SOCIAL CONNECTEDNESS
FELLOWSHIP PROGRAM

Food Insecurity in America:

Putting Dignity and Respect at the Forefront of Food Aid

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ABSTRACT

Food insecurity, defined by the USDA as a state when "access to adequate food is limited by a lack of money or other resources", is a pervasive problem in the United States. Millions of individuals do not have regular access to healthy, affordable foods, and many go hungry or face serious health repercussions as a result. This report explores the negative impacts of food insecurity, and identifies the successes and failures of relief efforts that are currently being made in the United States. Case studies of successful and innovative food aid programming in Boston, Massachusetts are examined and observations of efficacy identified. The results of the research conducted in this report provided evidence for implementing effective food programs nationally. Program recommendations made in this report based on research findings include integration of food aid into existing infrastructures as well as prioritizing dignity and autonomy in such programs.

INTRODUCTION: HUNGER IN THE UNITED STATES

Hunger remains a silent plague on the lives of many individuals in the Unted States. Often, the issue of hunger is considered in relation to the plight of economically disadvantaged nations — something that occurs outside of our own borders, save a handful of our poorest citizens. In reality, hunger is also a persistent challenge domestically that is regularly overlooked. Stigma, shame and isolation act to keep hunger sealed away within households, leaving the sheer number of citizens who are deprived of a basic need outside of the public consciousness.

In a recent report by the United States Department of Agriculture (USDA), statistics on 2016 household food insecurity in the United States revealed that a significant portion of the population suffers from varying levels of food insecurity. In order to survey households for food insecurity, the USDA Economic Research Service (ERS) released a food security supplement to the US Census Bureau's Current Population Survey. This survey included 3 questions on general household food insecurity, 7 specifically referring to adults within a household, and 8 on child food security for families with children under 18 (see figure below). Three or more responses indicating food insecure conditions at any point in the twelve months preceding the survey designated a

household as 'food insecure', while six or more responses designated a household "very food insecure." In total, 41,186 population representative households submitted answers to this supplemental survey.[1]

Questions Used To Assess the Food Security of Households in the CPS Food Security Survey

1. "We worried whether our food would run out before we got money to buy more." Was that often, sometimes, or never true for you in the last 12 months?
2. "The food that we bought just didn't last and we didn't have money to get more." Was that often, sometimes, or never true for you in the last 12 months?
3. "We couldn't afford to eat balanced meals." Was that often, sometimes, or never true for you in the last 12 months?
4. In the last 12 months, did you or other adults in the household ever cut the size of your meals or skip meals because there wasn't enough money for food? (Yes/No)
5. (If yes to question 4) How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?
6. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? (Yes/No)
7. In the last 12 months, were you ever hungry, but didn't eat because there wasn't enough money for food? (Yes/No)
8. In the last 12 months, did you lose weight because there wasn't enough money for food? (Yes/No)
9. In the last 12 months did you or other adults in your household ever not eat for a whole day because there wasn't enough money for food? (Yes/No)
10. (If yes to question 9) How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

(Questions 11-18 were asked only if the household included children age 0-17)

11. "We relied on only a few kinds of low-cost food to feed our children because we were running out of money to buy food." Was that often, sometimes, or never true for you in the last 12 months?
12. "We couldn't feed our children a balanced meal, because we couldn't afford that." Was that often, sometimes, or never true for you in the last 12 months?
13. "The children were not eating enough because we just couldn't afford enough food." Was that often, sometimes, or never true for you in the last 12 months?
14. In the last 12 months, did you ever cut the size of any of the children's meals because there wasn't enough money for food? (Yes/No)
15. In the last 12 months, were the children ever hungry but you just couldn't afford more food? (Yes/No)
16. In the last 12 months, did any of the children ever skip a meal because there wasn't enough money for food? (Yes/No)
17. (If yes to question 16) How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?
18. In the last 12 months, did any of the children ever not eat for a whole day because there wasn't enough money for food? (Yes/No)

1 Alisha Coleman-Jensen et al., "Household Food Security in the United States in 2016." *U.S. Department of Agriculture, Economic Research Service*, 2017.

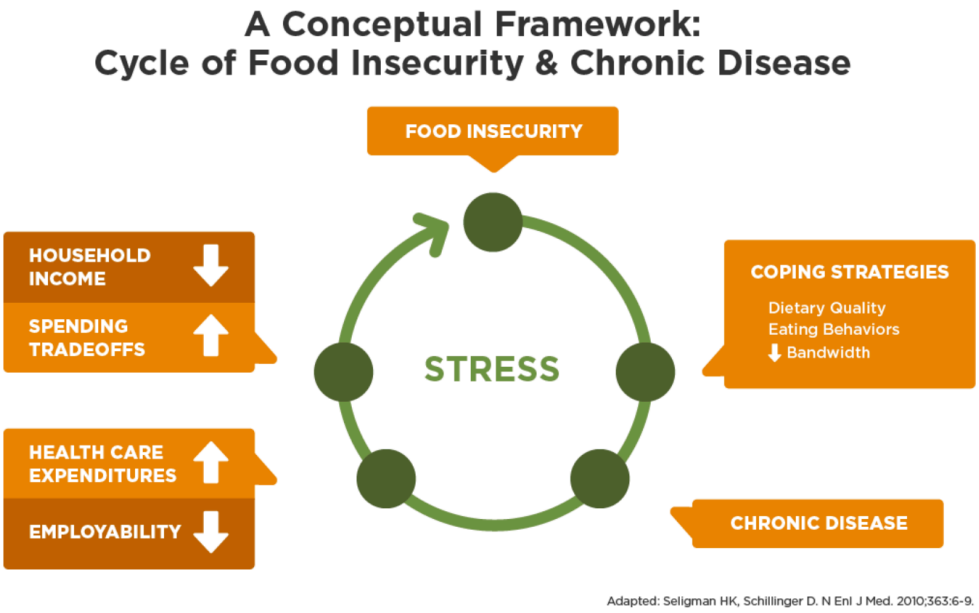
The results determined that 12.6% of United States households were food insecure sometimes, or all the time, in 2016. That is equivalent to 15.6 million households, 41.2 million individuals,[2] or roughly five times the population of New York City. These monumental figures reveal the persistence of hunger in America and the toll that it has taken on the lives of so many people every day.

HUNGER, POVERTY, AND HEALTH

Food insecurity, poverty, and illness are inextricably linked. One 2010 study found that among non-elderly adults, those with low food security had a 21% higher risk of hypertension (high blood pressure) than their non-food insecure counterparts, as well as a 50% higher risk of diabetes.[3] Some reports have correlated food insecurity with heightened risk of mental illness,[4][5] with frequent risk patterns occurring among children, adolescents, and pregnant mothers.[6] While there may be confounding factors associated with poverty and health outcomes, an insufficient nutritional intake *can* and does take a very real toll on the health of an individual over time.

The following infographic from Feeding America details a common cycle that exists for many food insecure individuals.[7]

2 Ibid.
3 Kushel, Margot B., Barbara A. Laraia, and Hilary K. Seligman, "Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants." *The Journal of Nutrition* 140.2 (2010): 304–310. doi:10.3945/jn.109.112573.
4 Ibid.
5 Craig Gundersen and James P. Ziliak, "Food Insecurity and Health Outcomes", *Health Affairs*, 34.11 (2015): 1830-1839, doi: 10.1377/hlthaff.2015.0645.
6 Ibid.
7 "What are the Connections Between Food Insecurity and Health?", *Feeding America: Hunger and Health*, Accessed September 2017.



The cycle begins with food insecurity (often triggered by insufficient household income), leading to "coping strategies" where one might sacrifice nutritional foods to ensure adequate caloric intake, or might change eating behaviors by either eating less or eating only highly processed junk foods that are typically sold at a low retail price. Decreased "bandwidth" might occur as well, in which both physical and mental capabilities are limited by hunger. These behaviors can lead to serious chronic illness, the most common of which include diabetes, obesity, and heart disease. Disease can then trigger financial losses as health care expenditures rise and employability or ability to work decreases. These kinds of financial hurdles can perpetuate poverty and create a debt trap from which it is incredibly difficult to recover. This frequently means that individuals must decide between basic expenses such as medical bills, food, or rent, and often they are unable to escape the cycle. In addition, all components of the cycle are propagators of stress, which can increase susceptibility to chronic illness.[8]

8 "What are the Connections Between Food Insecurity and Health?", Accessed September 2017.

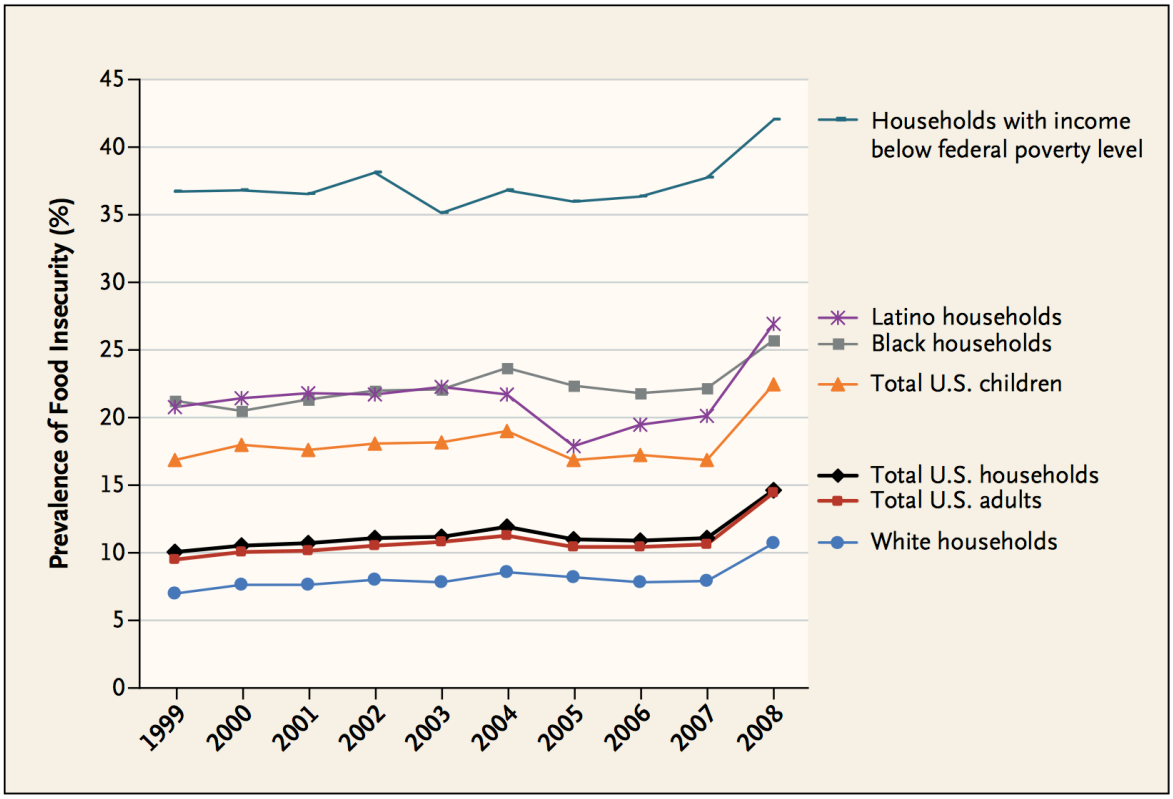
The cycle of hunger, poverty, and illness is widely recognized within the literature on food insecurity, but it is frequently overlooked by physicians in practice. Clancy Cash Harrington, a dietician and advocate for food insecure people, admits in her Ted Talk, "Like many other healthcare professionals, I was missing a piece of the puzzle…. I never stopped and asked my clients if they could afford the very foods I was asking them to buy."[9] It is not uncommon for this disconnect to occur. The issues of health and food access tend to be tackled within separate spheres, rather than viewed as highly interdependent. The complex linkages of the components associated with poverty, food insecurity, and health, however, are significantly difficult to untangle from one another. Lack of significant improvement in both hunger prevalence and related health disparities point to a need for more integrated resources that can combat the self-perpetuating hunger-illness cycle.

VULNERABLE POPULATIONS

While food insecurity negatively impacts everyone it touches, certain populations may be particularly susceptible to its impacts. This section will explore four highly vulnerable populations: ethnic minorities, single mothers, children, and the elderly. It is important to note that racial disparities in poverty and food insecurity exist across all populations. The intersection of race and other vulnerability factors is highly prevalent in the United States. In all households headed by black non-Hispanics, 22.5% experience food insecurity as do 18.5% of Hispanic-headed households. White households have a comparatively low prevalence of food insecurity, with only 9.3% experiencing difficulties obtaining sufficient nutritious food during the year.[10] These racial

9 Clancy Cash Harrington, "The Shocking Truth About Food Insecurity." *TedxWilmingtonWomen*. 2016. https://www.youtube.com/watch?v=HakCAdPrlms.
10 Hilary K. Seligman, M.D., and Dean Schillinger, M.D, "Hunger and Socioeconomic Disparities in Chronic Disease", *New England Journal of Medicine* (2010): 363:6-9 doi: 10.1056/NEJMp1000072

disparities have a historical persistence that shows little sign of abating. The graph below visually depicts racial disparities in food insecurity from 1999-2008. The purple and grey data points represent Latino and black households, respectively, while the blue data set represents white households.



Prevalence of Food Insecurity in the United States, 1999–2008.

The issue of continued racial inequality in the United States deserves its own independent analysis; however, for the purposes of this paper, these inequalities should be acknowledged as an intersecting factor in the proceeding discussion of other vulnerable populations.

The next group that is disproportionately affected by food insecurity is single mothers. As child-bearers and primary caretakers in many households, mothers play an important role in the

economic, emotional, and physical well-being of their families. Single mother-led households in the United States have a higher incidence of food insecurity than any other demographic group, at 31.6%.[11] This can result in severe outcomes for both the mother and her children. For example, nutrition is a vital component of maternal health, and failure to access a proper maternal diet during pregnancy has proven risks of health complications for both a mother and her growing baby. Issues such as gestational diabetes and high gestational weight gain are frequent among pregnant, food insecure mothers, while risks of low birth-weights and birth defects, such as cleft palate and spina bifida, are common among babies born to food insecure mothers.[12]

When providing for their families, single mothers face a number of hurdles. For example, food-insecure, single mothers frequently sacrifice their own nutrition to ensure that their children have enough to eat. They are also far more likely to forgo non-food expenses in an effort to provide meals for their families. Single mothers additionally tend to face high rates of social isolation, in which they do not have adequate networks of other adults to depend on for resources. These mothers are left with few external means of financial or emotional support, and reportedly are prone to depression and anxiety.[13] In short, food insecurity is a burden that plagues a large portion of single mothers in the U.S., and the impacts are typically felt by the whole household.

For a third group, children, food insecurity can severely hinder learning and development. For proper physical and mental growth, children require a nutritionally well-rounded diet with a sufficient caloric intake every day; yet, 1 in 6 children in the U.S. live in food insecure households.[14] Lack of food security can inhibit success in school, as malnutrition is linked to learning difficulties and decreased information retention. Hunger is also associated with behavioral issues and difficulty

11 Alisha Coleman-Jensen et al., "Household Food Security in the U.S.",2017.
12 Cullen, Kimberly A. and Louise C. Ivers, "Food Insecurity: Special Considerations for Women", *The American Journal of Clinical Nutrition*, (2011) 94(6):1740S-1744S, doi:10.3945/ajcn.111.012617.
13 Valerie S. Tarasuk, "Household Food Insecurity with Hunger Is Associated with Women's Food Intakes, Health and Household Circumstances", *Journal of Nutrition*, 131.10 (2001): 2670-2676.
14 "Databank Indicator: Food Insecurity", *Child Trends Databank*, 2016.

with interpersonal skills, leading to poor social and cognitive development. Mental health problems frequently arise in malnourished children and teens, as poor nutrition can be a causal factor for anxiety, depression, and suicidal ideation. Additionally, malnutrition is the primary cause of childhood obesity, and a number of studies have attributed food insecurity during childhood to heightened risk of chronic illness in adulthood.[15] Thus, childhood food insecurity wholly impedes healthy development and can set up children to face a number of complications and difficulties later on in life. For this reason, ensuring that children have proper diets is a crucial and time-sensitive matter that can determine a future of healthy adults.

Lastly, the elderly population disproportionately suffers from social isolation and many of the disadvantages that accompany it. Elderly, low-income individuals often carry the shared burden of food insecurity and limitations to autonomy. Many older people suffer from mobility issues and cannot do everyday tasks such as carrying groceries or walking for short distances. Lack of mobility can seriously hinder independence and can limit consumption options. Lack of nutritional knowledge and the inability to physically acquire nutritious foods frequently leave older persons housebound with insufficient diets.[16] Some symptoms of aging can include decreased sense of smell and taste as well as a slower metabolism. These physiological changes can mean that older people might not have the physical cues to eat calorically sufficient, varied diets.[17] Further, elderly people typically have comparatively small networks in which interaction with friends and family is limited apart from a spouse. In cases of bereavement of a spouse, extreme isolation can set in, triggering depression and a lack of desire to eat or cook healthy foods. Sometimes dependence on a late spouse for cooking or grocery shopping can leave a partner without the know-how to

15 Ibid.
16 Hélène Payette and Bryna Shatenstein, "Determinants of Healthy Eating in Community-dwelling Elderly People", *Canadian Journal of Public Health / Revue Canadienne De Sante'e Publique*, 96 (2005): S27-31.
17 Guylaine Ferland, "Nutritional Problems of the Elderly", *Current Perspectives on Nutrition and Health*, (1998): 199-212.

adequately provide for oneself following their partner's death. Physical inhibitors, isolation, and mental illness can all act to amplify food insecurity among older populations, especially those with extreme financial limitations.

While the aforementioned are some of the most vulnerable groups, other populations that are disproportionately impacted include rural households, households with one or more children, and households with individuals suffering from mental or physical disabilities. Across all populations, the driving factor for food security is income; food insecurity is triggered by household financial strain and poverty. While this paper covers food assistance programs and support for all populations suffering from food insecurity, the predominant causal factor is poverty, and thus the only way to end food insecurity is to tackle poverty first and foremost. That being said, poverty is a deeply ingrained and complex issue in the United States, which is why targeted food assistance programs are highly important and necessary for the wellbeing of vulnerable populations.

EXISTING SOLUTIONS AND THEIR LIMITATIONS

Government Programs

The United States government provides a number of services targeting food insecure individuals. The most popular and largely funded of these include the Supplemental Nutrition Assistance Program (SNAP), the Supplemental Program for Women, Infants and Children (WIC), and a handful of child-targeted meal programs such as the National School Lunch Program (NSLP), the School Breakfast Program (SBP), and the Summer Food Service Program (SFSP).[18] Together these programs, along with several smaller initiatives, make up the bulk of federal food aid.

18 "Food Assistance Programs", *Nutrition.gov*, Accessed September 2017.

The SNAP program, formerly known as food stamps, is the largest and most widely utilized government program. It allows eligible low-income households to receive a supplemental amount of money to spend on grocery items each month. Eligibility is determined by net income for a household falling at or below the poverty line. Able bodied adults without dependents are also required to work a minimum of 20 hours a week to remain eligible for SNAP benefits. Special exceptions exist for the disabled and the elderly, and sometimes for pregnant women and those with mental or physical health problems. A household must not possess more than $2,250 in assets to remain eligible for SNAP. As of 2016, there were 45.4 million participants using SNAP benefits in the U.S.[19]

The WIC program is a nutrition supplementation program that supports pregnant women, postpartum women, and infants and children under 5 years old. The program provides participants with access to supplemental nutritious foods, nutrition education and counselling at designated clinics, and screening and referrals to other health and welfare services. WIC-affiliated services are available nationwide through 90 state agencies and 47,000 retailers.[20] However, WIC is a federal grant program, meaning a set amount of funding is allocated and capped each year. Because of this, not all eligible women are able to receive WIC services and may be placed on a wait list.[21] For those that do receive WIC services, highly useful health and wellness resources become obtainable for those who might not otherwise have access to such resources.

Finally, the handful of federal children's meal programs available provide children from low-income homes with a meal supplementation. The National School Lunch Program (NSLP), implemented by Harry Truman in 1946, provided 7.1 million children with free or discounted

19 "SNAP: Frequently Asked Questions", *Snaptohealth.org*, Accessed September 2017.
20 "WIC- Special Supplemental Nutrition Program for Women Infants and Children", *USDA Food and Nutrition Service*, Accessed September 2017.
21 Ibid.

lunches in its first year and served 30.4 million children by 2016.[22] NSLP lunches must meet federal health requirements to be served in schools. The School Breakfast Program (SBP) is also administered primarily in public schools and is available for eligible low-income children. The third program is the Summer Food Service Program (SFSP), which is federally funded and state-administered. This program allows food insecure children to get meals in the summer time when they do not have access to the NSLP or SBP at school.[23] All three of these initiatives aim to supplement child meals outside of the home, which can act as an immense relief for parents struggling to afford meals for their children.

While these initiatives are invaluable to the wellbeing of food insecure individuals, they still do not meet the needs of vulnerable households. Nearly a quarter of eligible Americans fail to enroll in SNAP due to lack of awareness of eligibility, difficulty navigating the enrollment process, or reluctance to sign up because of stigma.[24] For those who do enroll in federal food aid programs, the benefits they receive, while helpful and often necessary, are not inherent solutions to food insecurity. Despite growing enrollment in government programs, the number of food insecure households has failed to significantly decline. Further, the future of these federal aid programs is uncertain, as the current U.S. government proposed budget cuts of $193 billion, 25% of the existing food aid budget.[25] If passed, budget cuts along with tightened eligibility requirements could leave millions of people without support.[26] As government programs fail to fully support or acknowledge the needs of low-income individuals, the importance of food assistance from external sources is becoming increasingly significant.

22 "Child Nutrition Programs", *USDA Food and Nutrition Service,* Accessed September 2017.
23 Ibid.
24 Arthur Delaney, "Food Stamps Avoided by Millions of Eligible Americans", *Huffington Post*, 2013.
25 Jenny Luna, "Trump Takes a Big Bite Out of His Voters' Food Stamps", *MotherJones.com*, 2017.
26 Mary Clare Jalonick, "House Republicans Plan to Overhaul Nations' Food Stamps Program", *PBS.org,* 2016.

Charitable and Non-Profit Initiatives

Although public programs provide many families with critical resources, many still struggle even after claiming benefits. Those who need extra support, or those who are ineligible for government programs, often turn to charitable and non-profit initiatives for emergency food relief. Thousands of food banks, soup kitchens, and meal delivery services span the country, aiming to fill the food access gap for struggling individuals. Over half the people using these resources also receive government benefits, such as SNAP.[27] These benefits are frequently exhausted before the end of the month, requiring individuals to turn to food banks for additional support. Many people even turn to food banks as a regular source of food for their families when the inability to afford basic monthly expenses becomes a chronic problem. The ever-growing need for food has left many food banks and other non-profit initiatives struggling to provide for their clients, particularly because they depend on donations to operate.[28] Though non-profit food initiatives are important and necessary for emergency food supplies, inconsistent and unpredictable donation levels make these programs unreliable for regular grocery or meal supplementation.

In addition to the uncertainty of donations, many of the foods available through these initiatives are low in nutrient content and do not constitute the components of a well-rounded diet. Donations received at food banks are typically non-perishables, including canned foods, pastas, and highly processed items that have long shelf lives.[29] Many food pantries have very basic amenities and cannot store anything that is perishable or that requires a controlled climate, such as fresh vegetables and meats. The diets of individuals who are dependent on these services are restricted by food availability, which can vary widely from program to program. Dependence on

27 Andrea Stone, "Study Sheds Light on Broadening U.S. Hunger Problem", *NationalGeographic.com*, 2014.
28 Ibid.
29 Francesca Gany et al. "Food Insecurity: Limitations of Emergency Food Resources for Our Patients", *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 90.3 (2012), doi: 10.1007/s11524-012-9750-2.

these services also limits freedom of choice, in which one has the ability to select foods based on nutritional needs and personal preference.[30] While charitable food pantries and soup kitchens are undeniably necessary when so many people cannot comfortably feed themselves and their families, they have limitations and are not sustainable solutions to food insecurity.

Stigma and Shame

Despite limited efficacy, federal and private food aid remain the current standard for those seeking food assistance; however, many people who could benefit from such programs opt not to use them. Stigma and feelings of shame are among the most prevalent barriers to food access (others include transportation difficulties and information gaps), and psychological barriers are estimated to be three times greater than barriers of time and effort. Currently, 1 in 4 SNAP eligible individuals do not apply for benefits,[31] and one study found that up to 27% of respondents to a survey on food aid said they would not use public welfare under any circumstance due to reasons related to stigma.[32]

In "The Stigma of Claiming Benefits: A Quantitative Study,"[33] three manifestations of stigma are defined. The first is 'personal stigma', defined as one's own "feeling that claiming benefits conveys a devalued identity." This form of stigma is self-directed and based on one's own preconceived notions of what it means to accept government welfare benefits or charitable donations. The second term, 'stigmatization', then refers to an individual's belief that *others* will devalue their identity. This is the perception that one will be looked down upon by others if they

30 Ibid.
31 Jonel Aleccia, "Broke and Ashamed: Many Won't Take Handouts Despite Need", *NBCnews.com*, 2013.
32 Roshini Brizmohun and Patricia A. Duffy, "Do Personal Attitudes about Welfare Influence Food Stamp Participation?", *Agricultural & Applied Economics Association Annual Meeting 2016,* 2016.
33 Ben Baumberg, "The Stigma of Claiming Benefits: A Quantitative Study", *Journal of Social Policy, 45*.2 (2016): 181-199. doi:10.1017/S0047279415000525.

choose to participate in social programs. The last form of stigma is called 'claims stigma'. This term encompasses the stigma and shame felt from the *process* of claiming benefits, including a feeling of privacy invasion, long investments of time filling out paperwork or waiting in line, and public visibility when using welfare facilities. 'Shame', consequentially, is defined as the strong emotion felt upon experiencing one or more forms of stigma.[34]

Frequently the fear of being noticed or tagged as someone who "takes handouts" prevents people from accessing all of the resources at their disposal. The recommendations portion of this paper discusses potential approaches that food assistance centres can take to be inclusive, minimize factors of stigma and shame, and maximize nutritional intake. First, we will look at a few profiles of innovative initiatives in Boston, Massachusetts.

COMMUNITY INITIATIVES: BOSTON, MASSACHUSETTS

Boston, a diverse, American, metropolitan city, is one hub of innovative food programming. Massachusetts is one of the highest spending states[35] for government-funded social programs and is a centre of non-profit work, new technology, and public health. The city also has a nationally representative population below the poverty line, with significant income inequalities and many persons dependent on public welfare services.[36] Thus, the following profiles may be good indicators of programs that can be adopted nationally.

Project Bread

Project Bread is one of the longest running hunger prevention organizations in

34 Ibid.
35 Thomas C. Frohlich, Michael B. Sauter, Alexander E.M. Hess, "States With the Most (and Least) Government Benefits", *247wallst.com*, 2014.
36 Katie Johnston, "Poverty Rate in Mass. Highest Since 1960", *BostonGlobe.com*, 2014.

Massachusetts, founded in 1974 as an extension of the Walk for Hunger, an annual 20-mile long fundraising walk in Boston. Today, Project Bread acts as an umbrella organization for hundreds of smaller initiatives, including food education, fundraising, policy movements, and community-based programs.[37] The organization acts as both a liaison to "actively promote and connect the most vulnerable populations in our state with established and effective anti-hunger programs in our communities,"[38] as well as a partner and investor for many of these programs. Although based in Boston, this community organization serves individuals all over the state of Massachusetts. Through its many projects and initiatives, Project Bread effectively touches the lives of the people living in over 266,000 food insecure households across the state.[39]

A few key initiatives spearheaded by Project Bread include the Foodsource Hotline, Chefs in Schools, and Massachusetts' Healthy Incentives Program (HIP). The Foodsource Hotline is the "only comprehensive statewide information and referral service in Massachusetts for people facing hunger."[40] It connects callers to counselors who can provide information on food assistance resources in their area. Each year the hotline serves over 46,000 callers seeking information. The hotline counsellors can also help people with the application process for SNAP.[41] This can be highly beneficial as it breaks down two common barriers to access: reluctance to expend time and labor on complicated paperwork and shame associated with physically going to an office to fill out government food assistance forms (i.e., 'claims stigma'). The Hotline is available in 160 languages and offers a phone line that displays text to a TTY device for hearing-impaired individuals.[42] Running the hotline requires few resources apart from a staff and computers to store a database of

37 Project Bread Director, "Project Bread Interview". Interviewed by Elena David, August 8
38 "Community Solutions: Our Initiatives", *ProjectBread.org*, Accessed September 2017.
39 Ibid.
40 Ibid.
41 Project Bread Director, "Project Bread Interview".
42 "Community Solutions", *Projectbread.org*.

information, but remains an effective tool for individuals who might not otherwise be able to access food assistance resources.

Another program, "Chefs in Schools" is one of Project Bread's in-school initiatives. Under the Chefs in Schools model, professional chefs are hired to train cafeteria staff in public elementary schools and high schools to improve the quality and palatability of healthy meals served for lunch. The goal of this program is to provide staff education on low-cost incorporation of nutritious foods into school meals so that a variety of healthy cooked options can be served each week on a public-school budget.[43] The program aims to boost nutrition levels while maintaining meal desirability in order to deter children from choosing not to eat their meal or from substituting it with snacks and vending machine items. A study conducted in the initial launch of this program found that children maintained their caloric intake when healthy, palatable meals were served as compared to unhealthy options, but greatly increased their intake of nutrient-rich items with low fat and sodium content.[44]

In 2017, Project Bread partnered with the state government of Massachusetts to launch the Healthy Incentives Program (HIP). HIP, funded by a USDA grant, is built on partnerships with local farmers. It allows customers with SNAP benefits to purchase locally grown produce at participating farmers' markets and receive full reimbursement of the purchase on their SNAP cards. Although capped at a monthly limit, this program highly incentivizes food insecure individuals to shop healthier and to incorporate more fruits and vegetables into their diet. The goals of HIP include supporting the livelihoods of local farmers while promoting healthy eating.[45]

43 Ibid.
44 Juliana F. W. Cohen, ScD, ScM et al., "Long-Term Impact of a Chef on School Lunch Consumption: Findings from a 2-Year Pilot Study in Boston Middle Schools", *Academy of Nutrition and Dietetics*, (2012), Doi: 10.1016/j.jand.2012.01.015.
45 Project Bread Director, "Project Bread Interview".

These three projects along with many others make Project Bread a hub for food services in which access barriers are broken and nutrition is put at the forefront.

Grow Clinic at Boston Medical Center

The close linkage between food security and health make hospitals excellent actors to identify and tackle issues of malnutrition. The Boston Medical Center (BMC), a hospital committed to addressing all the needs of its patients, has a number of programs that target food insecure households. Developed by physician Deborah Frank in 1984, the Grow Clinic is a special program that identifies children with "Failure to Thrive" (FTT), or lack of height and weight development along a normal growth curve.[46] As the most common reason for FTT is malnutrition, the Grow Clinic aims to identify children who have low caloric intake, low nutrient intake, or high fat and sodium consumption in their diets. The most common routes of entrance to the Grow Clinic include referral from a primary care physician or screening services in pediatric emergency as part of Children's Health Watch, a partner initiative.

The clinic uses an interdisciplinary model to incorporate medicine, nutrition, and social work into a treatment plan for a child and their family, tackling all determinants of FTT in order to effectively accelerate development. Treatment can include referrals to the Preventive Food Pantry (see the following section), diet and nutrition plans, home visits by social workers, and parent resources such as employment assistance, ESL services, and affordable housing assistance to tackle the integrated determinants of poverty.[47] Megan Sandel, pediatric physician and associate director of the Grow Clinic explains, "The clinic is built on the principle that we have a doctor and nutritionist and a social worker that see every family; that we do care not only in the clinic but

46 Megan Sandel "Grow Clinic Interview". Interview by Elena David, August 17, 2017
47 Ibid.

through home visiting and see kids in all of their different settings."[48] Sandel also notes that the clinic might assist families with resources to enable in-home nutritional choices, including one project that provided highchairs or kitchen tables to facilitate families' ability to eat cooked meals at home.

The Grow Clinic serves about 150 – 200 kids each year and graduates about half of them annually. A child may 'graduate' once they have entered a healthy growth curve and are determined to be able to maintain proper levels of growth.[49] The clinic prides itself on the ability to address health risks in an intensive and timely manner through a targeted and integrated approach. The clinic's services ensure that children and their families can receive comprehensive, holistic care to promote cessation of both FTT and its core causes.

Nutrition Resource Center at Boston Medical Center

Boston Medical Center is also working to directly innovate food assistance. With its implementation of two in-hospital services, the Preventive Food Pantry and the Demonstration Kitchen, that together comprise the "Nutrition Resource Center", BMC is creating a food-as-medicine service for its patients. The Preventive Food Pantry, run by director Latchman Hiralall, acts as a 'food pharmacy'. Doctors (including those in the Grow Clinic) can screen their patients for signs of food insecurity and prescribe bi-weekly food baskets to accommodate particular health concerns. Patients can then fill their prescriptions — food baskets with items appropriate for individualized health needs — in the pantry located on the basement floor of BMC. Prescriptions are modified to fit household size as well, so individuals filling a prescription for themselves can receive quantities of food that are adequate to provide for their entire family.[50]

48 Ibid.
49 Ibid.
50 Latchman Hiralall, "Preventive Food Pantry Interview" Interviewed by Elena David, August 17, 2017.

The majority of food items from the pantry are provided by the Greater Boston Food Bank (GBFB), one of the largest charitable food providers in Massachusetts. The Food Pantry also receives charitable donations from the public and some businesses, and has begun incorporating produce harvested from its new rooftop garden. The addition of refrigerators and freezers in the pantry have meant that produce, meats, and other perishable items can be utilized. The Food Pantry currently serves over 7,000 people each month and distributes 12,000 pounds of food a week.[51]

The Food Pantry works in conjunction with BMC's Demonstration Kitchen. The Demonstration Kitchen, run by chef and nutritionist Tracey Burg, provides health and budget-focused cooking classes every Monday to Friday. Doctors may prescribe or recommend a class to their patients based on their health needs. Classes are all themed to address specific needs, such as 'Diabetes Essentials', 'Kidney-Friendly Cooking', and 'Weight Management'. By incorporating both nutritious food and nutritional education as part of a successful health regimen, the Nutrition Resource Center acts to both normalize food assistance through integration into a hospital setting, and targets underserved populations that may not otherwise access food assistance resources.[52]

The Kitchen

"The Kitchen" is a cooking education program located inside Boston Public Market, a marketplace for local New England vendors. The program runs daily classes, workshops, and events on everything from fresh, local food preparation to nutritional education and culture-specific cooking. Managed by The Trustees, one of the largest land trust organizations in the world, the goals of the Kitchen are to connect Bostonians with fresh foods and nutritious cuisines. Sarah

51 Ibid.
52 Tracey Burg "Demonstration Kitchen Interview" Interviewed by Elena David, August 17, 2017.

Moser, Engagement Site Manager for the Kitchen, notes that the project is "a way of connecting people who live in Boston with agriculture and the land, and to help them learn how to cook with real, whole ingredients."[53]

While the majority of the classes offered at the Kitchen require a fee, partnerships have allowed the program to provide free community classes each week. Currently, the Kitchen partners with Project Bread and the University of Massachusetts Nutrition Education program, which host classes free of cost. Project Bread's chef, Vanessa Labranche, teaches two back-to-back classes on healthy budget cooking every Thursday, while the UMass Nutrition Education Program runs a bi-weekly class that educates SNAP-users on grocery shopping on a budget, cooking with healthy foods, and incorporating a balance of micronutrients into one's diet. Since the Kitchen started running in 2015, the popularity of its free classes has skyrocketed, now averaging 40 attendees per class each week.[54]

RECOMMENDATIONS

Given the efficacy of some of these Boston-based initiatives, this section will propose a series of recommendations for the future of food access. Food insecurity is an incredibly immobilizing reality that is tied to a complex web of causal factors. Thus, food assistance itself cannot dismantle the intricate systems at play that tie together poverty, food insecurity, and other challenges to wellbeing. However, food assistance initiatives *can* update their models to optimize processes, promote client autonomy, and reduce barriers to access, particularly stigma and shame. The following sub-sections will explore how an integrated approach can be highly beneficial in terms

53 Sarah Moser, "The Kitchen Interview" Interviewed by Elena David, September 8, 2017.
54 Ibid.

of reaching food insecure populations, and will recommend methods of reducing stigma and fostering autonomy.

Food insecurity has a number of causes and is follows closely to an individual's broader socio-economic circumstances. As a result, partnerships in which food access is integrated into a number of spheres can be more effective than restricting food access initiatives to non-profit silos. Indeed, public institutions as well as for-profit companies can both partner effectively with non-profit initiatives.

Food Access Integration into Anchor Institutions

Initiatives such as the Grow Clinic, the Nutrition Resource Center, and the Chefs in Schools program highlight the potential efficacy of integrating food access and nutritional education into existing public infrastructures, also called 'anchor institutions'. Anchor institutions are "enterprises such as universities and hospitals that are rooted in their local communities by mission, invested capital, or relationships to customers, employees, and vendors."[55] Because of the strong social and economic ties that anchor institutions have to their communities, they are excellent vehicles for identifying at-risk individuals, providing targeted services for such individuals, and normalizing, and therefore de-stigmatizing, aid.

A particular strength of anchor institutions is their ability to be excellent providers of wellness screening tools. In the case of hospitals, physicians can give simple screening questionnaires to determine if their patients might be struggling to afford food (among other issues, including mental illness, domestic violence, housing insecurity, etc.). At BMC's Grow Clinic, for

55 "Engaging with eds, meds, and other anchor institutions to help them help communities", *Democracy Collaborative,* Accessed September 2017.

example, malnourished children may be identified by their low growth curves, which can lead to identification of food insecure households.[56] In addition, higher education institutions are administering wellness questionnaires to identify adult students who may not be able to afford nutritious or sufficient amounts of food.[57] Screening can be the first step to ensuring that the needs of a population are met, and anchor institutions can provide the necessary tools.

In cases where a person in a food insecure household may not know about resources available to them, or for any reason might not choose to use such resources, integrated food access can leap a number of accessibility hurdles. In anchor institution-integrated food programs, individuals can receive information about food services and receive such services all in one location, at a place that they already utilize in their day-to-day lives. This breaks down barriers to access, including transportation, insufficient cost-benefit of travelling to food assistance centres, and lack of information on the best resources available. As with BMC's Preventive Food Pantry, health services and grocery pickup become a 'one-stop-shop'.

Finally, food access and nutrition programs can be utilized much more frequently if they are integrated into the systems that people use every day. As discussed earlier, some of the largest barriers to access are stigma and shame. Normalizing access to affordable, nutritious foods can ensure that the needs of all people are attended to within their day-to-day lives. One example of this is Project Bread's Chefs in Schools program. Delivering desirable and nutritious meal options to children who would already be using a school lunch cafeteria is one method of integrating nutritious food access seamlessly into a child's everyday life.

56 Megan Sandel "Grow Clinic Interview"
57 Stephanie Bianco,MS, RD, **"**Identifying Food Insecure Students and Constraints for SNAP/CalFresh Participation at California State University, Chico", *Csuchico.edu*, 2016.

Food Access Integration into For-Profit Companies

While public institutions can serve as effective centres of food assistance integration, another way that food access resources can more widely reach large numbers of people is through integration into for-profit companies — for example, grocery stores, marketplaces, and restaurants. There are three avenues in which food access programs can be integrated into businesses: first, through external subsidies provided by the government or social organizations; second, through 'cross-consumer subsidies' in which wealthier consumers pay a premium for items to subsidize the items for lower-income individuals; and third, via the 'social business model' in which a business accepts a reduced profit for the purpose of providing a societal need.[58]

These hybrid business models provide an opportunity to fill in the gaps between government-funded programs and classic charitable initiatives. The Kitchen at Boston Public Market is one instance where non-profit funded initiatives can effectively be integrated into for-profit spaces. While the majority of The Kitchen's classes have fees to cover supply and teaching costs, their partnerships with Project Bread and the University of Massachusetts allows free nutrition-based cooking classes to be offered to the general public every week.

These programs can bring healthy and affordable food options to the community, while often being more sustainable than charitable initiatives, as they are supported by a profit-building infrastructure and are not entirely dependent on fundraising. For-profit food access integration is also highly significant because it opens up consumer services to individuals who previously may have been barred from these industries due to financial limitations. Lack of participation in social rituals, such as sharing a meal in a restaurant with friends and family, can be highly isolating. When the possibility of participating in social activities opens up, so does social opportunity and improved

58 Ulrich Villis and Mehdi El Hajoui, "How Businesses Can Increase Food Access for the Poor", *Stanford Social Innovation Review*, *2012*.

quality of life. In this way hybrid business can provide food insecure individuals with both affordable food options *and* the ability to make decisions over food choices while participating in social activities.

Reducing Shame and Stigma while Fostering Autonomy

Incorporating nutritious and affordable food into the institutions that people use every day provides two critical services. The first is the direct supply of healthy food options when government programs and non-profit initiatives in their current state are failing to fully meet the needs of all food insecure individuals. The second is the normalization of these affordable and accessible food options, which in turn can break down the barriers of shame and stigma that prevent so many individuals from using food assistance services.

While the nature of these integrated programs within the spheres of people's day-to-day lives helps to break down stigma in and of itself, there are a number of ways that food projects can specifically target concerns around accepting 'handouts'. Food insecurity, among the many other socio-economic factors that accompany it, can leave individuals feeling powerless and lacking control of their own lives. Nutrition, cooking, and food education programs can equip individuals with the skills to take control of the foods they eat and their nutrition choices. BMC's demonstration kitchen is one example of cooking and nutritional education, in which people can gain skills to select, buy, and cook foods that are both healthy and within their budgets. Indeed, education can foster autonomy and allow people to take control of their lives.

These programs should also be built on a platform of dignity and respect. Measures that allow people the right to privacy are imperative and have frequently been neglected in existing food aid programs. Resources such as the Foodsource Hotline allow people to reach out for help within the privacy of their own homes. Simple structural measures, such as a private space for

individuals to pick up grocery bags at the Preventive Food Pantry, could also promote dignity and respect. Ultimately, simple innovations in the way people receive food assistance can go a long way towards preventing feelings of shame.

CONCLUSION

Food insecurity in America is a concerning reality that continues to plague millions of people and the numbers don't show trends of significant improvement. While government and non-profit initiatives can help some food insecure individuals, many others remain underserved as they struggle to provide nutritious foods for themselves and their families. The stagnation of this problem requires the implementation of innovative food and nutritional aid services.

Research has found that integrative food aid programs, where aid is integrated and normalized into the institutions that people use in their everyday lives, are highly effective in addressing food insecurity.[59] This approach uses holistic measures to break down barriers of shame and stigma, and fosters autonomy in making food choices. The recommendations in this paper focus on dignity and privacy-based solutions, which can ultimately give individuals greater control over their food choices. And in order for all vulnerable individuals to live healthy and productive lives, effective and inclusive food and nutrition services must be prioritized.

59 Ibid.

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