Kerstter & Goldberg, 2007).

**Table 2.3 The relationship between household income and food insecurity rates in British Columbia.**

<b>Annual Household Income</b>	<b>Food Insecurity Rate (%)</b>
Less than \$15,000	25.9
\$15,000 – \$30,000	13.4
\$30,000-\$50,000	7
\$50,000 or more	2.2

The rate of food insecurity for those who make less than \$15,000 a year was 25.9 percent compared to only 2.2 percent of those earning \$50,000 or more a year. The rate of food insecurity decreases as the annual household income increases. According to the figures above, in 2005, one in four British Columbians earning less than \$15,000 a year was food insecure.

Food choice is also affected by income level. More money is required to make healthier choices about what foods to eat and therefore, those with less income are less likely to

choose healthier foods (Jetter & Cassady, 2005; Ree, Riediger & Moghadasian, 2008; Ricciuto, Tarasuk & Yatchew, 2006; Turrell et al, 2002). Ricciuto & Tarasuk (2007) analyzed the results from four Family Food Expenditure Surveys in Canada. They found that households with higher income were more likely to purchase foods of higher nutritional quality. This association persisted over time (1986–2001) and in the case of vitamins A, C and thiamin it grew stronger.

Assessments of dietary intake in the context of food insecurity in Canada indicate high prevalence of inadequate nutrient intakes (Kirkpatrick & Tarasuk, 2008b; McIntyre et al, 2003; Tarasuk & Beaton, 1999b; Tarasuk, McIntyre & Li, 2007). Kirkpatrick & Tarasuk (2008b) analyzed data from the 2004 CCHS and found that adults and adolescents from households considered to be food insecure had higher nutrient inadequacies for protein, vitamin A, thiamin, riboflavin, vitamin B-6, folate, vitamin B-12, magnesium, phosphorus, and zinc. In Canada, there are no studies of this nature specifically targeting people with disabilities.

There are psychosocial consequences to living on low income and not being able to provide for one's basic need for food. There is also stigma associated with the use of food banks and other charitable resources (Hamelin, Habicht & Beaudry, 1999; Hobbs, MacEachern, McIvor & Turner, 1993; Tarasuk & Beaton, 1999a) as well as anxiety and stress related to uncertainty about where the next meal will come from (Hamelin, Beaudry & Habicht, 2002; Radimer et al, 1992). The connection between food insecurity and low income is illustrated in a quote from one participant in a study on low income families and household food insecurity in Quebec: *"Our phone bill increased from \$20 to \$30 this month. Either we pay \$15 or \$20 only, or we ask to disconnect the*

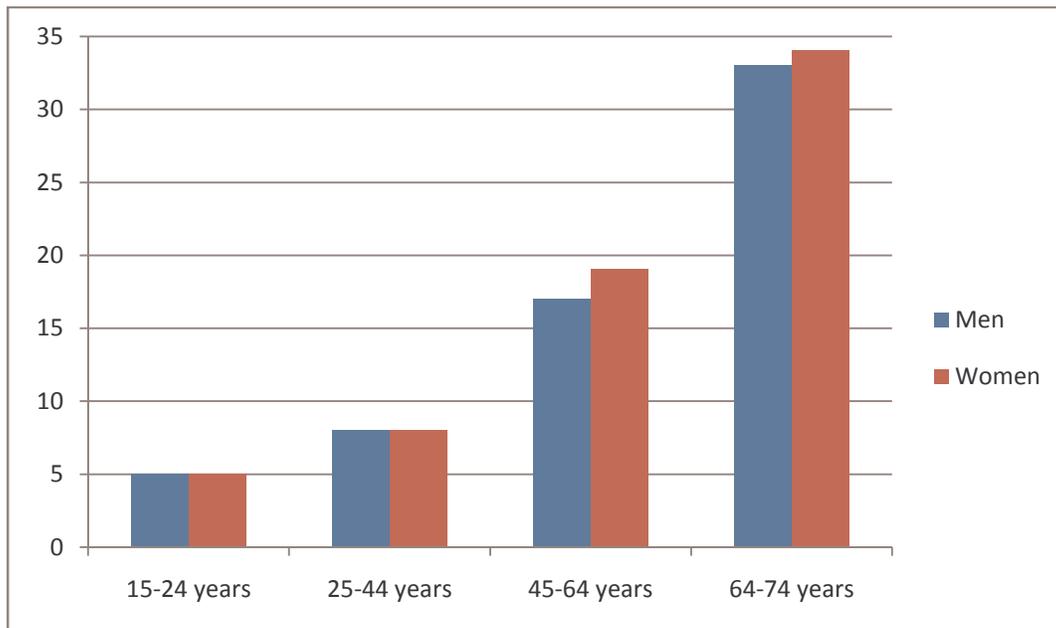
*phone. We have no choice; we already owe more than \$100 on our electrical bill. We must eat"* (Hamelin et al, 2002). Most of the research related to these consequences has focused mainly on low income families and single mothers (McIntyre et al, 2002; Hamelin et al, 2002; Radimer et al, 1992; Dowler, Turner & Dobson, 2001; Hamlin, Habicht & Beaudry, 1999; First Call, 2009). In British Columbia, the majority of low income issues have been directed towards children and families (First Call BC, 2009). It is important, therefore, to understand and identify the experiences of people with disabilities as there is a clear need to concentrate this type of research on this population.

## **2.3 Disability**

### **2.3.1 Prevalence of disability in Canada**

According to the Participation and Activity Limitation Survey (PALS), in 2006, 14.3 percent of the population reported some level of disability (4,417,870 Canadians). This was an increase of 1.9 percent from 2001 (12.4 percent) (Statistics Canada, 2007b). Approximately 15 percent of British Columbians report having at least one physical disability (HRSDC, 2008). Figure 2.2 outlines the disability rates by age and sex in Canada for 2006, taken from the PALS (HRSDC, 2008).

**Figure 2.2 Disability rates (percentage) by age and sex in Canada for 2006**



The most common types of disabilities reported by Canadians 15 years or older were related to pain, mobility and agility (11 percent or 3 million adults) (Statistics Canada, 2007b). The other most common types of disabilities included hearing (5 percent or 1,265,000 adults), vision (3.2 percent or 815,000 adults) and speech (1.9% or 480,000 adults) (Statistics Canada, 2007b). Women tend to report slightly higher disability rates than their male counterparts (15.7 percent and 13.4 percent, respectively) (HRSDC, 2008). The differences in the rates between men and women begin at age 25 and continue through the senior years, therefore, women make up the majority of people with disabilities in Canada (HRSDC, 2008). However, there are more single men on PWD in British Columbia than single women (27,353 and 21,167, respectively) (Kerstter & Goldberg, 2007).

### **2.3.2 Disability and health**

People with disabilities face unique challenges in creating and sustaining their health and quality of life (Hourston, 2007). In the United States, people with disabilities are twice as likely to drop out of high school (21 percent versus 10 percent), twice as likely to have inadequate transportation (31 percent versus 13 percent), and more than twice as likely to go without needed health care (18 percent versus 7 percent) (National Organization on Disability [NOD], 2004). Canadians with disabilities are also three times more likely to experience unmet health care needs especially related to their emotional or mental health (McColl et al, 2003). They also underutilize screening programs and report being in fair or poor health more often than adults without disabilities (BC Ministry of Human Resources, 2004). Research has shown that disability can often lead to poorer health due to secondary conditions (BC Ministry of Human Resources, 2004; Hall, Colantonio & Yoshida, 2003; Humphries, 2003; White, 1994). People with disabilities are more likely to suffer from chronic health conditions such as obesity (Weil et al, 2002), high blood pressure, heart disease, asthma, diabetes, migraine headaches and cataracts (CCDS, 2004). People with disabilities may also require assistance with their daily living activities; however a large majority are not receiving the help they need. Fifty-three percent of Canadians with disabilities reported having unmet needs with heavy household chores, grocery shopping, going to appointments and housework (HRSDC, 2008).

People with disabilities also face challenges in terms of psychosocial factors. Elderly women with disabilities who indicated they had financial difficulty acquiring food had higher levels of depression than women not reporting such difficulty (Kleges et al, 2001). People with disabilities are less likely to socialize, eat out, or attend religious services

than their counterparts without disabilities and are much more worried about their future health and well-being (NOD, 2004). Half are worried about not being able to care for themselves or being a burden to their families compared to a quarter of other Americans (NOD, 2004). Canadians with disabilities are also less likely to feel a sense of belonging to a community than those without disabilities (Uppal, 2006). Employment is also a factor affecting the emotional well-being of people with disabilities. Canadians with disabilities who were unemployed were found to be less happy than those who were employed (Uppal, 2006).

### **2.3.3 Disability and low income**

People with disabilities are at higher risk of being in a low socio-economic position (Davis & O'Brian, 1996; Havercamp, Scandlin & Roth, 2004; National Organization on Disability, 2004; Phipps, 2003). In the United States, three times as many people with disabilities live in poverty with annual household incomes below \$15,000 than people without disabilities (26 percent versus 9 percent) (National Organization on Disability, 2004). In the United States, only 35 percent of people with disabilities reported being employed full or part time, compared to 78 percent of those who do not have disabilities (NOD, 2004). In Canada, in 2001, only 35 percent of men with a disability had full-time, full-year work, 28 percent had part-time and/or part-year work, and 37 percent did not work at all (Statistics Canada, 2001). Of Canadians aged 16 and over with disabilities in 2006, 14 percent were low income (Statistics Canada, 2008b). A single person on PWD in British Columbia receives \$10,877.04 a year for all their living expenses which is far below the LICO line. In British Columbia, less than 16 percent of people on PWD reported any extra earnings above their regular benefits (Krestetter & Goldberg, 2007).

This means the large majority of people on PWD in British Columbia are highly dependent on their benefit amounts to meet their needs. The Dietitians of Canada and the Community Nutritionists Council of BC (2007) have determined that after cost of food and shelter, a single male on PWD living in British Columbia would have \$4 left over for all his other living expenses.

In 2009, in British Columbia, a single person on PWD receives a basic annual income after taxes of \$10,877.04 (BC Coalition of People with Disabilities [BCCPD], 2008). The LICO for a single person living in Vancouver, BC (Population over 500,000) is \$17,570 per year (Income Statistics Division, 2007). There is a gap of \$6,692.96. The Social Planning and Research Council of BC estimated the yearly income required by a single person living in metro BC without a disability is \$16,346.40 (Atkey & Siggner, 2008). This estimate was not considered sufficient for a person with a disability due to additional medical costs associated with having a disability. Nevertheless, there is still a gap of \$5469.36. Because of this gap, there have been several recommendations to the government to drastically increase the amount of disability-related benefits (BCCPD, 2007; Canadian Centre for Policy Alternatives, 2008; The Dietitians of Canada & Community Nutritionists Council of BC, 2007; Riches, 1999). The most recent increases in PWD benefits were \$50 towards shelter assistance in March of 2007. However, it has made minimal difference if any, since affordable housing continues to be a major issue for people on PWD (BCCPD, 2007).

It costs more to live with a disability because of the added medical costs such as assistive devices. In 2006, 63 percent of people with disabilities in Canada required the use of technical aids or specialized equipment to help them perform one or more daily activities

(Statistics Canada, 2008a). Of this group, 28.9 percent used such equipment but needed more aids and 9.9 percent had none of the equipment required (Statistics Canada, 2008a). The cost of purchasing or maintaining assistive devices was the most common reason cited by 56.1 percent of those with unmet needs (Statistics Canada, 2008a). People with a pain limitation represented the highest percentage among disability types who cited cost as the most common reason for unmet needs at 70.3 per cent (Statistics Canada, 2008a).

#### **2.3.4 Disability and food security**

People with disabilities are at higher risk for being food insecure than people without disabilities (Canadian Council on Social Development [CCSD], 2003). A study on HIV-positive individuals living in Vancouver, BC found their rate of food insecurity was five times higher than in the general Canadian population (Normén et al, 2005). Table 2.2 provides a summary of the most recent data on food insecurity among persons with and without disabilities by age and gender. The data was taken from the NPHS (CCSD, 2003).

**Table 2.4 Rate of food insecurity among persons with and without disabilities by age and gender.**

Population Type	Age Group (years)		
	15-34	35-49	50-64
Men without disabilities	10.6%	7.7%	4.1%
Men with disabilities	25%	20.3%	14.3%
Women without disabilities	12%	8.9%	2.5%
Women with disabilities	24.4%	24.1%	7%

There is a clear gap between those with and without disabilities. One-quarter of women and men aged 15 to 34 with disabilities experienced food insecurity (24.4 percent and 25 percent, respectively) compared with 12 percent and 10.6 percent of their counterparts without disabilities (CCSD, 2003). Food insecurity decreases with age. Of men with disabilities, 25 percent of those 15-34 years old were food insecure compared to 14.3 percent of those 50-64 years old. This trend is seen in both men and women with and without disabilities. The data listed above is from 1998. Unfortunately, there is no recent survey data on the food security status of people with disabilities in Canada.

People on PWD face economic barriers and physical obstacles when attempting to achieve adequate food security. Many individuals with disabilities face limitations in income, as well as requiring assistance to help them grocery shop and prepare meals (Wiel et al, 2002). Mobility problems are the disability most often reported by adults (Statistics Canada, 2008b). Hall, Colantonio & Yoshida (2003) surveyed Canadian women with a disability and found the most common barriers to food they encountered

were: too tired to cook (54.6 percent), organic/health foods too expensive (34.8 percent), nutritious foods too expensive (34.5 percent), lack of desire or will power (31.5 percent), government disability pension does not cover cost of food (30.6 percent), difficult to shop (25.1 percent) and not enough time for attendant to shop or prepare food (21.2 percent). The most common services identified to improve nutrition were: increase in disability pension (45.2 percent), assistance with shopping (31.3 percent), programs that deliver food (28.8 percent), increase attendant time for shopping/cooking (22.0 percent) and food box programs that provide single servings (20.1 percent). Nosek et al (2004) interviewed women with disabilities regarding their health issues. They identified fatigue and weakness as disability-related barriers to following a healthy diet. The disability-related barriers prevented the women from cooking or limited the types of meals they could cook. Studies have also shown that difficulties in three or more nutrition –related activities (such as chewing, self-feeding, shopping for basic necessities, carrying a shopping bag, cooking a warm meal and using fingers to grasp or handle) increases the risk of inadequate intake of energy and vitamin C (White, 1994). The majority of nutrition related studies regarding adults with disabilities focused on the elderly (Sharkey, 2008). In Canada, there is a severe lack of research regarding food security and people with disabilities who are on PWD.

## **2.4 Summary of the literature review**

The Community Nutritionists Council of BC (2004) states that food security exists when “food is obtained in a manner that upholds human dignity; food is safe, nutritionally adequate, personally and culturally acceptable; food is sufficient in quality and quantity to sustain healthy growth and development and to prevent illness and disease” (p. 3). The absence of food security (food insecurity) has a negative impact on a person’s mental, emotional and physical health. In Canada, we currently do not have consistent data to track changes in the food security of the population. We also have little data on the food security of people with disabilities. Low income has a profoundly negative effect on food insecurity. People who are PWD are living with incomes far below the LICO lines and are at risk for being food insecure. The majority of research studies regarding food security in Canada focus primarily on low-income families, the elderly, women and children. There is little research regarding the experiences of people with disabilities who are on PWD with respect to attaining adequate food security.

## **3 STUDY DESIGN AND METHODS**

### **3.1 Qualitative research design**

Qualitative inquiry was the central defining methodological feature of this research project. In quantitative procedures researchers typically utilize deductive reasoning to test a predetermined hypothesis (McMillan & Schumacher, 1997). However, in qualitative research, most categories and themes emerge from the data, rather than being imposed on the data prior to data collection (McMillan & Schumacher, 1997). Qualitative methods allow the researchers to access the data in the real world as it is experienced by the people who live it (Rossman & Rallis, 1998). Therefore, qualitative methods use inductive reasoning to explore the research objectives (Denzin & Lincoln, 2000). Inductive reasoning is, by nature, a more open ended approach and more appropriate for exploratory studies (Denzin & Lincoln, 2000). Because few investigations had been conducted about the experiences of people on PWD with regard to food security, it was necessary to use qualitative methods in order to allow the information to emerge from the participants themselves (Bouma & Atkinson, 1995).

#### **3.1.1 Paradigm of researcher**

In qualitative inquiry, the researcher is viewed as an instrument and a participant in the research process (Robinson & Tolley, 2004). Therefore, it is important to note the paradigm and belief system of the researcher. This research is located within a constructivist paradigm which is characterized by certain assumptions about the nature of reality (i.e. ontology) and how we know about that reality (i.e. epistemology) (Labonte & Robertson, 1996). More specifically, the constructivist paradigm holds that reality is

socially constructed and the realities depend on the persons who hold them (Labonte & Robertson, 1996). In a constructivist epistemology, the researcher is a “passionate participant” and is “actively engaged” in the research process (Lincoln & Guba, 2000). The research presented here was not intended to provide a solution to a problem but rather to act as a tool to better grasp the experiences of the participants (Robinson & Tolley, 2004).

### **3.2 Community partner and research site**

For over 30 years, the BC Coalition of People with Disabilities (BCCPD) has acted as a non-profit umbrella organization, information/referral centre and point of contact whose goal is to assist people with all types of disabilities. Every year, they serve over 25,000 people with disabilities. Their clients include people who use wheelchairs, people with visual or hearing impairments, and people with hidden disabilities, mental health disabilities, learning disabilities, HIV/AIDS and other chronic illnesses. One of the mandates of the Coalition is to “use education, advocacy, and special projects to work toward the dissolution of the physical, attitudinal, and systemic barriers in society” (BC Coalition of People with Disabilities). In 2003, their Advocacy Access Program had a total of 1,129 cases (including Canada Pension Plan and Persons with Disability Benefits cases) (S. Hourston, personal communication, August 11, 2004). They have also established a Wellness and Disability Initiative (WDI), which was created to offer health and wellness information for Canadians with disabilities through a variety of media (plain language, videos, closed/open captioned videos etc.) (BC Coalition of People with Disabilities, 2004).

Before submitting a formal proposal and collecting any data, I sought assistance from the BC Coalition of People with Disabilities in October 2004. Shelley Hourston, Advocate at the BCCPD, was contacted to inquire as to the utility and appropriateness of the research to their clientele. I became aware of Shelley Hourston through a colleague at the Institute of Health Promotion Research, a research institute located at the University of British Columbia. I also conducted an informal focus group style meeting with Shelley Hourston and four other advocates from the BCCPD to discuss their views on food security and people with disabilities. This meeting served to provide a broader context about the issues and to familiarize myself with the clientele and research site. Shelley Hourston then approached the board at the BCCPD on my behalf to obtain permission to recruit their clients and utilize their office space. The board expressed a strong interest in the issue of food security for people with disabilities and offered their full support. The collaboration with the BCCPD increased accessibility to key informants, information, and the research setting itself. This is known as negotiating entry through official and unofficial gatekeepers of an organization (Marshall & Rossman, 1999).

After appropriateness of the research project was determined, and in conjunction with the thesis committee members and Shelley Hourston, a formal proposal (which included a rationale, short literature review and methods section) was submitted to the thesis committee and accepted in March 2006. I then sought ethical consent to proceed with the study from the Behavioural Research Ethics Board at the University of British Columbia and received approval on July 27, 2006 (Appendix A). Recruitment began in August of 2006.

### 3.3 Sampling technique

Qualitative research is interested in the credibility of the data and not on the generalizability of the results (Marshall, 1996). Therefore, opportunistic and snowball purposeful sampling techniques were implemented to recruit participants. Opportunistic sampling takes advantage of recruiting by utilizing those in the field who are in contact with potential participants (Patton, 1990). I collaborated with the BCCPD to identify clients on PWD who would like to participate in the study. The BCCPD allowed me to recruit their clients by distributing posters and information pamphlets (Appendix B) at their offices and by making their clients aware of the study through verbal communication. They also advertised the study in their monthly magazine entitled *Transition* which is distributed province-wide on a quarterly basis (BCCPD, 2009). Snowball sampling is recruitment by asking participants to refer others who they perceive as also being good candidates to provide rich data (Patton, 1990). At the end of the interview, the participants were given small information flyers to distribute to friends or acquaintances who they felt would be good candidates to be interviewed. If they were interested in the research project, the potential participants then contacted me or left their contact information with one of the advocates at the BCCPD. The aim of the research project was to conduct between 12 – 20 interviews. In qualitative inquiry, this sample size is usually considered sufficient to gain enough depth and breadth of information for the identification of themes (Lincoln & Guba, 1985).

### **3.3.1 Inclusion criteria**

Those who contacted me or expressed desire to be contacted were asked a series of questions via telephone or email correspondence to determine if they met the inclusion/exclusion criteria. The criteria were as follows:

- 1) must have been 18-65 years old at the time of the interview
- 2) diagnosed as having a disability (physical and/or psychological)
- 3) currently receiving PWD benefits
- 4) living on their own (non-institutionalized) in Vancouver, British Columbia
- 5) having no cognitive or developmental impairments

Those living alone may be at higher risk for food insecurity than those living with others; therefore, it was chosen as one of the inclusion criteria. Being on PWD benefits is an important criterion because people on PWD are on a fixed income and their disability must be severe enough to warrant income assistance. In 2006, a single person with the PWD designation was eligible for: monthly support (\$531.42/month) and shelter assistance (\$325/month) (BCCPD, 2008). On March 28<sup>th</sup>, 2007, four months after the data was collected, the shelter assistance was increased by \$50 to \$375/month.

### 3.4 Interviews

A powerful technique in qualitative research is the face-to-face semi-structured interview. This tool has been used for generations and grants qualitative researchers the ability to “hear” data (Rubin & Rubin, 1995). Rubin and Rubin (1995) consider main interview questions to be focused, linked questions that provide direction in the interview; they cover an overall process, event or subject, and divide and organize the research topic in ways that make sense (such as phrases in a process, or parts of a concept). They are generally worded broadly enough to encourage open answers from participants, yet narrowly enough to provide the necessary data (Rubin & Rubin, 1995). Follow-up questions are more specific and create “scaffolding” for the interview (Rubin & Rubin, 1995). They help to keep the questioning on topic and link what is asked in individual interviews to the overall interview design. Further, follow-up questions allow for richer, more-in depth answers; to explore themes and concepts fully; and to clarify, test and modify existing themes (Rubin & Rubin, 1995). An example of an interview question, follow-up question and a probe are:

- Interview Question: What types of food do you wish you could eat but cannot?
- Follow up: Why would you like to eat those types of foods?
- Probe: What about ethnic foods?

The interview questions in this study were developed through an iterative process where they were emerged from the research question, literature review, and objectives and were

refined based on observations from interview responses. The final semi-structured interview guide is presented in Appendix C.

Kvale (1996) proposes the following six criteria for an interview to be considered high quality:

1. “The extent of spontaneous, rich, specific, and relevant answers from the interviewee
2. The shorter the interviewer’s questions and the longer the subject’s answers, the better
3. The degree to which the interviewer follows up and clarifies the meanings of the relevant aspects of the answers
4. The ideal interview is to a large extent interpreted throughout the interview
5. The interviewer attempts to verify his or her interpretations of the subjects answers in the course of the interview
6. The interview is ‘self-communicating’ – it is a story contained in itself that hardly requires much extra description and explanation.” (p.145)

I referred to the list of criteria above before and after interviews to determine which criteria needed to be improved prior to the next interview taking place. This practice served as a reminder on how to conduct interviews and, therefore, assisted in producing better quality interviews.

In addition to the open ended qualitative questions, the interview also included contextual questions regarding basic demographic information including sex, age, income, and ethnicity, type of disability, cause of disability, number of years with disability and the types of community organizations that were accessed. The participants were also asked four food security questions used by the Canadian Community Health Survey (Health Canada, 2004). The Canadian Community Health Survey is a cross sectional survey conducted at the health region level to determine the health status of the population. These four questions are just a few acquired from a larger survey tool used to determine income related household food security status. For the purpose of this project, the questions were asked in order to provide a broader context and are not considered statistically relevant. However, they add another level of information with which to build a more in depth snapshot of the participants' experiences and allow the sample to be characterized in relation to the general Canadian and British Columbian population. The four food security questions can be found in chapter 4.

The first face-to-face interview occurred on September 1, 2006. The interviews were conducted at the offices of the BCCPD. This site was chosen because it was an environment where the participants felt comfortable, safe and accepted. It was easily accessible to people with physical disabilities and the participants were familiar with the environment and the transportation routes for arriving at the destination. The site also provided a safe place for me as there was a possibility that the participants could have a mental illness, therefore, if erratic behaviour were to occur other people would be available with experience on how to handle such situations. All the interviews were recorded on cassette tapes. The length of interviews ranged between 30 minutes to 2

hours. The total number of interviews conducted was 20. However, it was determined during the interview process that four of these participants did not in fact meet the inclusion criteria. Two did not live alone and two were people with developmental disabilities. These four were excluded from analysis. The last interview took place on November 23, 2006.

### **3.5 Data analysis**

There is more than one way to analyze qualitative data. In qualitative research, the process of organizing, analyzing and interpreting data is referred to as data analysis. Some qualitative researchers are cautious of utilizing cookie cutter methods because an important feature of qualitative research is the creative participation of the researcher (McMillan & Schumacher, 1997). However, most researchers will agree that the analysis of qualitative data is a progression that entails three primary actions: 1) data reduction, 2) data display, 3) conclusion drawing and verification (Miles & Huberman, 1994). Data reduction is the selection, simplification and transformation of the data. In this step the researcher makes decisions on what data to code, which data to extract, and which sections of data highlight patterns. Data display is how the researcher presents the data. It assists with organizing large quantities of data into logical and clear forms. This step also creates the foundation for drawing conclusions. Finally, conclusion drawing refers to the process of inductively drawing significance and value from the data.

Immediately following each interview I wrote detailed field notes containing a description of the location and environment of the interview, people present, and a summary of the non-verbal behaviour of the participant, the interviewer's initial

impressions and any preliminary analysis (Morse & Field, 1995). All the interviews were tape-recorded and I did not encounter any technological problems with the recordings. All the interviews were then transcribed verbatim by me. Attention to transcription quality is important to guarantee an accurate written translation of what was verbally communicated (Poland, 2002). I adopted several strategies suggested by Poland (2002) to ensure the transcripts were good quality. They are as follows:

- 1) use of high-quality recorder and cassette tapes
- 2) transcription of all interviews myself to establish consistent syntax
- 3) review of some of the transcripts against the audio recording to look for mistakes
- 4) use of field notes to clarify the context of the interview

All personal identifiers were removed and a participant/interviewee code was assigned to each participant to protect confidentiality (Kvale, 1996). After concluding this section of data preparation I went on maternity leave for one year commencing on August 1<sup>st</sup>, 2007. For the first step upon returning, I read the interview transcripts several times and broadly open coded each one by hand. Open coding assisted me in organizing the data (Strauss & Corbin, 1998). To avoid 'word overload' I did not undertake line by line coding (Sandelowski, 1995). These codes were developed by determining the main ideas within each paragraph. Examples of some open codes extracted from the first level of analysis of participant seven are as follows:

- disability causes chronic fatigue and pain
- disability affects mobility
- obtaining groceries frustrating process
- not eligible for home support
- "food doesn't have all the vitamins and nutrients that I need"
- can't use food banks

- has many food allergies but cost of specialty food expensive
- cost of rent increases, but no increase in disability payments
- food acquisition affected by high cost of rent
- no rent subsidy
- is aware of importance of buying locally for the environment and to support local farmers, but is unable to do so due to finances
- variability of food is limited
- eat lots of food from a can
- skips meals because too tired to cook
- convenient food too expensive
- needs to take some medications with food which she hasn't on occasions
- wary of working part-time because case workers imply that may not need PWD

At the conclusion of reading and coding each transcript I wrote a point form abstract detailing the main ideas and first impressions of the interview. These abstracts were then compared to the field notes that were initially written immediately following each interview to contrast them with my impressions a year before. These first steps assisted me in becoming reacquainted with the data. Once I had a grasp on the overall themes, topics were used to guide the next step in the coding process (Sandelowski, 1995). The four topics were 1) where and how the participants get their food 2) how participants prepare their food 3) what types of foods do the participants eat and 4) other. The topics were chosen to further focus on the relationship and experiences of the participants around food security and more specifically on the process of accessing, preparing and eating food. Table 3.1 summarizes some examples of the codes extracted from one of the participants.

**Table 3.1 Examples of codes generated using topics**

Where and how they get their food?	How they prepare their food?	What types of foods do they eat?	Other
1) trouble reaching food in store 2) trouble carrying food home from store 3) high cost of specialty food 4) can't use food banks due to physical limitations 5) difficulty carrying things on bus 6) prefers to buy locally but is unable due to finances	7) difficulty lifting pots 8) difficulty standing for long periods of time 9) difficulty cutting and chopping 10) Difficulty opening lids 11) cooks in batches 12) chooses easier to prepare meals (i.e. sandwiches) 13) skips meals because too tired to cook	14) eating a lot of tuna in tins 15) skipping meals because not enough food 16) food allergies limit type of food 17) limited variability due to cost 18) limited variability due to physical limitations 19) low nutritional quality of food 20) limited choice	21) not eligible for home support 22) no rent subsidy 23) rent cost affect food acquisition 24) lack of food affects medication schedule 25) difficulty walking 26) can't afford convenient pre-made meals 27) feels bad that can't afford to have people over to eat 28) can't afford supplements 29) pays for some medications herself

The copy and paste functions of a word processor were used to improve efficiency of the data analysis. Sections of the transcripts were ‘copied’ from one document and ‘pasted’ onto another which contained other quotes with similar topics. This allowed for easier management of the data. After completion of coding using these topics, I coded the transcripts again to identify more specific themes within each topic. The third level of coding was undertaken to re-examine the data and search for any codes that may have been overlooked during the second level of coding. The codes from the third level of analysis were then organized into themes. These themes were used to organize the data

into more manageable sections. Examples of some themes generated by the codes from one participant are outlined in Table 3.2.

**Table 3.2 Example themes derived from codes**

Theme	Codes
Shopping difficulties	<ul style="list-style-type: none"> <li>• trouble reaching food in store</li> <li>• trouble carrying food home from store</li> <li>• difficulty carrying things on bus</li> <li>• difficulty walking</li> </ul>
Can't access food banks	<ul style="list-style-type: none"> <li>• can't use food banks due to physical limitations</li> </ul>
Social impact	<ul style="list-style-type: none"> <li>• feels social pressure that can't afford to host meals</li> <li>• feels frustration – not eligible for home support</li> </ul>
Cost of food	<ul style="list-style-type: none"> <li>• high cost of food in general</li> <li>• prefers to buy locally but is unable due to finances</li> <li>• skipping meals because not enough food</li> <li>• can't afford convenient pre-made meals</li> <li>• food allergies – specialty foods more expensive</li> </ul>
Rent cost	<ul style="list-style-type: none"> <li>• no rent subsidy</li> <li>• rent cost affect food acquisition</li> </ul>
Difficulty preparing food	<ul style="list-style-type: none"> <li>• difficulty lifting pots</li> <li>• difficulty standing for long periods of time</li> <li>• difficulty cutting and chopping</li> <li>• difficulty opening lids</li> <li>• skips meals because too tired to cook</li> <li>• cooks in batches</li> </ul>
Medical costs	<ul style="list-style-type: none"> <li>• pays for some medications herself</li> <li>• lack of food affects medication schedule</li> <li>• can't afford supplements</li> </ul>
Limited variability	<ul style="list-style-type: none"> <li>• limited variability due to cost</li> <li>• limited variability due to physical limitations</li> <li>• eating a lot of tuna in tins</li> <li>• low nutritional quality of food</li> <li>• limited choice</li> <li>• chooses easier to prepare meals (i.e. sandwiches)</li> </ul>

Next, I used constant comparative analysis to compare and contrast the themes identified between participants. Constant comparative analysis is a method where each interview is compared and contrasted with the others to build an understanding of themes within the experience of interest (Thorne, 2000). This analysis tool is usually undertaken when developing a grounded theory investigation; however, it can be used when conducting any type of qualitative inquiry. Strauss and Cobin (1998), explain that making comparisons has several functions in qualitative research:

- helps analyst move more quickly from the level of description to one of abstraction;
- helps analyst obtain a grasp on the meaning of events or happenings that might seem otherwise obscure;
- counters the tendency to focus too greatly on a single case by immediately bringing analysis up to a more abstract level;
- facilitates the linking and densifying of categories”. (p. 84)

The process of constant comparison analysis allowed for the identification of the broader categories and sub-themes within those categories.

The final step was analyzing the themes and categories based on the different components of the definition for food security explained in the previous chapter. The participants’ responses were sorted using the six components as major categories. This priori framework was used only after coding was concluded so as not to “close off recognition of other ways of organizing the data” (Sandalowski, 1995). The themes were then organized into the food security definition framework.

### **3.6 Rigor**

There were several techniques used by the investigator to enhance the rigor of the research. Coding and data analysis were reviewed and discussed by three of my peers (co-workers from a research institute) at several points during the research process. The peers were chosen because of their familiarity with qualitative data analysis techniques. This is called peer debriefing and it increases the credibility of the data because it takes into account more than one point of view (Morse & Field, 1995). My peers were given transcripts and asked to extract the themes and key points. The themes and key points identified by my peers were then compared to those identified by me. Any similarities and differences were further discussed for clarification and theme development.

Theory triangulation chooses participants with different theoretical perspectives and examines their views on the same experiences (Patton, 1999). In this investigation, participants with different types of disabilities were chosen to provide a wider range of experiences.

A member check is a technique often used in qualitative research to enhance the trustworthiness of the data. It gives participants the opportunity to react to their responses and to clarify any misunderstandings on behalf of the researcher (Lincoln & Guba, 1986). However, in this research project, I decided to abstain from conducting member checks. Sandalowski (1993) explains that member checks may not be appropriate in all circumstances and warns that in some cases it may actually be detrimental for the research process. For this research project, by the time I had analyzed the data, approximately two years had passed since the participants had been interviewed. The

passing of time can change how participants' view their circumstances. For example, the participants may have learned new strategies or have adjusted to their circumstances in a new way since they were last interviewed. Sandelowski (1993) explains it this way:

The stories that members tell in interviews are themselves constantly changing. They represent members' efforts to order, find meaning in, and even live with the events in their lives at a particular moment in their lives. Stories previously told may elicit feelings members no longer have, regret, and/or have forgotten; a life event previously told as a tragedy may subsequently be told as a romance. Members may want such stories removed as data. (p. 5)

For this reason, I decided it was best not to conduct member checks.

### **3.7 Ethical considerations**

It is critical when conducting research with vulnerable populations to be cognizant of ethical issues and to design research methods that take them into consideration (Flaskerud & Winslow, 1998). The participants in this study belonged to a population from a sensitive socio-economic position; therefore, I was aware of their vulnerability to feeling exploited and took measures to prevent that from occurring. Because there was considerable amount of time required of the participants and an inconvenience of travelling to the research site, the interviewees were offered a \$25 gift card from a local grocery store of their choice. Each participant provided written consent indicating they understood the nature of the interview; they knew what was involved in participating; they understood the purposes of the project and any risks involved, had agreed to participate and understood that they may withdraw at any time without consequence (Appendix D). Due to the nature of the topic, there was a risk that the participant might experience increased emotional stress as a result of the interview or feel uncomfortable discussing personal material (Kvale, 1996). Four of the participants became emotional

during the interview. When this occurred, the interviewer offered to stop the interview or to take a break to allow the participant time to him/herself. In all four cases the participants decided to complete the interview. The interviewer also prepared a list of appropriate, affordable counselling resources as well as food acquisition resources and gave a copy to each participant at the conclusion of the interview (Appendix E). Besides the \$25, the participants did not receive any other direct benefits from the study but some informants reported that participating in this research interview was a rewarding experience. A similar phenomenon was observed in a study by Morse and Field (1995) where the participants indicated that it was a privilege to be asked their experiences and be seriously listened to. I also collected sensitive demographic data. This data served only to contextualize the information and was not used to draw unfair stereotypes or to further stigmatize the population (Flaskerud & Winslow, 1998). Confidentiality of the interviewees was assured by removing all identifying information such as names of people and places from the transcripts and results documents. Any raw data such as audiotapes or my research notes that contained identifying information were kept in a secure location.

## **4 RESULTS**

This chapter describes the findings of the research project. The first section provides demographic information for the participants as well as the results of the food security survey questions that were asked during the interview. The second section explains the qualitative results with quotes from the interviews. The last section provides a table displaying the relationship between the qualitative results and the food security definition.

### **4.1 Participants**

Demographic information for the 16 participants is presented in Table 4.1. As described in the methodology section, the criteria for participating in this study excluded those who lived with others, therefore, none of the participants were married or in common-law relationships. Participants ranged in age from 34 – 61 years (mean = 47 years). The number of years participants had been on PWD ranged from 1 - 30 years (mean = 12 years). Seven of the participants had more than one type of disability. The number of disabilities types per participant ranged from 1-4.

**Table 4.1 Participant profiles**

<b>Demographic</b>	<b>Category</b>	<b>Number of Participants</b>
<b>Sex</b>	Men	9
	Women	7
<b>Age (years)</b>	30 – 39	4
	40 – 49	4
	50 – 59	6
	60 – 69	2
<b>Years on PWD</b>	0 – 2	1
	3 – 5	2
	6 – 9	4
	10 – 14	4
	14 – 20	3
	21 – 30	2
<b>Ethnicity</b>	Caucasian (European descent)	11
	Aboriginal, Inuit, Métis	5
<b>Highest Level of Education Completed</b>	Elementary School	4
	High School	5
	Trade School	1
	College	3
	University	2
	Graduate School	1
<b>Cause of Disability<sup>1</sup></b>	HIV	6
	Multiple Sclerosis	1
	Brain Injury	2
	Arthritis, Fibromyalgia, Chronic Fatigue Syndrome	5
	Partial Paralysis	2
	Visual Impairment	1
	Severe Depression	2
	Other <sup>2</sup>	6
<b>Subsidized Housing</b>	Yes	12
	No	4
<p>1 Numbers in this section total &gt; 16 because many participants had more than one disability                  2 The ‘Other’ category refers to other chronic illnesses that contribute to their disability. These have not been named because they are rare and may be used to identify participants.</p>		

**Table 4.2 Responses to the Canadian Community Health Survey questions**

Question	Type of Response	Number of Responses
<b>1. Which of the following statements best describes the food eaten in your household in the past 12 months?</b>	a) You always had enough of the kinds of food you wanted to eat	2
	b) You had enough to eat but not always the kinds of food you wanted	6
	c) Sometimes you did not have enough to eat	8
<b>2. You worried that food would run out before you got money to buy more.</b>	Often	5
	Sometimes	7
	Never	2
<b>3. The food that you bought just didn't last, and there wasn't any money to get more.</b>	Often	5
	Sometimes	8
	Never	3
<b>4. You couldn't afford to eat balanced meals.</b>	Often	8
	Sometimes	4
	Never	4

As shown in Table 4.2, participants' responses to four food security questions derived from the Canadian Community Health Survey indicate that all but two of the participants' had some level of food insecurity. The two participants who did not indicate food insecurity answered a) for question 1 and 'never' for questions 2, 3 and 4. They were both Caucasian males that had been on PWD for 30 years, the longest time of all the participants, and also had subsidized housing. At the other extreme, four participants' responses suggested they were highly food insecure. Three of those answered c) and one answered b) for question 1 and three answered 'Often' for questions 2, 3 and 4. One answered 'Often' for questions 2 and 4, and 'Sometimes' for question 3. These

participants were all female, three being Caucasian and one Aboriginal. Three of these four women did not have subsidized housing. They had been on PWD between 5 and 11 years.

The rest of this chapter describes the experiences of these participants with regard to food security. It was evident that the food security of the participants was affected by multiple factors. These factors can be organized into three major categories: living with a limited income, living with a disability and living with psychosocial issues. It is important to note that some factors relate to more than one category. The following sections describe these factors in greater detail. The participants have been given aliases to protect their anonymity.

## **4.2 Living with a limited income**

### **4.2.1 Prioritizing expenses**

Many of the participants in this study described how the monthly benefit they received was not sufficient to pay for all of their expenses. As described in a previous chapter, the participants were living on an income far below the Low Income Cut-offs. Therefore, it was not surprising that other expenses took priority over buying food.

#### **4.2.1.1 Rent**

Rent was the largest expense for all participants. The cost of rent varied and was highly dependent on whether or not the participant received subsidized housing. Twelve of the 16 participants had subsidized housing, which meant they paid a monthly rent of \$250 to \$400. The participants who did not have access to subsidized housing paid \$545 to \$725

per month on rent. All those interviewed qualified for subsidized housing based on the criteria described in a previous chapter. The participants reported long waiting periods with 5 years being the average length of time spent on waiting list. All participants who had been on PWD for 15 years or more had subsidized housing. Table 4.3 summarizes the relationship between years on PWD and access to subsidized housing.

**Table 4.3 Years on PWD and access to subsidized housing**

	<b>1-14 Years on PWD</b>	<b>15-30 years on PWD</b>
<b>In subsidized housing</b>	7	5
<b>Not in subsidized housing</b>	4	0

Judy did not have subsidized housing even though she had been on PWD for 10 years.

She explained why it is difficult for her to get affordable housing:

I'm on the BC Housing list. I'll never get off it because I have a house and they do it on need. I'm eligible for co-op units but a lot of them have been leaky condos, so they spent their money fixing up the condos and the subsidies have gradually disappeared, and so they kept the subsidies only on the disability outfitted apartments and I'm eligible for it cause I have a scooter. But when they interview you they say, 'well, you don't really need the wheelchair outfit right?' I can benefit sitting down in the kitchen but I can survive without it. There is somebody else, like the last time I was interviewed. I've been interviewed a couple of times. I've been on waiting lists for 3 years and I've only recently started to get interviewed for co-ops and I've applied for like 75 co-ops. So I started to interview for one in the west-end and they gave it to a double amputee. You know obviously that makes sense she was in the hospital she had nowhere to go and she really needed a wheelchair set up and her present home didn't do it, so she couldn't go home. So she was in the hospital so they gave it to her. That will always happen to me.

Three of the four participants without subsidized housing spent 65 – 85 percent of their monthly benefit on rent. These are the same three women who were at the highest level of food insecurity based on the food security questions from the previous section. The fourth participant without subsidized housing, an Aboriginal male, chose to live in a single room occupancy hotel at a cost of approximately \$400 a month.

Lori, who did not have subsidized housing, explained that because of her rent cost she had to budget her money very strictly and avoided buying even the smallest item if it was not absolutely necessary:

I have to budget right down to the penny because my rent is way more than is covered on disability, you know. I get, it's like \$856 or something like that per month and my rent is \$545, plus I have insurance, plus I have utilities. So I have, you know, I can't afford to pay that extra 50 cents or whatever at the 7-11.

Those with subsidized housing expressed what a “big difference” it made financially.

Brenda explained how having the subsidized housing allowed her to pay for things that have increased her quality of life:

If it wasn't for [subsidized housing] I wouldn't be able pay for my own cleaning. I wouldn't be able to pay for my vitamins. I wouldn't be eating nearly so much organic foods and I wouldn't feel as good. I like, have a rather holistic approach to my pain relief. I got to the point where I couldn't take any more aspirin. I couldn't take any more Tylenol because every time I did I would get this pain in my side and so I take very little Naproxen, that pain killer. I was able to reduce the amount that I take pretty much by half by doing all the physical therapy, going to the massage therapy and physiotherapy and I also see an acupuncturist which I wouldn't be able to afford.

The participants with subsidized housing discussed how much more difficult it is for those without subsidized housing and remembered what they had experienced prior to having subsidized housing themselves. Kate recalls her situation:

Yeah it's been very hard. It's been really horrible. It's been horrible. It's been like, the rent was \$575 or \$600. It was, it was horrible. \$610 one was in the beginning. Whoa it's just been horrible. It's just not much to eat and then going to food line-ups and food banks you know, stuff so I'm glad I'm past that. I'm in a subsidized housing, a non-profit place, and I'm finally getting some food in me.

However, rent was not the only expense that limited the amount of money the participants could spend on food each month, which meant that having subsidized housing was not the complete answer to all their financial hardships.

#### **4.2.1.2 Medical needs**

People on PWD are afforded several medical benefits such as Medical Services Plan (MSP) and Pharmacare coverage with no deductible, as well as other health supplements such as dental and optical coverage. However, there are still many services which they do not receive such as the cost of some assistive devices, physiotherapy, occupational therapy, massage therapy, certain medications and nutritional supplements. For some, these services are crucial to managing their sometimes debilitating conditions. Bonnie had multiple health issues. She explained how the financial burden of her medical needs had to take priority over buying food, which is why she sometimes had to go without:

The disability income from the government is not adequately meeting dietary and medical needs. And out of that amount that you get you are expected to pay... rent, utilities, medical treatments such as physio and massage, dietary, pharmacy items, OTC items, medical transportation, prescriptions not covered by medical, that for me are life saving, such as Benadryl for my severe allergies. They refuse to pay that now. They used to on a special authority form. Nitroglycerin only

partly covered so I end up paying most of it myself. It's a nitro spray and some of the antibiotics I need for my eyes because of the autoimmune disease and respiratory puffers that can be anywhere up to \$200 a month, which I don't have to spend on that, but I try to space it out. The prescriptions I need for my eyes because I have serious eye problems and I might be losing vision in one eye. With the autoimmune disease I need specific drops and one prescription is between \$80 and \$90 and it only lasts two weeks because it's a 5 ml bottle. And you are expected to pay all that out of your small monthly disability. So you can appreciate that does not leave enough for food so that is why you go without food for a few days.

Vitamins and other nutritional supplements can be effective in helping to manage and reduce the symptoms of certain illnesses. Prior to the provincial budget cuts implemented by the Liberal government in 2001, some of these used to be covered by PWD. However, they are no longer covered and the participants have to pay for them out of their monthly benefits. Ensure® is a high calorie drink that is easily digested and designed to supplement a meal. Bonnie explained how she depends on and has to pay for Ensure® when her gastrointestinal problems arise:

Then because of the GI problems I had, including some minor bleeding, sometimes I have to rely on Ensure®. And I had a doctor's letter for that and that used to be covered but it is no longer covered by the Ministry.

For others, however, the expense was too much regardless of the health benefits they received when they were using them. Jeanette revealed that finances were the reason she stopped taking vitamins even though they were beneficial:

I was doing all the vitamin supplements that a dietitian had advised me to. It felt really good but it really did burn, you know drain my finances. So that's why right now I'm not doing it and I'm gonna have to figure something out to get back on that.

Similarly, Rohan explained how finances often prevented him from following his doctor's advice. The suggestions from his doctor (such as vitamin supplementation) could often incur extra costs which made it difficult for him to comply:

I try sometimes but most of the times I can't even though I tell the doctor that I will try. It doesn't usually work.

Researcher: Why do you think it's difficult to follow what he suggests?

It comes down to managing your money, never could never will. I doubt if anybody else can either. We all have the same problems.

#### **4.2.1.3 Pets**

Pets were an expense that, for some participants, took priority over food. Seven of the 16 participants interviewed owned one or more pets. Having a pet provided them with much needed emotional support. Carol expressed how her dog and cat helped her maintain her "sanity". Her dog in particular gave her a reason to go out for walks, which she otherwise would not have done and which is also beneficial for her physical health. Pet ownership, however, was an added expense, especially when a veterinarian was needed, but one she was willing to sacrifice her food security for as evidenced by the following quote:

With all my bills I'm always short on food, but I'm NEVER short on dog food or cat food, never. I just won't have the comfort of eating pancakes at night, which are my favourite. I just won't have that. I just won't be able to eat at night but that's okay as long as my animal is ok. Right now she has an ear infection and it's just stressing me out.

A pet will get ill and require medical attention at multiple points throughout its lifespan. These situations usually occurred suddenly and unexpectedly. Some of these pet owners had to borrow money from friends to pay for veterinarian bills. However, for these

participants the rewards of having a pet far outweigh the financial burden, especially for those with severe depression and/or mobility issues.

#### **4.2.1.4 Other extra living expenses**

Other expenses which limited the amount of money the participants had left for food were essentials such as clothing. Eric needed to access specialty shops for things like clothes and shoes. Eric expressed frustration in regard to shopping for these essentials because of his size:

Clothing, because being a larger person I can't buy at a conventional shop. So I have to go to a dress shop that specializes in larger sizes and because you are larger you get the privilege of paying twice as much. Whereas, in reality, it's not that much more material being used but because you're oversized you pay more. Same thing with shoes, I have wide feet so if I go to a specialty store that sells wide-fitting shoes, it's almost twice as expensive as conventional shoes.

Other expenses which took priority for some of the participants, especially those with more severe physical limitations, were telephone, cable television and internet. Those with disabilities which limited their mobility and energy felt that having these things were crucial to their mental well-being as it provided them with a "lifeline to the outside world".

#### **4.2.2 Dependence on non-profit organizations**

The majority of the participants in this study were strongly dependent on free and/or reduced cost meals and groceries from non-profit organizations. These organizations included the Greater Vancouver Food Bank, Dr. Peter Centre, Vancouver Native Health,

AIDS Vancouver, Positive Women's Network, People with AIDS, Salvation Army, BC Housing and Partners in Hope Food Co-op.

#### **4.2.2.1 Cost of food**

Food banks were the resource most often mentioned by the participants in this study. Eight of the 16 participants reported currently using food banks on a regular basis and 2 others reported having used food banks in the past. One reason for accessing the food banks was the high cost of groceries. Rohan explained how buying groceries could get very expensive and how the food bank was a great help to him:

Well, you certainly can't go out and buy food any time you want. I only shop maybe once a month. You can't stock up. You know, a guy can go to the store and easily spend \$100 on all kinds of things you don't eat like sugar, salt, pepper, ketchup, mustard all this kind of stuff. Just stuff that you eat, you gotta have fresh milk, fresh bread every week and thank God for the food bank I get fresh milk every week and sometimes bread.

The food bank and other non-profit organizations are sometimes the only alternative when unexpected expenses arise such as dental work that is not covered or veterinarian bills. The Dr. Peter Centre provides breakfast and lunch for people with HIV/AIDS Monday to Friday every week. Carol was a regular user:

I have to rely on the Dr. Peter Centre a majority of the time to eat. So which means I have to get on the skytrain and come all the way downtown, and then have breakfast and lunch down here.

All of the six participants with HIV ate meals at the Dr. Peter Centre every week with most of them using their free meal program five days a week.

#### **4.2.2.2 Nutritional quality of food bank food**

The majority of the participants were very grateful for the existence of food banks and other non-profit organizations. However, they also expressed frustration and regret that the majority of the food they were provided with was not nutritionally adequate. Judy explained the type of food she received from the food bank.

I also go to the food bank but I find that if I want to live on Ichiban noodles and pasta it's great but it's not... I don't... I mean they want to fill you up to make you comfortable but there is no nutritional value in the food that they give you. Having good nutrition is like, you know, an unattainable goal for me on welfare.

Mark described the type of food he received from the food bank:

It sucks sometimes. It's not meant to feed you for a week it's just meant to top you up so it can be really crappy sometimes, tin food. The good part of it is that you get two fresh fruits: two bananas, two oranges or two apples. There is milk so that's the thing we can look forward to each week. So there is always fruit and vegetables and that milk. Other than that there is usually some tin food or something packaged. It's nasty. Chef Boyardee sort of spaghetti meatballs or something. It's not nice.

#### **4.2.2.3 Safety of food bank food**

The safety of the food provided at food banks was also an issue. Some participants reported often being given food items that were “unbelievably expired”. None of the participants, however, reported becoming ill from ingesting the expired food. Judy explained how in the past she had been given outdated food:

The food bank food also is often unbelievably expired, like really bad. Some foods you can't tell, some you really really can like they really are four years expired. I find it interesting that restaurants can't because of liability issues, can't donate their leftovers easily but the food bank can distribute expired food. So I don't understand, you know, how they are allowed to distribute expired food.

Theoretically the expiry date is supposed to mean something. I mean I guess if it just means taste then whatever go ahead and distribute it but some of it is quite scary. You think this has been back in the warehouse for like 20 years, you know.

#### **4.2.2.4 Non-profits as a means to reduce hunger**

Although the nutritional quality of the food they receive may not have been ideal, it served an important purpose: to reduce hunger. The participants discussed how helpful it was to have these resources to help them reduce or avoid the feeling of being hungry. For those who had access to these organizations, hunger did not seem to be a major issue. Rohan stated that he never goes hungry because of the wide availability of non-profit organizations:

I get by. I get by because there is a food bank, because there are places I can go to eat and there are many places. You can start at 7 in the morning and go to 7 at night and eat free somewhere in the city. So hunger should not be an issue but it is I know it is, but it really isn't with me.

Another participant took advantage of the free meal provided by the BC housing complex she lived in. This same housing complex also contained a small store that sold low cost food. Having these sources gave her comfort, knowing that she never has to go hungry.

For those people who used non-profit organizations on a regular basis the days when they were not available or closed would be a day they experienced hunger. Weekends when the Dr. Peter Centre did not provide free meals, were particularly difficult for Mark. He may only have had one meal on those days.

Living on a limited income meant that participants often had to prioritize other expenses such as rent, medical costs, pets and other living costs (e.g. clothing, internet, cable

television) over buying food. This led to a strong dependence on non-profit organizations for their food to prevent hunger. Unfortunately, the food they received from these organizations (especially food banks) was of low nutritional quality and sometimes not safe for consumption.

### **4.3 Living with a disability**

Many of the participants described how their physical disability affected their mobility and energy level which in turn affected their food security. The level of mobility varied greatly between participants. The participants affected by HIV only, the visually impaired informant and the one with a brain injury only were the most mobile in terms of their ability to walk, carry and prepare food. Those with medical issues affecting their muscles, joints, pain and energy levels such as those with Fibromyalgia, Arthritis, Chronic Fatigue Syndrome, Multiple Sclerosis, and Partial Paralysis reported having more difficulty with mobility and energy. Eight of the 16 participants used a device to assist with mobility such as a wheelchair or crutch. Table 4.4 compares the response, to survey question 1 of participants whose disability did affect their mobility and energy versus those whose disability didn't.

**Table 4.4 Responses to survey question 1 – mobility/energy**

<b>Question 1) Which of the following statements best describes the food eaten in your household in the past 12 months?</b>		
<b>Answer</b>	<b>Mobility/energy affected by disability</b>	<b>Mobility/energy not affected by disability</b>
<b>a) You always had enough of the kinds of food you wanted to eat</b>	0	2
<b>b) You had enough to eat but not always the kinds of food you wanted</b>	2	4
<b>c) Sometimes you did not have enough to eat</b>	6	2

Six of the eight participants with disabilities that affected mobility and energy responded c) to question 1. At the other extreme, only two of the eight respondents with disabilities that did not affect mobility and energy responded c) to question 1.

#### **4.3.1 Accessing non-profit organizations**

Not all participants accessed the food services offered by non-profit organizations. Some of these participants expressed a desire to be able to use the services but had barriers that prevented them from doing so. These barriers were caused by their physical disability or medical issues such as allergies, which limited the kinds of foods they could ingest.

##### **4.3.1.1 Physical limitations as a barrier**

The participants who were not accessing food banks and other sources of free or low-cost food gave physical limitations as one of the reasons why they could not take advantage of such services. A few of them had attempted to use the food bank and other services but

found that they had difficulty transporting the food back to their home. For those with disabilities that strongly affected their mobility, this was a major issue. Table 4.5 shows how many participants with and without mobility and/or energy level issues accessed and did not access food banks.

**Table 4.5 Food bank access – mobility/energy**

	<b>Mobility/energy affected by disability</b>	<b>Mobility/energy not affected by disability</b>
<b>Accessed food bank</b>	2	6
<b>Did not access food bank</b>	6	2

It is interesting to note that participants were more likely to access food banks if they did not experience mobility and/or energy level issues. Six of those without mobility and energy accessed food banks while only two with mobility and/or energy level issues accessed them. Andrew, who has pain and mobility difficulties, explained why he stopped using the food bank:

I used to go to the food bank but it's too hard on the body to do that.

Researcher: And can you elaborate a little bit on that why it's hard?

Well there used to be the one at Trout Lake which is the one I would go to. They used to have a...if you were disabled you could go to the front but they eliminated that because they found that people were abusing it. I imagine maybe people who they perceived as not being disabled were going ahead or I don't know why they did that and it's quite a ways off the bus route. So I have to, like, walk to the bus the number 20 and then because Commercial Drive kind of veers off so you gotta walk several blocks from when you get off the bus to the Trout Lake spot and stand in line for ages and ages and then walk. It's just too much for what I get there. It's worth it to me to not have other things during the month so I can not have to do that.

Judy had an “invisible” disability, meaning you would not know she had an illness by her physical appearance alone. Because of this, she encountered resistance to using the food bank for people with disabilities, even though standing for a long period of time was very draining for her. In the end, her only solution was to volunteer at the food bank. She relates her story in the following quote:

But when I went to the [food bank for people with disabilities] they’re like well you can walk it’s only for people who can’t walk and so in the end I volunteered so I could sit down. They said if you volunteer you can sit down and we’ll give you food but if you’re just a customer you have to stand. So it was ridiculous right, poor combination. I think, while I was there, I managed to change that a little bit, that idea that you know there are lots of disabilities where standing in line is big. Like for me, I can stand in line but I’m going to be sick for four days afterwards because of the blood pressure thing you have after-effects from standing for a long time, but I can walk fine, but standing is killer.

Judy is no longer volunteering at the food bank since discovering the Partners in Hope Food Co-op which provides a delivery service of low priced food. Unlike the Food Bank, however, the food co-op requires a fee of \$25 for a single adult. Judy felt that it was worth the cost for the amount and quality of the food she received. Unfortunately, they were only able to provide the service to a limited number of people.

#### **4.3.1.2 Special diets as a barrier**

In some cases people on PWD have conditions which have strict dietary requirements. For example, two of the participants in this study had severe food allergies which prevented them from ingesting most foods. Brenda arrived at the interview with a four page explanation of all her food restrictions. It was evident that this was a significant part of her life which required much energy. Some examples of things she had to avoid were gluten, dairy, citric acid, monosodium glutamate (MSG), nuts and most meats except

chicken. Because of this very strict diet, Brenda could only eat food bought at certain specialty stores. When asked about using the food bank she provided this explanation below:

I don't have that luxury. If I don't eat what is good for me I feel it within hours if not half a day. If I don't eat the right foods I feel it. If I don't eat the right food at the right time you know it could lead to emotional complications of you know well I'm already feeling kind of depressed but now I'm going into hypoglycaemic low blood sugar. It can be very difficult to juggle and the finances frankly I couldn't do it without help from my parents because I just have to have the food that I need and I need it when I need it and if I can't prepare it myself I need the help and my parents pay for the help.

It is evident that Brenda would not benefit from using the food bank since she would not be able to eat the majority of the food provided. She would also not be able to take advantage of free meals because she would not be able to control what ingredients are added to them and the risk of going into anaphylactic shock would be too great.

Bonnie was also on a specialized diet due to her medical diagnosis and severe allergies. She was severely allergic to dairy, wheat, corn, nuts, tomato-based products and food colourings. Besides her allergies, her digestive system had difficulty digesting raw foods and most vegetables. When asked if she had ever used the food bank she gave this answer:

I am unable to access food banks because they don't at all meet the needs of special diets. I've tried. I've really tried and I've come home with maybe four items where as other people go home with bags of groceries. I'm not allowed to have canned foods anymore because the salt content.

### **4.3.2 Shopping for groceries**

All the participants needed to access a grocery store to purchase food. For some of them it was a difficult and unpleasant experience which left them physically and emotionally drained.

#### **4.3.2.1 Accessing grocery stores**

For some of the participants, choosing the most appropriate store was not based on price or food preference. Instead, they were restricted to choosing only those locations that accommodated their disability. For example, Eric used a walker. He recounted where he preferred to shop prior to becoming partially paralyzed and why he no longer shopped there:

If I'd be more mobile, I could get to different stores. Like, for example, when I first came to Vancouver I liked to shop in Chinatown. You can walk around. I'm used to Toronto, not here. Toronto Kensington Market where you can go from shop to shop and choose and pick your vegetables. Now, I'm so limited to what I can do. Even if I do manage to get to Chinatown, because it's so crowded I can't get around with my walker. And I'm limited to how much I can buy. So yes it makes a big difference.

#### **4.3.2.2 In-store challenges**

Once in the store, participants experienced obstacles that made it difficult to access items from store shelves. Often they would need to ask store employees for help reaching those items. The size and weight of the product was also a reason to ask for help. Eric described a couple of instances when asking for help was needed:

When I go grocery shopping at Safeway they usually keep this [walker] for me behind the desk and I'll take a wagon and I'll go around. The wagon gives me

stability to hold on to something. Usually I need someone to help me because sometimes I can't get something from the shelf and put it in the wagon. Other times it's too awkward or too heavy so I get someone to help me.

Sometimes you don't want to shop because you know the store is way too large and the articles are put in such a way that is very difficult to reach. Someone gave me a ride to Superstore on Marine Drive. I wanted to buy something but it was so high up I couldn't even reach it. So I called the manager and said 'you know you didn't put it high enough by stretching I might be able to reach it, maybe you should put it higher'.

For some participants, having to ask for help on a regular basis was frustrating and they simply refused to at the expense of buying the product. Jeanette, who uses a wheelchair full-time, explains how she reacted when she couldn't reach an item off the shelf:

In a store, if there is something I can't reach, pretty much 8 of the 10 times I'll just get mad and leave the store rather than simply say 'hey grab that down for me'.

Shopping itself was physically draining activity for some of the participants. The act of walking around for a period of time would be enough to leave them housebound for one or two days afterwards. Brenda explained how it affected her:

I get tired really easily. So if I can't find something at a store, I might just have to go without it because I might not be able to get out of the house again for another day. Like I had a busy day so I can't think anymore.

For Kate who has a brain injury the environment and budgeting process was extremely overwhelming. Unlike Brenda, she physically had the strength and energy to get to the grocery store but mentally it was difficult for her to process numbers and to budget how much she could spend. She carried in her wallet a small piece of paper with the amount of money she could spend on certain items every week. This helped her organize her budget, but the experience of shopping was still not an easy task for her. She explains below:

I get so nervous in the store. There is so much stimulation going on that I can't calm myself to, you know. I don't know what I'm doing when I buy and I buy too expensive but I can't calm myself to do the math to see if this is gonna work. And if, I don't know, it's like I'd have to go and write down all the prices go home and figure it out then go.

#### **4.3.2.3 Transporting food**

The issue of transporting food was an area of frustration for many of the participants with disabilities that greatly affected their ability to carry food. None of the participants in this study owned their own vehicle so all used public transit and/or HandyDART for transportation. Although all participants experienced the physical consequences of their disabilities to some degree, there were varying levels of mobility and pain. Those with higher physical restrictions and pain reported the challenge they faced in terms of carrying food after shopping. This meant that they could only shop at stores within walking distance to their homes. Judy used to live in an area that did not have grocery stores within walking distance of her home. This meant she had to take transit when she went shopping for food. She recalled her experience in the following quote:

When I used to live at\_\_\_\_\_ to get the groceries home was just hell. To get them on the bus, get them off the bus stop, and then try to walk to my place with groceries. It was hard enough walking but with the groceries it was just hell.

Other difficulties in transporting food noted by the respondents were: lifting carts on and off the bus, carrying multiple items while using crutches, having to make multiple trips in one day due to being able to carry only a few items and standing for long periods of time.

### **4.3.3 Eating food**

The process of choosing what foods to eat was affected by the challenges they encountered in preparing the food. This produced a preference for more convenient foods.

#### **4.3.3.1 Food preparation**

Food preparation was limited by the participants' physical disability. Those whose mobility was not greatly affected did not report problems with food preparation. Those with greater levels of mobility issues discussed the difficulties and limitations they encountered when preparing food. Out of the eight participants with mobility issues, only three had homecare and out of those three, only two had government provided homecare. One of those with government provided homecare, however, did not include food preparation. The third person had family members pay a private company to assist her four hours a week with household chores. Therefore, the majority of the participants had no choice but to prepare food on their own regardless of their limitations.

The acts of cutting, slicing, peeling and standing were the most common difficulties expressed by the participants. Brenda had to separate food preparation process into steps that could take a few days to complete. She explained how chicken was challenging:

But when I actually get the food home it can be very tiring and it can be very hard on my wrists. So say today I'm going to go buy chicken and I'll get home, cook it. Just that process, I might be too tired to chop it up and freeze it until tomorrow or the next day, depending on how my wrists are. I have to be careful about that. So getting fresh cooked vegetables and meat can be quite difficult.

Some required assistance from others to prepare certain foods. Bonnie recounted how she used to receive assistance from homemakers, but since the government cutbacks, has been depending on her neighbours for help.

If I do have money for food it would take me quite a while to prepare it because I have a lot of trouble with joints. I used to have homemakers to help me with meal prep and some of the personal care. But since the cutbacks from government I no longer get homecare at all, period. I have to be careful what I buy and if it's a food item I cannot slice or cut very well I have to rely on a neighbour to cut it for me.

Eric remembers a time when his homecare worker bought a salmon and prepared it for him "as a favour because they are not supposed to". He would have otherwise not been able to do it himself. However, the disadvantage of depending on friends or neighbours for assistance is they may not be as reliable as a professional source. Judy discovered this when the friend she had hired to help her cook suddenly cancelled on her:

Like for a while I had one of my friends working for me as my cook. And one week she cancelled on me and said "I'm not sure when I can come back". And I was just devastated because I was completely out of pre-prepared food and that would cause a problem for me that day and the next day and for the next two weeks.

John was living in a single room occupancy hotel at the time of the interview. He avoided utilizing the shared kitchen on his floor by cooking meals using an electric frying pan, popcorn maker and kettle. This greatly limited the type of food he could prepare.

Those who have adapted to their disability did not report having issues with food preparation. For example, Jerry, who has been visually impaired his whole life, "can cook just about anything in the microwave". Therefore, he did not feel that his food security was compromised.

#### 4.3.3.2 Convenience foods

For the participants in this study, simplicity and convenience were a strong factor in determining what foods to eat. Their physical limitations, including pain level, energy level and mental state, determined what types of food they chose. Carol had lost the use of her legs and was losing dexterity in her hands, and so depended heavily on her homemakers to prepare meals. Unfortunately, her homemaker only came in the evening which left her most of the day to fend for herself. In the 2 weeks prior to the interview, she had begun to purchase frozen meals from a private company. She was asked to give an example of what a typical day was like for her before she discovered the private meal service:

I wake up and have my coffee, coffee, coffee and maybe some fruit and a couple of chocolate bars until the homemaker comes and prepares a good meal.

Researcher: In the afternoon would you eat anything or snack on anything?

...that would just be chips and chocolate bars. I'm terrible. That's it. I'm awful.

Researcher: Why would you pick those foods?

Well, for the simplicity to tear open a piece.

For others, convenience foods were used as a tool to ease hunger when they could not find the energy or motivation to prepare a meal. When Andrew felt too tired to cook he would just "sit there and eat a bag of chips".

Living alone was another reason some participants preferred to eat easy-to-prepare meals. They felt cooking for one was too much of an effort. This was more common among the male participants. Allan explained how the change in living situation was a factor in choosing to eat canned food:

Yeah, I eat a lot of canned stuff at home now that me and my girlfriend aren't like [living together]. It's just me at home right, something easy and quick.

Rohan gave this response when asked what types of food he prepares at home; "Well, noodles. Just noodles all the time you know".

Judy had difficulty preparing food especially later in the day and she did not have subsidized housing, which limited her financially. Before her disability became difficult to manage, Judy would not have chosen to eat at fast food establishments. However, the convenience and affordability of fast food has made it a desirable option for her:

The other thing I've done recently is eaten at McDonald's which I had not done in 20 years like in 10 or 15 years I had no McDonald's food. And you know I will go and I will buy a burger because it's \$1.39.

Living with a disability presented many challenges in terms of accessing non-profit organizations and grocery stores. Physical limitations were a barrier when shopping for, transporting and preparing foods. This led to choosing foods that were more convenient and not necessarily nutritious such as potato chips and fast food.

#### **4.4 Living with psychosocial issues**

Living with a disability and a very limited income greatly affected the participants' mental and emotional health. Many discussed the stress of having limited choice on what foods they had access to. They also experienced embarrassment and feeling uncomfortable using food banks. Many expressed frustration with the system as a whole.

#### **4.4.1 Disassociation from other users of non-profit organizations**

Although most of the participants used food banks and other non-profit organizations on a regular basis, they expressed that they did not see themselves as a “regular” user. Many reported feeling uncomfortable and out of place and wanted to explain that they were different from the other people that used those services. There was a strong awareness that some clients were illegal drug users and with that awareness was a need to disassociate themselves from them. Carol shared her thoughts on the type of people she encountered at the food bank:

The people that go there are usually pretty rough and scary, and a lot of them too, a lot of them too are not respectable. You know, they’re drug addicts. I don’t know what respectable is. I shouldn’t judge. But in my terms, in my way of thinking, I find a lot of people who go to a regular food bank are unrespectable and they’re very disrespecting too.

Other words and phrases used by participants to describe the “regular” food bank users were “killing themselves”, “drug addicts”, “scary”, “drug crazed”, “less social skills”, “less education”, and “having issues”.

There was a hierarchy of acceptability expressed by some of the clients. Allan, for example, felt that the People with AIDS Society Food Bank was an acceptable source of food whereas soup kitchens and the regular food banks were for drug addicted people.

I wouldn’t say I don’t get embarrassed a bit about going to the food bank right? Sure I’m a little embarrassed but that’s what they are there for right? And it’s not like I go stand in a soup line, this is due to HIV. Like, I don’t go to the other food banks.

#### 4.4.2 Embarrassment

For the participants, a feeling of embarrassment about how they have to get their food was prevalent. The majority of these feelings were caused by their experiences in accessing non-profit organizations, most commonly the food bank. Carol experienced a feeling of being judged when she attended the food bank:

A lot of times the people at the food bank, they treat you a little less than, a little less than what you are. Because, I don't know, they feel like you're degenerates and you can't, don't want to work and things like that. So that's a little uncomfortable too.

Others described being made to feel unwelcomed, patronized and accused. When Eric was asked about accessing food banks he stated "I'd rather go hungry than go there".

Bonnie experienced embarrassment not only by the food bank experience but by several levels of interactions related to her quest for food. Because of this, she felt embarrassed almost on a daily basis. She explained her situation like this:

The one about how I have to get my food does not make me feel uncomfortable or embarrassed about my life circumstances. Yeah, that's an issue too because the little bit of pride that one does have you have to give it up totally because you have to actually ask for food. Sometimes you may even have to ask your neighbours, 'oh do you want to share leftovers' or something like that or you go to the food bank and you ask to trade an item. 'Could I trade an item for something I'm not allergic to?' You actually get shouted at and told to leave. That's how bad it is. Or if you request a crisis grant from government because you really need extra dietary items due to a problem that has come up or a medication problem or any situation. You are made to feel very embarrassed and the answer is a flat no. If you have used up your amount of crisis grants you do not get a crisis grant for food. And if you end up in the emergency room or you end up in the hospital for two weeks because of that the answer is 'it's not their problem it's your problem'...so when it comes to dignity again you are made to feel embarrassed.

#### 4.4.3 Having limited choice

Some of the participants reported feeling deprived of being able to choose what foods to purchase and consume. Those who used the food bank regularly explained that insufficient finances are the reason why they “can’t afford the proper foods”. Those with subsidized housing generally had more money for food than those without.

Table 4.4 compares the responses to survey question 4 of participants with and without subsidized housing.

**Table 4.6 Responses to survey question 4 – with/without subsidized housing**

<b>Question 4) You couldn’t afford to eat balanced meals?</b>		
<b>Answer</b>	<b>Without subsidized housing</b>	<b>With subsidized housing</b>
<b>Often</b>	3	5
<b>Sometimes</b>	0	4
<b>Never</b>	1	3

The results show that of the 12 participants who had subsidized housing, five ‘Often’ and four ‘Sometimes’ could not afford balanced meals. Of the four without subsidized housing three answered ‘Often’ and one answered ‘Never’. It seems that this issue affected most participants regardless of how much money they had left for food after rent costs.

This sense of having limited choice was a source of stress, especially for those who in the past had been able to work. Eric gave an example of how having a disability, and subsequently depending on PWD, restricted his choices on what foods he could purchase:

You have less to choose from. You cannot buy stuff that you always want to buy. You cannot buy the quantity that you want for some stuff and the quantity that you can buy you have to stretch it out to last you for the month. For example, Safeway has olives and I really like olives. One time I bought an assortment of olives. When I came to the cashier it was like 28 dollars. I told the guy 'I'm very sorry but there is no way I'm going to pay 28 bucks for this'. Lucky they are very nice, they say okay no problem. Things, like, that you know, you have to deprive yourself. I like fresh salmon but it's so expensive. Fresh cheeses from different countries but again it's so expensive. So either you buy smaller amounts or you don't buy it at all.

Judy purchased food through a food co-op that delivered a box of food at a reduced price. She was quite conscious of the benefits of eating healthy foods, however, she did not choose what groceries came in the box and ate what she received. She explained that she would eat items that she did not like such as fries, tater tots and perogies because it came in the box. Her sense of having limited choice caused stress and even reduced her appetite. She explained her situation in the following quote:

So I don't have enough food security because it's stressful getting food and I don't get to choose not to have things like MSG. I don't get to choose good nutrition and I don't get to choose what I eat on a day-to-day basis. Like the last week of the month I just look in the cupboard and that's what I'm eating which is surprisingly annoying. I never realized how much a day-to-day choice, like, you look in the fridge and you kinda go, what I feel like eating. When there aren't any choices you're just, like, you really don't want to eat.

The issue of having limited choice also had negative effects on the participants' physical health. They were so concerned about eating at all that sometimes they would choose to eat foods that they knew would be unsafe for them. Andrew explained that before he had received subsidized housing his finances were so limited and his physical health so poor that he had to resort to eating food that gave him food poisoning:

I wouldn't be able to buy food for two weeks out of the month, especially in a five week month. I was eating food and I was getting food poisoning on a regular basis

because I was thinking “Well it’s only been there three, four days”. Now I’m very picky about what I eat and how long it’s been in the fridge.

Researcher: Why would you eat the food that’s been there three, four days?

Because I was too tired to do it. I was too tired to cook more. I was too tired to get to the store to buy it. I didn’t have the money to buy it.

The participants with allergies or medical conditions affected by the food they ate also reported eating food they knew would cause them an adverse reaction. The main reason was because their food supply is so limited that if they got any food for free they would take advantage of it. Lori explained that she would eat something given to her, just because she did not have to pay for it:

I’ll have other things if people bring me something, like friends bring and that’s when I tend to eat things that I shouldn’t eat. Things that have a bad effect on my system, but it’s like free food right? What am I gonna do? So because I don’t have enough money to get all the things I want, I do, I definitely take advantage of that if I can, you know, if somebody brings something.

Other issues that limited what food they ate were: having to rely on pre-made frozen meals, having lost the ability to cook for themselves, and not being able to eat at restaurants due to finances.

#### **4.4.4 Adjusting**

The participants had varying levels of feeling adjusted to their situation. Some felt that for the most part they had emotionally adjusted to certain aspects of their financial and medical situation. Others had been able overcome some of the feelings of embarrassment of how they have to get their food or did not feel entitled to ask for special treatment. Table 4.7 groups the responses to survey question 3 by number of years on PWD.

**Table 4.7 Responses to survey question 3 - years on PWD**

<b>Question 3) The food you bought just didn't last, and there wasn't any money to buy more?</b>			
<b>Answer</b>	<b>1-10 years on PWD</b>	<b>11-20 years on PWD</b>	<b>21-30 years on PWD</b>
<b>Often</b>	2	3	0
<b>Sometimes</b>	5	2	1
<b>Never</b>	1	0	2

One of the participants who had been on PWD for over 30 years answered 'Sometimes' to question 3. None answered 'Often. However, seven participants who had been on PWD for 1-10 years answered 'Often' or 'Sometimes'. The length of time on PWD may affect how they perceive their food security as time allows for acceptance and strategy building.

Prior to his disability, Dustin worked at a construction job and did not have to worry about having enough money for food. However, 21 years later he has developed strategies such as bargain shopping and has adjusted financially:

I don't like it. I'm used to better. Last time I worked I was making \$50,000 a year. So this is a big change and being 21 years now...I've learned to adjust.

Rohan expressed that after 10 years with his disability he has adjusted emotionally to the culture of standing in food lines. He is no longer afraid of the people he encounters and is not bothered by the environment:

See the people down at Native Health, although if you're not used to them it can be a very scary experience. I'm used to them so it doesn't bother me so it's not scary for me. For many others, it would be a very scary experience standing there. No, I've come to terms with my HIV having it for 10 years now.

Judy had been on PWD for 10 years and had accepted her dependence on food banks. In the past she resisted using this service but the need had been so great that she was forced to adjust:

At the very beginning of my disability I wouldn't be caught dead in a food bank. Like forget it, but now I've become accustomed to being in this situation. Like, I don't feel embarrassed anymore. I feel entitled now so it becomes less and less of an issue and when you really need food, dignity goes out the window. You can maintain it as long as you can maintain it and still eat right?

#### **4.4.5 Caught in the middle**

Many of the participants in this study expressed their desire to be provided with homecare or other services from the government. However, because their situation was not deemed critical enough to warrant extra help they were repeatedly denied. Unfortunately, due to limited resources, government agencies must prioritize according to need which leaves many from this group with no choice but to accept that there will always be people in more serious situations than they are. They are caught in the middle of a disability continuum. As we saw earlier, Lori had mobility issues that made it difficult for her to go grocery shopping. She often had to make multiple trips because she could only carry a few items at a time. She had asked for help with shopping but was denied and was in the process of trying to find a solution to her shopping challenges:

I'm just right now trying to figure out what to do about that because I've applied in the past for assistance with these things. To have somebody who can come and help me even for a couple hours a week to do my grocery shopping and do some of the things in my home that I can't do as far as, you know, cleaning or whatever. And I've been told I'm not eligible for it.

They are often told that their situation is not worthy of getting more help and this has created a culture of comparison with people that are in more dire circumstances than they. As a result some of them have given up asking for help because they believe there are people “in worse shape”, “who probably need it more”.

For the participants with rare disabilities or illnesses who do not have a larger organization to advocate for them, it can be difficult to access help and resources. Judy has three rare conditions which drastically affect her energy level. She has tried to contact several disability related organizations but has been told she does not meet their mandate. When asked how she feels about that she replied:

I'm lost. People with chronic illnesses that don't have an umbrella organization get lost.

Living with a limited income and living with a disability had psychosocial consequences for the participants. Their dependence on food banks meant that they often felt embarrassed about how they had to get their food and this created a need to disassociate themselves from “regular” food bank users. This dependence also created a feeling of having limited choice on what foods they ate. Although, some participants were in need of extra help preparing and shopping for food they were caught in the middle of a disability continuum and were repeatedly denied. This meant they had no choice but to adjust to their situation and the participants were at varying levels, dependent on how long they had been on PWD.

## 4.5 The triple burden

The three main factors discussed previously: living with a limited income, living with a disability and living with psychosocial issues, presented unique challenges for people on PWD. Individually each factor negatively reduced the food security of the participants. Unfortunately, living with a limited income and living with a disability also compounded to magnify the issue. Brenda explained how her disability and her limited income worked together to reduce her ability to shop, buy and transport food:

Lifting and carrying can be a problem, especially if I want to buy something in bulk because it's on sale and I use transit. I don't have a car and I don't generally book HandyDARTs because they cost extra than what a bus pass will give you. So, I don't generally have a lot of money for that and delivery costs money too.

Brenda was unable to save money by buying bulk because she could not transport the items via transit and she could not afford to transport the items using delivery services or HandyDART (a one way trip costs \$2.50 for 1 and 2 zone, \$3.75 for 3 zone and \$5.00 for 4 zone).

Their inability to afford food that was easier to prepare also exemplified how together limited income and disability affected the variety and quality of the food eaten by the participants. Pre-sliced vegetables and meats are more expensive and therefore, not affordable for those on PWD. However, for those who found cutting and slicing difficult, buying the cheaper unprocessed versions was a waste of money, because they could not prepare them. Eric provided an example of a product which he was unable to purchase:

I would like to be able to buy foods that are pre-sliced or pre-cut up but they have become prohibitively expensive. For example, if you buy a chicken breast at a bistro it's twice as expensive as buying the chicken, cutting it up yourself,

removing the bone and the skin. If you buy skinless boneless you are paying twice as much for the same piece of meat.

Worrying about the food running out and not having enough money to buy more was a reality for most of the participants and was more prominent in those with disabilities that affected mobility and energy. Table 4.8 displays this relationship.

**Table 4.8 Responses to survey question 2 – mobility/energy**

<b>Question 2. You worried that food would run out before you got money to buy more</b>		
<b>Answer</b>	<b>Mobility/energy affected by disability</b>	<b>Mobility/energy not affected by disability</b>
<b>Often</b>	5	1
<b>Sometimes</b>	3	4
<b>Never</b>	0	3

Out of the eight participants with higher mobility and energy issues, five reported ‘Often’ being worried. On the other hand, of those with disabilities that did not affect mobility and energy level only one report ‘Often’ being worried. Living with a disability affecting mobility/energy also meant that they were more likely to have less access to food and therefore, be worried that the food would run out. Those who could not access food banks because of their disability were more likely to suffer from psychosocial issues. Lori does not have subsidized housing, has severe mobility issues and food allergies. She explained what occurred when she invited a friend over to dinner and asked her if she could contribute financially to the meal:

One of them got quite upset with me and said that I was being really stingy. That the way you do these things is that I have them for a meal and one day they have me for a meal. But each time I’ve been to that friend’s house for a meal she made something that I couldn’t eat at all. So I’d end up not eating anything having a cup of tea or whatever and visiting. And I didn’t want to be rude so I wouldn’t say

anything but I hate it that it seems so petty you know. Like, I have to ask if you are going to come here and eat this much then you have to give me that much in return. I don't want to be like that but it's the circumstances. It's not my personality or my preference to do that, you know.

Having food in the home did not necessarily mean that it will be eaten, especially for those participants with medical conditions that fluctuate daily and sometimes hourly. Andrew explained that although he was able to access food, his good intentions to prepare a healthy meal were often overridden by his fatigue and pain issues:

I'm lucky. I live on Commercial Drive where there are a lot of markets. So I usually try and go at least every other day to pick up things. But they tend to sit in my fridge because I'll have this great idea and then my body just kicks me in the ass and I just can't do it.

The lack of adequate food security also had serious medical consequences for the participants. Their financial inadequacy prevented them from acquiring the food they needed to maintain health. By not having proper nutrition, this affected their physical health which also prevented them from acquiring the food they need. Bonnie, who could not access food banks due to severe allergies, explains how her lack of food sometimes prevented her from taking the medications she needed and which ultimately sent her to the hospital:

There are days, because of the inadequacy of the amount people with disabilities are given by government, there are days that I simply don't have money for food so I go days without food and the consequences of that are serious when you are dealing with multisystemic problems, because there is a list of medications that I have given you that I am unable to take without food. There are so many that require a full stomach or with food or just ½ hour before food. So that is really complicated because it interrupts the whole medication cycle...it's really terrible to the point where I've ended up in emergency rooms. I'll be so ill my electrolytes are imbalanced, kidney problems to the point where my respiratory infections are so bad I have to get into the hospital so it's technically costing the system so much more money that way.

The triple burden of disability, low income and psychosocial issues prevented most of the participants from attaining adequate food security at some level.

#### **4.6 Food security definition and factors affecting food security**

The relationship between the definition of food security and the factors that affect the food security experienced by the participants can be found in Table 4.9. This table provides a summary of how the food security definition and the factors that affect food security derived from the participants are related.

**Table 4.9 The relationship between the food security definition components and the three main factors: living with a limited income, living with a disability and living with psychosocial issues**

<b>Components</b>	<b>Living with a limited income</b>	<b>Living with a disability</b>	<b>Living with psychosocial issues</b>
<b>Food is obtained in a manner that upholds human dignity</b>	High dependence on non-profit organizations (e.g. food banks)  Cannot afford to use delivery services or HandyDART to transport food	Difficulty accessing grocery stores  Difficulty shopping and must ask for help often  Difficulty transporting food items	Embarrassed often about how they must get food  Uncomfortable being associated with other clients of non-profit organizations  Feel unwelcomed, patronized, accused and judged at food banks
<b>Food is safe</b>	Food bank food is sometimes expired  Will eat foods that will make them sick because it is free	Will eat foods that will make them sick because too tired to cook	
<b>Food is nutritionally adequate</b>	Low nutritional quality of food bank food  Choose food based on price not nutrition	Choose food based on convenience not nutrition  Difficulty preparing food so buy fast food	Feel that “good nutrition is an unattainable goal”
<b>Food is personally and culturally acceptable</b>	No choice as to what foods they receive from food banks and other non-profit organizations so it is not always personally acceptable	Depend on others to cook food  Cannot always choose how food is prepared	Have limited choice in what foods to eat  Feel stressed about not being able to eat what they want
<b>Food is sufficient in quality and quantity to sustain healthy growth and development</b>	Lack of affordable housing means high rent  Non-profit organizations are a means to reducing hunger	Cannot access non-profit organizations due to mobility limitations  Cannot access non-profit organizations due to dietary limitations	Owning a pet improves mental health but reduces the amount of money left for food
<b>Food is sufficient in quality and quantity to prevent illness and disease</b>	Prioritizing of expenses limits the amount of money left for food  The lack of food can interfere with medication  Dietary supplements are not covered by the ministry (e.g. Ensure®, vitamins, protein powders)	Cannot access non-profit organizations due to physical limitations  Many medical expenses not covered by the ministry (e.g. physiotherapy)	Stressful asking for help and being denied by the ministry

## **4.7 Summary of the results**

Living on a limited income meant that participants often had to prioritize other expenses such as rent, medical costs, pets and other living costs (e.g. clothing, internet, cable television) over buying food. This led to a strong dependence on non-profit organizations for their food to prevent hunger. Unfortunately, the food they received from these organizations (especially food banks) was of low nutritional quality and sometimes not safe for consumption. Living with a disability presented many challenges in terms of accessing non-profit organizations and grocery stores. Physical limitations were a barrier when shopping for, transporting and preparing foods. This led to choosing foods that were more convenient and not necessarily nutritious such as potato chips and fast food. Living with a limited income and living with a disability had psychosocial consequences for the participants. Their dependence on food banks meant that they often felt embarrassed about how they had to get their food and this created a need to disassociate themselves from “regular” food bank users. This dependence also created a feeling of having limited choice on what foods they ate. Although some participants were in need of extra help preparing and shopping for food they were caught in the middle of a disability continuum and were repeatedly denied. This meant they had no choice but to adjust to their situation and the participants were at varying levels of adjustment depending on how long they had been on PWD. The triple burden of disability, low income and psychosocial issues prevented most of the participants from attaining adequate food security at some level. Those without subsidized housing and disabilities that affected mobility and energy were worse off in terms of attaining adequate food security.

## **5 DISCUSSION**

The primary purpose of this research was to describe the experiences of people with disabilities who are on PWD benefits with regard to food security. The three major factors that affected the food security of the participants were 1) living with a low income, 2) living with a disability and 3) living with psychosocial issues. The triple burden of disability, low income and psychosocial issues prevented most of the participants from attaining adequate food security at some level. Those without subsidized housing and those with disabilities that affected mobility and energy were worse off in terms of attaining adequate food security. This chapter includes a discussion of the results, limitations of the study, as well as the impetus for future research and suggestions for improving services and policies for people on PWD.

### **5.1 Living on low income**

Depending on PWD benefits as their only source of income had a substantially negative effect on the food security of the participants. In British Columbia, the rate of food insecurity for those who make less than \$15,000 a year was 25.9 percent compared to only 2.2 percent of those earning \$50,000 or more per year (Kerstter & Goldberg, 2007). People on PWD receive a total yearly income of \$10,877.04 which is far below the LICO for a single person living in Vancouver, BC (\$17,570) (Income Statistics Division, 2007). The financial difficulties in attaining food experienced by people with disabilities have been acknowledged elsewhere. Some common financial barriers to food identified for women with disabilities have been that organic and/or health foods are too expensive, nutritious foods are too expensive and the government disability pension does not cover

the cost of food (Colantonio & Yoshida, 2003). The most common service identified to improve nutrition for this population was increasing the disability pension (Colantonio & Yoshida, 2003). The harmful effect that low income has on food security is well documented for families and single parent households (Che & Chen, 2001; Heart Health Coalition, 1997; Ledrou & Gervais, 2005; Tarasuk & Beaton, 1999b). Therefore, it is not surprising that the participants in this study indicated the disability benefits they received were not sufficient to meet their nutritional needs. The fact that the PWD benefit amount is inadequate to meet the living costs of people with disabilities has been discussed extensively (BCCPD, 2007; Canadian Centre for Policy Alternatives, 2008; The Dietitians of Canada & Community Nutritionists Council of BC, 2007; Riches, 1999). Unfortunately, up until now, little has been done to increase the support and people with disabilities are still experiencing financial obstacles to food security, as highlighted by these participants.

Living on poverty-level incomes meant that participants often had to prioritize other expenses over buying food. The largest expense that took priority over food was the cost of housing. A similar phenomenon is observed in low income single mothers in that they will often sacrifice food to pay for more urgent expenses like rent and utilities (McIntyre et al, 2002). The participants without subsidized housing reported having more difficulty attaining adequate food security than those with subsidized housing. In BC, it has been identified that low income households have difficulty affording both housing and nutritious food (Dietitians of Canada & Community Nutritionist Council of BC, 2007). This situation is, in part, due to a lack of affordable housing units which leads to long waiting times for those hoping to receive subsidized housing (BC Housing, 2007). The

participants with subsidized housing reported waiting times of 5 years or more. Those without subsidized housing who were currently on wait lists depended on the private market for their shelter. However, the private market is not an affordable option as the price of a bachelor suite is far beyond the amount allotted by PWD (CMHC, 2007). Three of the four participants without subsidized housing spent 65 – 85 percent of their monthly benefit on rent. This number is far above the 30 percent needed to be considered in core housing need (McClanaghan and Associates, 2006). Two of the participants opted to live in SRO hotels at a cost of \$400 per month. This was not ideal due to the shared kitchen arrangement which meant they were limited to the types of food they could prepare in their rooms. These hotels are most often frequented by intravenous drug users and are also not the safest option for this population (Shannon et al, 2006). Affordable housing has been identified as a major issue for people on PWD (BCCPD, 2007). The participants without subsidized housing were worse off in terms of not being able to afford to buy nutritious food because the majority of their income went towards shelter.

Unlike other low income households, those with disabilities also carried the added financial burden of medical costs associated with having a disability. A national survey found the cost of purchasing or maintaining assistive devices was the most common reason cited for unmet needs by 56.1 percent of people with disabilities (Statistics Canada, 2008a). Indirectly related to these medical issues were other costs that took priority such as owning a pet, internet and cable television. Those with mobility and energy issues felt they needed these things in order to maintain and/or improve their emotional and mental well-being. People with disabilities are less likely to socialize

(NOD, 2004) or to feel that they belong to a community (Uppal, 2006). The pets, internet and cable television fulfilled part of this need for the participants; therefore, they chose to spend their limited income on them. This is important in light of the fact that Canadians with disabilities are three times more likely to experience unmet health care needs related to their emotional and/or mental health (McColl et al, 2003). However, these costs reduced the amount of money they had to buy sufficient food and in turn decreased their food security.

The participants' inability to afford sufficient food led to a strong dependence on non-profit organizations. Just over 22 percent of food bank users in BC indicated that disability-related income benefit was their source of income (Food Banks Canada, 2008). Unfortunately, the participants felt the food they received from these organizations (especially food banks) was of low nutritional quality and sometimes not safe for consumption. Other research on the type of food that is distributed at food banks revealed the inadequacies related to nutrient content and safety (Tarasuk & Beaton, 1999; Tarasuk & Eakin, 2003, Teron & Tarasuk, 1999). This indicates that the majority of the participants using food banks are not eating food of sufficient nutritional quality. It has been documented that food banks cannot meet the all the nutritional needs of their clients (Tarasuk & Beaton, 1999; Tarasuk & Eakin, 2003, Teron & Tarasuk, 1999). Therefore, food banks are not a satisfactory solution to end the food insecurity problems of people with disabilities. The food bank did, however, reduce the incidence of hunger for those who could access them.

## 5.2 Living with a disability

Living with a disability presented many physical challenges in terms of accessing non-profit organizations and grocery stores. Unfortunately, the participants with mobility and energy issues could not access food banks because they had difficulties standing in line for long periods and transporting the food. Starkey, Gray-Donald and Kuhnlein (1999) found that those who were less mobile were underrepresented in terms of who was accessing food banks. Participants with 'invisible' disabilities encountered resistance to using the food banks designated for people with disabilities. This added to their accessibility issues because they felt judged by the volunteers. Mobility problems are the disability most often reported by adults in Canada (Statistics Canada, 2008b). This indicates that the majority of people with disabilities experience mobility problems; yet, they are also the same ones who are unable to access food banks. This indicates that food banks cannot meet the needs of the entire food insecure population especially people with disabilities that have mobility and energy issues and those with invisible disabilities.

The participants with mobility and energy issues also experienced barriers when shopping for, transporting and preparing foods. It is well known that people with disabilities often require assisted grocery shopping and help preparing meals (Wiel et al, 2002). It was not surprising that the majority of participants with mobility and/or energy issues indicated they would like assistance with shopping and/or cooking but did not qualify for home support services. Studies have shown that those experiencing difficulty in three or more nutrition-related activities (such as slicing food) are at increased risk of inadequate nutrient intake (White, 1994). Fifty-three percent of Canadians with

disabilities reported having unmet needs with heavy household chores, grocery shopping, going to appointments and housework (HRSDC, 2008). Although some participants were in need of extra help preparing and shopping for food they were caught in the middle of a disability continuum and were repeatedly denied support. This may indicate that people with disabilities that are not receiving all the assistance they need with food related activities such as cooking and shopping may be at higher risk for inadequate nutrient intake.

The participants with physical difficulties in obtaining and preparing food tended to choose foods that were more convenient and not necessarily nutritious such as potato chips, chocolate bars and fast food. This was in large part due to pain and physical limitations encountered in preparing and cooking food such as slicing and standing for long periods of time. The literature indicates that food choice is strongly affected by low income (Jetter & Cassady, 2005; Ree, Riediger & Moghadasian, 2008; Ricciuto, Tarasuk & Yatchew, 2006; Turrell et al, 2002; Ricciuto & Tarasuk, 2007). There are no studies in Canada exploring how having a disability affects food choice. However, these results indicate that people with disabilities that affect their mobility and energy experienced added barriers to healthy eating due to their disability as well as their income. Other studies have concluded that some common barriers to food experienced by women with disabilities are being too tired to cook, lack of desire or will power (Colantonio & Yoshida, 2003), fatigue and weakness (Nosek et al, 2004). Assessments of dietary intake in the context of food insecurity in Canada indicate high prevalence of inadequate nutrient intakes (Kirkpatrick & Tarasuk, 2008b; McIntyre et al, 2003; Tarasuk & Beaton, 1999b; Tarasuk, McIntyre & Li, 2007; Lee & Frongillo, 2001). This implies that people

with disabilities that experience mobility and energy issues have an added risk for poor dietary intake and nutritional status beyond income alone.

### **5.3 Living with psychosocial issues**

Living with a limited income and living with a disability had psychosocial consequences for the participants. Their dependence on food banks meant that they often felt embarrassed about how they had to get their food. The stigma associated with the use of food banks and other charitable resources is common among low income households (Hamelin, Habicht & Beaudry, 1999; Hobbs, MacEachern, McIvor & Turner, 1993; Tarasuk & Beaton, 1999a). Their dependence on food banks and other non-profit organizations also created a feeling of having limited choice in what foods they ate. This feeling of deprivation has also been explored in low-income families (Hamelin, Beaudry & Habicht, 2002; Radimer et al, 1992).

There were other psychosocial issues that had not previously been identified in people with disabilities or other low income groups. The participants felt the need to disassociate themselves from other food banks clients who they deemed to be drug users. The length of time on PWD may affect how participants perceive their food security as time allows for acceptance and strategy building. Although some participants were in need of extra help preparing and shopping for food they were caught in the middle of a disability continuum and were repeatedly denied support. This meant that those participants who required assistance but were not receiving it experienced high level of frustration on a daily basis.

## 5.4 Triple burden

The factors, living with a limited income, living with a disability and living with psychosocial issues, compounded to negatively affect the food security of the participants. For example, they were unable to save money by buying in bulk because of transportation issues caused by their disability. Pre-sliced vegetables and meats are more expensive, therefore, they cannot afford to purchase them, but they are also unable to prepare the less expensive versions due to their disability. Other literature supports the fact that low income households (Kerstter & Goldberg, 2007) and people with disabilities are at higher risk for being food insecure (Canadian Council on Social Development [CCSD], 2003). Worrying about food running out and not having enough money to buy more was more prominent in those with disabilities that affected mobility and energy. Other research has shown that people with disabilities who indicated they had financial difficulty acquiring food had higher levels of depression than those not reporting such difficulty (Kleges et al, 2001). Their social life is affected because they are unable to extend a dinner invitation to their friends or go out to restaurants due to their low income. People with disabilities are already less likely to socialize (NOD, 2004). Not having income to share a meal in a social environment further isolates this population, which can result in a reduction in their emotional and mental well-being.

Their lack of adequate food security also had serious medical consequences as they were sometimes unable to take medications that require a full stomach, which led to the further deterioration of their health. Research has shown that disability can often lead to poorer health due to secondary conditions (BC Ministry of Human Resources, 2004; Hall,

Colantonio & Yoshida, 2003; Humphries, 2003; White, 1994) such as obesity (Weil et al, 2002), high blood pressure, heart disease, asthma, diabetes, migraine headaches and cataracts (CCDS, 2004).

## **5.5 Study limitations**

This research is limited, in part, by the section of the population of people with disabilities that it excludes. The disability population is extremely diverse as it includes a range of disabilities and affects people of all ages. Consequently, there is a need for research that is tailored to the specific issues of the various sub-populations. This research excluded members of the disabilities population who were not living alone, who were children and elderly, and who were working. An important sub-section of the population who may be at greatest risk for food insecurity, are those who are not sufficiently mobile to leave their homes. The people who participated in this research had to commute to the offices of the BCCPD. This means a portion of those with the greatest mobility issues were not able to participate. However, it was necessary to exclude sections of the population as a means to create boundaries around the research.

Although efforts were made to have participants speak openly about their experiences, they could have inadvertently or intentionally withheld comments that they would normally share because they were aware their thoughts were being scrutinized and recorded. Despite its limitations, the study design adopted for this inquiry is compatible with its purpose and objectives. Although this qualitative inquiry is not generalizable in the statistical sense, the findings may be transferable (Marshall & Rossman, 1999). The

study is bounded and situated in a specific context, and therefore, the reader can make decisions about the study's usefulness for other settings.

## **5.6 Implications and strategic directions**

This research has potential implications for a variety of stakeholders. The participants identified several challenges they experienced in their day-to-day living with regard to food security. These experiences provide us with an introduction to this very complex issue. This discussion will focus on implications and strategic directions for three specific areas: 1) research 2) practice and 3) policy. The research section focuses on further research questions that are yet to be answered in the current literature. The practice section is intended for those who are working in the community with people with disabilities, such as non-profit organizations and medical practitioners. Lastly, the policy section provides suggestions to the provincial government on ways to change and/or improve the current policies affecting people with disabilities.

### **5.6.1 Research**

This investigation provides documentation on a topic that had not previously been studied in depth and generates a number of issues and questions for further consideration. There are several important quantitative questions which have not been answered and are basic to understanding the food security situation of people with disabilities in Canada. These questions include:

- What are the national and provincial rates of food insecurity among people with disabilities who are and are not receiving PWD?

- Are these rates changing over time?
- How do these rates compare between provinces?
- Are the food insecurity rates higher in provinces where the PWD rates are lower?

Since housing is a prominent financial burden reducing food security of people with disabilities, more quantitative information on the housing situation and needs of this population is required. Questions such as:

- How many people with disabilities are not currently receiving subsidized housing?
- How many people with disabilities are on waiting lists?
- What is the average waiting time to receiving subsidized housing?
- What percentage of their disability benefit are people with disabilities spending on housing costs on average?

There are also many questions that remain unchallenged regarding the nutritional status and dietary intakes of people with disabilities in Canada. The precise nature of the dietary intake of people on PWD living in the community and whether or not it is adequate and/or which nutrients are lacking is unknown. This is important in understanding the health effects this may have on this population and for comparison purposes with the general population.

It would also be beneficial to quantify the added medical costs of living with a disability and other health issues. There is currently no justification for the benefit amounts people on PWD receive. The government should re-evaluate based on specific criteria and

current cost of living estimates. Research into these costs needs to be undertaken that are specific to this population.

This research was qualitative and, hence, exploratory and descriptive in nature. The results of this research could serve as a backdrop into a more detailed exploration into the feelings and perceptions of people with disabilities. Given the research was broad in its conceptualization of food security; a survey could be extended to the entire disability population. A survey could examine the experiences of people with disabilities and food security with questions regarding barriers that they have experienced and the importance of factors associated with accessing adequate food security such as housing, medical costs, low income, food bank use, and home support. These would reveal the need, or lack thereof, for appropriate solutions to the issues identified. Service providers and decision makers would also benefit from quantitative and qualitative research that measures perceptions and feelings and/or provides a needs assessment, whereas this research only began to identify pertinent issues.

### **5.6.2 Practice**

The present research provides information about the daily issues faced by people on PWD that may assist in addressing their food security needs through responsive programming. As a society, in general, there is an overwhelming ignorance to the challenges people with PWD face in terms of food security. This is evidenced by the fact that some participants experienced social stigma related to not being able to afford to host a meal or asking neighbours to share their leftovers. It was especially troubling to see the lack of social support in the lives of the participants. Social pressure to be independent

has created a belief that asking for assistance means they will be perceived as being a burden on their family members and friends. As a society we should be assisting those with disabilities on a personal level first and then at a community level. This begins with increasing public knowledge of the issues and encouraging the family, friends and neighbours of those with disabilities to play an active role in the lives of their loved ones. This is the first step in addressing their food security needs at a community level.

For medical practitioners such as doctors and dietitians it is important to keep in mind the financial situation of their clients with disabilities and keep this in mind when providing medical advice, since supplements and medications are expensive. It may not be possible for their clients to afford them and therefore, alternative advice should be given. Physicians should attempt, when possible, to prescribe medications that are covered by Pharmacare. Dietitians, likewise, should attempt to provide nutritional advice which is appropriate to their financial situation, such as recommending the consumption of more or less of the types of foods they actually have access to.

A major challenge for community-based service providers is reaching all levels of the population, especially those who are “caught in the middle” in terms of the disability continuum. People with disabilities often require assistance grocery shopping and preparing meals. Although some organizations provide shopping support for seniors, there are very few that provide this type of assistance to non-elderly people with disabilities. The majority of meal delivery programs are aimed at those who are homebound, which excludes those who are not homebound. There exists a significant portion of people on PWD that do not qualify for home support and are not homebound, but still require some level of assistance with shopping and/or cooking. Examples of

these are people with brain injuries who have difficulty with budgeting their grocery money and other math related activities. They require assistance with shopping as well, even though they are not homebound nor experience mobility problems. Another example is those who have difficulty transporting groceries due to pain. All the participants in this study did not own or have access to a vehicle and, therefore, had to carry their groceries home. Those with pain issues found it extremely difficult and needed help but did not have the social support networks that could assist them. It would be beneficial if more grocery stores offered free delivery for people with disabilities. Currently, the majority of grocery stores require a delivery fee or a minimum order amount between \$25 and \$200. Grocery stores that waive the delivery fee for seniors and people with disabilities are more high-end and expensive. Although some of these services are already available for this population, many were not aware of their existence, so more advertising of these services would be useful. More services are needed for the portion of the population who are “caught in the middle”, that is, not able to shop on their own but also not home or wheelchair bound.

Accessing food banks and other non-profit organizations was a problem for the participants with mobility issues. There is a need for more delivery services of free or low cost food such as the Partners in Hope food co-op for those who cannot lift or carry food, or stand in lines for long periods of time. It is also essential for more organizations to recognize the special needs of their clients with disabilities. More food banks should try to be accessible to this population. It is important to note that food bank use adds to the psychosocial issues expressed by the participants’ feelings of discomfort in utilizing these services. This is especially important in terms of ‘invisible’ disabilities, as not all

people on PWD use wheelchairs. Those with ‘invisible’ disabilities are the most vulnerable to feeling “judged” by the volunteers. Therefore, food banks and other non-profit organizations need to educate their volunteers on disability issues. The participants with strict dietary requirements and/or severe food allergies were unable to access non-profit organizations because they did not meet their nutritional needs. There is a call for programs of this nature to address the needs of those with dietary limitations so they may also benefit from their services.

That said it must be realized that food banks and other non-profit organization will never be able to fully meet the nutritional needs of their clients and ultimately only provide a very short term solution to hunger. Therefore, non-profit organizations should also be assisting in lobbying the government for policy change which will have greater effect on food security than food donations alone. Ultimately, the ideal situation is to eradicate the need for food banks altogether, or at least reduce the need. Unfortunately, the current trend is to create more food banks.

### **5.6.3 Policy**

The current research provides ammunition for advocacy groups (such as the BCCPD) to lobby the government to increase support to people with disabilities. It also provides information that will aid in educating the public about the realities of people who depend on PWD for their survival, in hopes that it leads to public support for policy change. There are several steps the provincial government can take to improve the food security of people on PWD. They are as follows:

1) The government should consider a significant increase in the PWD benefit amounts. Low income is a major risk factor for food insecurity and the current amounts are insufficient to meet the food security needs of this population. Those who experience food insecurity are more likely to be hospitalized with secondary conditions which ultimately cost the government more money. It would be practical to provide more personalized criteria for assistance that takes into account the person's social support networks and severity of disability. The addition of more specific criteria should include issues of food security such as the ability to shop and cook as well as food allergies and other special dietary needs.

2) People with disabilities experience added medical costs. These include nutritional supplements such as vitamins and/or meal replacements which are crucial for management of their medical issues as well as prevention of secondary conditions. It would be beneficial to provide a separate benefit independent of the PWD benefit amount, specifically for these costs.

3) There is a need for more affordable housing units and rent subsidies for people with disabilities. Although, people on PWD automatically qualify for subsidized housing, the waiting times are long and there are not enough disability outfitted units to meet the housing needs of this population. SROs are not an ideal form of shelter for this population.

4) A significant portion of people on PWD do not qualify for home support but still require some level of assistance. For those who are 'caught in the middle', the qualifications for home support are too stringent. Home support needs to be available not

only to those who are in desperate need but also to those who require help with a few activities such as shopping and/or preparing meals. It is also important to understand that the experience a person has with their disabilities can change on a day-to-day basis. There are 'good' days and 'bad' days. Therefore, providing assistance on an as needed basis would reduce the cost on the system and allow the person to perform the task they are able to, when they are able to. The current system views the person's disability as being either black or white, that is, severe or not severe. This is not realistic and leaves out a proportion of the population that is considered "grey" or in-between.

## **5.7 Conclusions**

This research provides new insight into three variables, namely, food security, low income and people with disabilities. The participants in the present research lacked adequate food security at some level and this was due to their low income, disability and psychosocial issues. The existing policies and services for people on PWD are not sufficient to meet their food security needs; the most obvious being the amount of disability benefit income support. However, increasing the benefit amounts will not remove all their nutrition related issues, especially for those with physical disabilities that affect how they purchase, prepare and cook food. Therefore, more support in the form of shopping and cooking assistance should be made readily available to all people with disabilities who require it. This assistance needs to come from several venues, specifically, social support networks (family and friends), community agencies (non-profit organizations) and government assistance (home support).

The present research not only acted as an avenue for people on PWD to tell their stories and subsequently have a voice in the community, but it may also lead to changes in policies and services which will ultimately benefit them. The results of this study will help the public, decision makers and service providers to understand the multiplicity and complexity of factors that are pertinent in addressing food security for people on PWD.

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# APPENDICES

## Appendix A: Behavioural research ethics board certificate of approval



The University of British Columbia  
Office of Research Services and Administration  
**Behavioural Research Ethics Board**

### *Certificate of Approval*

PRINCIPAL INVESTIGATOR Frankish, J.C.	DEPARTMENT Health Promotion Research	NUMBER <b>B06-0525</b>
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT UBC Campus ,		
CO-INVESTIGATORS: Gerbrandt, Judith, Land & Food Systems		
SPONSORING AGENCIES		
TITLE: The Experiences of People with Disabilities Who Are on Persons with Disability Benefits with regard to Food Security - A Qualitative Study		
APPROVAL DATE <b>JUL 27 2006</b>	TERM (YEARS) 1	DOCUMENTS INCLUDED IN THIS APPROVAL: July 20, 2006, Consent forms / Mar. 14, 2006, Advertisement / Mar. 19, 2006, Questionnaires
CERTIFICATION:  The application for ethical review of the above-named project has been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.  -----  <i>Approved on behalf of the Behavioural Research Ethics Board</i> by one of the following: Dr. Peter Suedfeld, Chair, Dr. Susan Rowley, Associate Chair Dr. Jim Rupert, Associate Chair Dr. Arminee Kazanjian, Associate Chair		
This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures		

## Appendix B: Recruitment poster and information pamphlet



# SEEKING VOLUNTEERS *for* A STUDY ON FOOD AND DISABILITY ISSUES

### What is the Study About?

We are interested in how people who receive Persons with Disability (PWD) benefits get and prepare food. The study is being done for a thesis project by a student in the Master of Science in Human Nutrition program from the University of British Columbia.

**Title of project: The Experiences of People on Persons with Disability Benefits with Regard to Food Security**

### Who Are We Looking For?

People who:

- are 18 years of age or older,
- are on Persons with Disability (PWD) Benefits
- are comfortable speaking in English,
- live alone AND
- are willing to be interviewed for ~60 minutes in person at the offices of the BC Coalition of People with Disabilities (BCCPD) located at #204 – 456 West Broadway (at Cambie), Vancouver.

### If You Are Interested in Participating...

Please call Julieta Gerbrandt, graduate student, at 604-822-9214. If you have any questions about the study, you may also contact Dr. Jim Frankish, principle investigator, by phone (604-822-9205) or by e-mail ([frankish@interchange.ubc.ca](mailto:frankish@interchange.ubc.ca)).

**Volunteers receive a \$25 gift card to the grocery store of their choice**

<p><b><u>Volunteers needed for a food and disabilities Study</u></b></p> <p>We are interested in how people who receive Persons with Disability (PWD) benefits get and prepare food. The study is being done for a thesis project by a student in the Master of Science in Human Nutrition program from the University of British Columbia.</p> <p><b><u>Who Are We Looking For?</u></b></p> <p>People who:  are 18 years of age or older,  are on Persons with Disability (PWD) Benefits  are comfortable speaking in English,  live alone AND  are interested in being interviewed for ~60 minutes at the offices of the BC Coalition of People with Disabilities (#204- 456 W. Broadway).</p> <p><b><u>If You Are Interested in Participating...</u></b>  Please call Julieta Gerbrandt at 604-822-9214 or email at <a href="mailto:Julieta@interchange.ubc.ca">Julieta@interchange.ubc.ca</a></p> <p>Each participant gets a \$25 gift card for a grocery store of their choice</p>	<p><b><u>Volunteers needed for a food and disabilities Study</u></b></p> <p>We are interested in how people who receive Persons with Disability (PWD) benefits get and prepare food. The study is being done for a thesis project by a student in the Master of Science in Human Nutrition program from the University of British Columbia.</p> <p><b><u>Who Are We Looking For?</u></b></p> <p>People who:  are 18 years of age or older,  are on Persons with Disability (PWD) Benefits  are comfortable speaking in English,  live alone AND  are interested in being interviewed for ~60 minutes at the offices of the BC Coalition of People with Disabilities (#204- 456 W. Broadway).</p> <p><b><u>If You Are Interested in Participating...</u></b>  Please call Julieta Gerbrandt at 604-822-9214 or email at <a href="mailto:Julieta@interchange.ubc.ca">Julieta@interchange.ubc.ca</a></p> <p>Each participant gets a \$25 gift card for a grocery store of their choice</p>
<p><b><u>Volunteers needed for a food and disabilities Study</u></b></p> <p>We are interested in how people who receive Persons with Disability (PWD) benefits get and prepare food. The study is being done for a thesis project by a student in the Master of Science in Human Nutrition program from the University of British Columbia.</p> <p><b><u>Who Are We Looking For?</u></b></p> <p>People who:  are 18 years of age or older,  are on Persons with Disability (PWD) Benefits  are comfortable speaking in English,  live alone AND  are interested in being interviewed for ~60 minutes at the offices of the BC Coalition of People with Disabilities (#204- 456 W. Broadway).</p> <p><b><u>If You Are Interested in Participating...</u></b>  Please call Julieta Gerbrandt at 604-822-9214 or email at <a href="mailto:Julieta@interchange.ubc.ca">Julieta@interchange.ubc.ca</a></p> <p>Each participant gets a \$25 gift card for a grocery store of their choice</p>	<p><b><u>Volunteers needed for a food and disabilities Study</u></b></p> <p>We are interested in how people who receive Persons with Disability (PWD) benefits get and prepare food. The study is being done for a thesis project by a student in the Master of Science in Human Nutrition program from the University of British Columbia.</p> <p><b><u>Who Are We Looking For?</u></b></p> <p>People who:  are 18 years of age or older,  are on Persons with Disability (PWD) Benefits  are comfortable speaking in English,  live alone AND  are interested in being interviewed for ~60 minutes at the offices of the BC Coalition of People with Disabilities (#204- 456 W. Broadway).</p> <p><b><u>If You Are Interested in Participating...</u></b>  Please call Julieta Gerbrandt at 604-822-9214 or email at <a href="mailto:Julieta@interchange.ubc.ca">Julieta@interchange.ubc.ca</a></p> <p>Each participant gets a \$25 gift card for a grocery store of their choice</p>

## Appendix C: Interview guide

### Introduction:

This interview will take approximately 60 minutes. During the interview, we will first talk about your experiences with how you access food and we will end with some questions about yourself. Your responses are important in helping us learn how to assist people with disabilities in this area. With your permission, the interview will be recorded on audio tape. Please note that you may leave the study at any time, or choose not to answer a question, without any consequences. If you have any questions during the interview, please feel free to ask me. Do you have any questions before we begin?

### Consent:

Before we start, you need to sign a consent form that says you understand the procedures of the study and that you are willing to be interviewed. There are two copies of the same form. One copy is for you to keep which contains important phone numbers should you have any concerns after the interview is over. The other copy is for our records. I will read the consent form and you may follow along on your copy. Feel free to interrupt if you have any questions.

*Give the “interviewee copy” to the interviewee. Read the form to them explaining sections and answering questions as they come up. Ask if they still want to participate and if they say yes ask them to sign the consent form.*

### Begin:

Now if it is okay with you I will begin recording.

*Press the record play button once they indicate it is okay to do so.*

First I want to talk about your disability, then I will ask some questions about food and finally I will ask some questions about you. It is important that you give me as much detail as possible. I want you to think of this not as an interview but more of a conversation. Please feel free to talk about anything that is important to you and if you are unsure about a question don't hesitate to ask me.

1. To begin please tell me about your disability. (Prompts: symptoms, timeline of disability, cause of disability etc.)
2. How does your disability affect daily living activities? (Prompts: Preparing food, buying food, eating)

Now I want to talk about food.

3. I want to know what a typical day is like for you in terms of eating. What do you eat first, what do you eat next...etc.?
4. Can you tell me where you get your food?

5. Tell about how you feel when you have to go get food (Prompts: stressed, anxious embarrassed, excited etc.)
6. Do you have any regular expenses that limit the amount of money you can spend on foods? (Prompts: cigarettes, alcohol etc.).
7. Now I want to show you a definition of what we call “Food Security”. Here is a copy for you to follow along as I read it out to you.

*Pass copy of definition to participant.*

I have enough food security when:

The way I get food makes me feel uncomfortable  
The food I eat is safe and does not make me sick  
The food I eat has all the vitamins and nutrients I need  
The food I eat reflects my beliefs, values and culture  
The food I eat is fresh, tastes and smells good enough to make me want to eat it  
The amount of food I eat gives me enough energy so I am not hungry

How does this definition relate to your experience?

(Prompts: Can you tell me about a time you had to get food in a way that made you feel uncomfortable? What concerns do you have about food safety? How important is it to that the food you eat have enough vitamins and nutrients? Can you tell me about how the food you eat smells and tastes to you? Does the food you eat reflect your beliefs, values and culture? Can you tell me about a time you had to go hungry?)

8. Do you think you would eat different food you if you didn't have a disability? Why or why not?
9. How does your disability affect the food you eat?
10. What do you think would help you have better food security?

Demographics:

Now I am going to ask you some questions about yourself. These answers will be combined with answers from other people to give us an overall description of the people we are talking to in our study. Again this is confidential and will not be used to identify you personally.

1. What is your age? \_\_\_\_\_ years
2. What is your gender? \_\_\_Male \_\_\_Female
3. What is/are your disability or disabilities? \_\_\_\_\_
4. How long have you had the disability? \_\_\_\_\_ Years
5. How long have you been on PWD? \_\_\_\_\_
6. Do you receive any financial supplements? (Diet, nutritional, crisis grants, family bonus and national child benefit, enhanced medical coverage) \_\_\_\_\_
7. What type of place do you live in? (e.g. House or Apartment) \_\_\_\_\_
8. What is the highest level of education you have completed?
  - A grade in elementary school
  - Elementary school
  - High school
  - Trade school
  - College
  - University - undergraduate
  - University – graduate
  - Other – specify \_\_\_\_\_
9. To which ethnic or cultural group did your ancestors belong? For example, French, Scottish, Spanish etc. \_\_\_\_\_
10. Do you use any community groups or service organizations? Which ones? \_\_\_\_\_
11. Which of the following four statements best describes the food eaten in your household in the past 12 months?
  - You always had enough of the kinds of food you wanted to eat
  - You had enough to eat but not always the kinds of food you wanted
  - Sometimes you did not have enough to eat

- Often you did not have enough to eat

This last part is a series of 3 statements. I want you to tell me if you often, sometimes or never agreed with the statement.

12. You worried that food would run out before you got money to buy more.

- Often
- Sometimes
- Never

13. The food that you bought just didn't last, and there wasn't any money to get more.

- Often
- Sometimes
- Never

14. You couldn't afford to eat balanced meals.

- Often
- Sometimes
- Never

Thank very much for your time and for sharing so much of yourself with me today. I might need to contact you again to clarify some of your responses in the next 3-6 months. Would you be interested in talking to me again?

\_\_\_yes                      \_\_\_no

If yes, could I call you sometime to arrange another meeting?

\_\_\_yes                      \_\_\_no

In this envelope is a \$25 gift certificate for the supermarket of your choice to say thank you for your time and participation. Inside the envelope is also a list of resources you might find useful for your information. (*Hand envelope to interviewee*)

I just need you to sign this sheet saying that you have accepted the gift certificate for our records. (*Pass sheet for interviewee to sign*)

Again thank you for taking the time to speak with me today. Your participation has added valuable insight and information to our research study.

## Appendix D: Consent form

### Consent Form

#### FOOD SECURITY AND PEOPLE WITH DISABILITIES

You, (print your name) \_\_\_\_\_, agree to participate in a study titled “ Food Security and People with Disabilities”. The study is been conducted by a graduate student of the University of British Columbia as the thesis project to receive a Master’s degree in Human Nutrition. If you have any questions you may contact the student or supervisor. The graduate student’s name is Julieta Gerbrandt (phone 604 822 9214; email [julieta@interchange.ubc.ca](mailto:julieta@interchange.ubc.ca)). The thesis supervisor and principle investigator is Dr. Jim Frankish (phone 604 822 9205; email [Frankish@interchange.ubc.ca](mailto:Frankish@interchange.ubc.ca)).

The primary purpose of this research is to describe the experiences of persons with disabilities who are on Persons with Disability (PWD) benefits in getting, buying, preparing, and eating food. You have been asked to participate in this study because you are a person with a disability who is on PWD. The findings of the study will provide knowledge about how getting, buying, preparing, and eating food is experienced by people on PWD.

Your participation will involve the completion of a 60 minute face-to-face interview with the graduate student. With your consent, the interview will be audio-taped.

Any information that you give to us will not be given to anyone else. The information will only be used for the purpose of this study. Only the student and supervisory committee will have access to the information; these will be stored in locked filing cabinets, and be password-protected on computers. Your name will not appear in any reports or presentations from this study.

You might feel uncomfortable or upset during the interview. For this or any reason you may refuse to participate, or withdraw from the study at any time without any consequences and have your answers erased. We are not part of the BC Coalition of People with Disabilities and if you refuse to participate it will not affect your relationship with the BC Coalition of People with Disabilities at all.

We have provided you with a list of counselling services and food organizations you might find useful. You have the right to ask questions related to the study, and to receive answers for your questions. If you have any concerns about how you were treated or your rights as a part of the study you may telephone the Research Participant Information Line in the Office of Research Services at the University of British Columbia, at 604 822 8598.

You will receive a \$25 gift card for the grocery store of your choice for participating in the interview.

You have received a copy of this consent form, and have read and understood the consent form. Your signature below means you agree to participate in this study. You keep a copy of the signed consent form and another copy of the signed consent form will be kept for the records of the project.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Appendix E: Counselling and food resources handouts**

### **Counselling Resources**

If you feel emotional distress during this interview you have the right to stop the interview at any time. If you feel the need to talk to someone after this interview here is a list of free resources that you may contact.

#### **24-Hour Distress Line**

The 24-Hour Distress Line provides free, confidential, non-judgmental emotional support 24 hours a day, 7 days a week for people experiencing feelings of distress or despair, including feelings which may lead to suicide. They are there for you if you're worried about something, feel upset or confused, or you just want to talk to someone. You don't have to be suicidal to call them.

Telephone number: 604-872-3311

#### **Here to Help BC**

Our BC Mental Health Information Line puts free information about mental health and mental illness at your fingertips. Anyone can use it, 24 hours a day, seven days a week, outside the Lower Mainland. The line provides pre-recorded information about mental health services across BC, as well as symptoms, causes, treatments, support groups, and publications on various mental illnesses including:

For personalized information or referrals...

Just press "0" once you're in the main menu. Trained volunteers are standing by for your call between 9 to 4 on weekdays. After-hours or if operators are busy on other calls, our voicemail is available 24 hours a day. Your call is returned within one business day.

Telephone number: (604) 669-7600 or 1-800-661-2121

#### **Family Services of Greater Vancouver**

1616 West 7th Avenue  
Vancouver, BC, V6J 1S5

Phone: 604-731-4951

Fax: 604-733-7009

E-mail: [contactus@fsgv.ca](mailto:contactus@fsgv.ca)

Web: [www.fsgv.ca](http://www.fsgv.ca)

This program offers affordable counselling programs and other support services to families, individuals, and youth on the lower mainland. Provides early intervention for families, couples, and individuals, including counselling, education, and mediation for personal and workplace issues.

## Food Resources

### Greater Vancouver Food Bank Society

The GVFBS helps feed more than 9,000 people **each week** in 15 depots located in Burnaby, New Westminster, Vancouver and the North Shore. Additionally, the GVFBS aids over 100 food- serving agencies within these areas, providing help to another 16,000 individuals weekly.

1150 Raymur Avenue  
Vancouver, BC, V6A 3T2  
Tel: 604-876-3601  
Fax: 604-876-7323  
Office Hours: 8:30 am - 4 pm  
Website: [www.foodbank.bc.ca](http://www.foodbank.bc.ca)

### Partners in Hope Food Coop

Members of this co-op pool their resources to purchase foods in bulk and then distribute them in individual meal portions. The focus of this food co-op is to ensure that members have a variety of nutritious food to eat throughout. Food is delivered in the following areas: 33rd Avenue and North to Coal Harbour, Boundary Road and west to Main Street and West End. Other orders can be picked up at the co-op or arrangements made for a convenient meeting place within the delivery areas noted above.

557 E. 21st Avenue  
Vancouver, BC V5V 1R2  
  
Tel: 604-929-3552  
Fax: 604-648-8450  
Mobile: 778-862-4800  
E-Mail: [office@partnersinhope.ca](mailto:office@partnersinhope.ca)  
Website: [www.partnersinhope.ca](http://www.partnersinhope.ca)

### Vancouver Coastal Health Website

This website provides a comprehensive list of free and low cost meals available by community location.

<http://www.vch.ca/nutrition/foodresources.htm>