Running Head: FAMILIES FIRST FOOD SECURITY

Families First Food Security Study

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Table of Contents

Abstract

This study was developed to gain insight into what mechanisms and approaches Family First clients use to maintain food security. The Families First program services families in Manitoba that have children who are at risk for a poor childhood. An interview survey was created in order to conduct a quantitative survey to Families First clients regarding food security. Food security is a determinant of health. It is a component of nutritional status and affects human development and is related to quality of life. There is an association between food insecurity and inadequate nutrition, poor mental health, childhood behaviour problems and childhood quality of life. This project is important to help Families First program better serve their clients. This project could also be used for program planning and practice for health regions and public health departments. The information collected from the project could be used to inform public policy.

Families First Food Security Study

Project Description

I plan to conduct a quantitative survey study on food security in the Assiniboine Regional Health Authority (ARHA) in southern Manitoba. An interview will be conducted with 15 Families First clients by their home visitors and will consist of open and close-ended survey questions. The purpose of my research is to gain insight into what mechanisms and approaches these families use in seeking food security. The survey will determine if they consider the food they obtain to be healthy/acceptable food while addressing family environmental concerns.

Background Information

The Families First program services families who have children aged 0-5 who are at risk for having a poor childhood. To qualify for the program the child requires 3 or more risk factors of a poor childhood; which can include primary, secondary or tertiary prevention.

Risk Factors include: Actual or potential diseases or anomalies with the baby, difficult or negative feelings about labour, drug and/or alcohol use during pregnancy, multiple births, a mother who had her first child born prior to age 18, smoking by mother, low education, low income or financial difficulties, single parent, frequent moves or changes in jobs, no prenatal care before 6 months gestation, mental illness or cognitive delays in either parent, substance abuse by either parent, prolonged postpartum maternal separation, assessed lack of bonding, social and physical isolation, relationship distress or power and control issues, parent using harsh or inappropriate discipline practices, open file with child protection agencies, a parent's history of childhood abuse or neglect.

Families First is funded by Healthy Child Manitoba and was implemented provincially in 1999 under the name *BabyFirst* (Brownell et al., 2007). This program emphasizes positive

parenting, improved child health and development, enhanced parent-child interaction and optimal use of community resources (Brownell et al., 2007). A main goal of the program is the prevention of child maltreatment. Home visitors are paraprofessionals that are supervised by public health nurses (Brownell et al., 2007). To be eligible for Families First all postpartum referrals in Manitoba are briefly screened (Brownell et al., 2007). Families that score "at risk" are then given an in depth assessment. Those that score above the cut off then become eligible for home visits (Brownell et al., 2007). Regular home visits are offered for up to 3 years (Healthy Child Manitoba, no date).

Conceptual Framework

Food is a basic human need, which is illustrated by Maslow's Hierarchy of Needs. According to Maslow's Hierarchy of Needs one's basic needs such as food, clothing and shelter need to be met before one can reach other levels of need such as social security then going up to love and belonging, esteem, then experiencing purpose and finally being able to self-actuate.

Campbell (1991) argued that food security is a component of nutrition status for individuals and populations and is not just a risk factor for a poor diet. Campbell (1991) stated that food insecurity is not only a risk factor for malnutrition and poor diet but also directly related to quality of life and health in the broad sense (social, mental, and physical well-being). Campbell (1991) defined food security as "access by all people at all times to enough food for an active, healthy life and at the minimum includes the following 1) the ready availability of nutritionally adequate and safe food and 2) the assured ability to acquire personally acceptable foods in a socially acceptable way" (p. 408-409). In 1999 Hamelin, Habicht and Beaudry added to Campbell's ideas. Hamelin and colleagues (1999) stated that food security affects human

development and they argue that household food insecurity has social repercussions. The consequences of food insecurity may be physical, psychological and socio-familial with social implications that include decreased learning and productivity, increased need for health care, psychological suffering and possibly increased potential for conflicts in the community (Hamelin et al., 1999).

The Dietitians of Canada (DC) (2005) position statement recognizes food security as a social determinant of health and recommends taking a population health approach to address the root cause of food insecurity. We can do this though improvements in social policies and programs that provide social support and economic security also called the social safety net (DC, 2005). These include employment insurance and social assistance, and funding for education and health care (DC, 2005). Food security is seen as component of nutrition status; it affects human development and is also related to quality of life.

Literature Review

In 2004, 2.7 million Canadians lived in food insecure households (Health Canada, 2007). Most are low-income, aboriginal, living in single female-led households, and living in households with young children or 3 or more children (Health Canada, 2007). As shown in the following literature review, food security is a determinant of health, (DC, 2005; McIntyre, 2003). Mental health, nutritional status, childhood behaviour problems, childhood quality of life and overall health are all associated with food security. It is important to identify families with young children at risk to learn how they cope with their situations regarding food security to inform practice and policy for the Family First program and throughout other programs that food security may be an issue. In 2004 8.8% of the Canadian population (2.7 million people) lived in

food insecure households and in 2004, 412 300 Canadian households were food insecure (Health Canada, 2007). Of these surveys 44% had both adults and children being food insecure, 48% had only adults food insecure and 6% only children food insecure.

There is a relationship between household income and food insecurity (Health Canada, 2007). In households where the main sources of income were social assistance or workers compensation/employment insurance they were more food insecure. This involves an increase in food insecurity among households in the lowest and lower middle income bracket, off reserve aboriginal families, those who do not own a dwelling, single female parent households and households with young children or three or more children (Health Canada, 2007). These stats give a snapshot of food security in Canada but do not show strategies used to maintain food security (Tarasuk, 2001).

Hamelin, Merceir and Bédard (2008) examined the perception of needs and conditions required for food security. They looked at the differences between the perceptions of households that are food insecure and stakeholders (community workers, program developers etc.). Both groups agreed that having financial resources or being able afford food is necessary for food security. Hamelin and colleagues (2008) found that households' feel they require regular and sustainable access to food with diet quality being of particular importance to families. Stakeholders rated meeting basic nutritional/survival needs as most important. The stakeholders perceived the households to be more satisfied with collective kitchen programs than the households indicated. This could be due partially to households putting a greater emphasis on diet quality than just having enough food. In order to develop effective programs, economic assess to food is important, therefore increasing food security requires acting on financial related factors (Hamelin et al., 2008). This study showed that the needs of food insecure households

may not be what stakeholders perceive. Women who feel socially isolated often report hunger with food insecurity (Tarasuk, 2001). Derrickson and Brown (2002) found that stakeholders defined hunger as quantity, physical sensation and also quality. Stakeholders mentioned hunger and inadequate balance and healthy foods (Derrickson and Brown, 2002). Stakeholders also emphasised the importance of emotional insecurity in food insecure people (Derrickson and Brown, 2002).

Programs such as collective kitchens are intended to increase food security to low-income people. In 2007 Engler-Stringer and Berenbaum conducted interviews with 16 collective kitchen users that identified themselves as low-income. They found that the participants typically joined for financial reasons and perceive that they save money from joining the group. Many collective kitchen participants find the food of high quality with good portions, whereas many participants indicated food quality and food safety concerns with food banks (Engler-Stringer and Berenbaum, 2007). Participants found using collective kitchens more socially acceptable then other food charity. Engler-Stringer and Berenbaum (2007) emphasised that collective kitchens may have a positive effect on food insecure participants but are not the answer to food insecurity, therefore lobbying for other solutions such as increasing social assistance and minimum wage are important. Rock (2006) stated that charitable food insecurity solutions such as food banks and collective kitchens do not reduce social disparities.

Many food insecure people do not participate in programs. Martin, Cook, Rogers and Joseph (2003) found that some programs are deemed more socially acceptable then others and that this perception of what is socially acceptable differs culturally. For example Martin and colleagues (2003) found that in the U.S., black households are less likely to receive food stamps then Hispanic households but Hispanic households are more likely to indicate that they feel

uncomfortable using food pantries than non-Hispanic households. Acceptability is also different among age groups. Martin and colleagues (2003) found that the elderly seemed more comfortable using private programs such as food banks to increase food security while the Hispanic population seemed more comfortable using public programs such as food stamps.

Food insecurity is associated with nutrition status. Widome, Neumark-Sztainer, Hannan, Haines and Story (2009) found that food insecure youths had more risk factors for overweight than their food secure counterparts. Food insecure youths indicate less healthy foods at home and also may eat more fast food (Widome et al., 2009). Also, youth that were moderately food insecure (not severely food insecure) were more likely to have a BMI over the 95th percentile (Widome et al., 2009).

Tarasuk (2001) found significant difference between fruit and vegetable consumption between those who are food secure and those who are food insecure. Kirkpatrick and Tarasuk (2008) examined the relationship between children and adults food intakes and food security state. Adults who were food insecure were found to have lower energy intakes and diets lower in protein, fat and fibre. There was also a negative association between food insecurity and intake of fruits and vegetables, and milk products, in most groups. Kirkpatrick and Tarasuk also found no association between food insecurity and energy intake for children, further showing that adults will compromise their own diets so their children will have enough.

Starkey and Kuhnlein (2000) compared Montreal food bank users' food intake with *Canada's Food Guide to Healthy Eating.* They found that food bank users have a lower intake of milk products compared to the general population in Quebec.

Programs aimed at increasing food security are beneficial. Those who attend collective kitchens indicate an increase of fruit and vegetable consumption at home (Engler-Stringer &

Berebaum, 2007). Formal programs have also shown a nutritional benefit. In the U.S. infants in the Supplemental Nutrition Program for Women, Infants, and Children (WIC) program showed positive growth and health status (Black et al., 2004). Black and colleagues (2004) also found that not only subsidized food and nutrition advice through the program increased the health of the children, but they also showed better utilization of the health care system.

Many health professionals and paraprofessionals promote food security and those not traditionally considered health promoters even promote food security (Keller, Dwyer, Edwards, Senson & Edward, 2007). Keller and colleagues indicated that there are six caregiver roles in promoting food security, monitoring, coordination, promoting services, education, advocacy, and providing social support. Monitoring includes monitoring food intake especially to those who are isolated, and also monitoring clients' needs for further support or services. Coordination is to assist clients in negotiating the system and promoting to help clients trust the system. Education is to help clients make healthier and lower cost choices at the grocery store and also providing recipes with low cost ingredients. Advocacy can include helping clients fill out forms for assistance or going to a food bank for them. Encouraging social interaction and personalization of service give clients a social supportive environment. Social services such as meals on wheels, transit and shopping services need to be supported in their roles in promoting food security.

Many studies on food assistance programs take place in urban centres. Swanson, Olson, Miller and Lawrence (2008) looked at how formal government food assistance programs, as well as informal supports, are used by rural low-income families. This study used quantitative and qualitative questions drawn from interviews with the "Rural Families Speak" project. Swanson and colleagues' (2008) study objectives were to discover families' food security status in relation to support utilized and how mothers view their own use of support to meet food needs. The

study included 326 low-income families with at least one child 12 years of age or less. Swanson and colleagues (2008) found that 40% of the participants were food insecure. The researchers examined the formal supports including the Food Stamp Program, National School Lunch and/or Breakfast Program and WIC. Most of the participants were enrolled in WIC (81.7%), and 80.1% or participants utilized the National School Lunch and/or Breakfast Program and 57.4% of those eligible to receive food stamps did (Swanson et al., 2008). The use of these formal programs had no significant association with food security status. The study, however, showed that food stamps may provide some protection against hunger (Swanson et al., 2008). Swanson and colleagues found that even though formal supports are not significantly associated with food security status that families had positive feelings about the National School Lunch and/or Breakfast Program and found WIC helpful and generous. This shows that formal programs are beneficial to families but are not sufficient for meeting rural family food needs.

Swanson and colleagues' 2008 study also showed a significant association between social skills and food security status. Those who were members of organizations, had interpersonal relationships, got together with friends, and kept in touch with friends were less likely to be food insecure. Non-formal assistance such as emergency food and eating with friends or family was associated with less food insecurity. This study showed the importance of social interaction to meet the basic needs of rural families.

Nnakwe (2008) also found that as food insecurity increased, the amount of foods eaten per food group decreased when using a food frequency questionnaire. The study indicated that those with less education were more food secure than those with high school or more education. This anomaly could be because the higher educated may have a higher income and therefore, in the study were not qualified to receive services. Coping strategies to meet food needs included a

less varied diet, the use of food assistance programs and the use of emergency food programs such as food banks, emergency kitchens and shelters. Nnakwe's study also indicated that food insecurity was associated with decreased dental status, appetite, and regularity of meals. The study further supports the Canadian Community Health Survey that households with children headed by a single female parent are at increased risk of food insecurity (Health Canada, 2007).

McIntyre and colleagues (2002) examined households with single mothers with at least 2 children under the age of 14. The study included weekly interviews with 139 mothers in four Atlantic Canadian provinces that had an income at or below the Statistics Canada low-income cut-off for the region (McIntyre et al. 2002). Ninety percent of the participants received social assistance as the major source of income and 90% of participants received supplementary food assistance mostly from food banks or family (McIntyre et al. 2002). Most of the households (96.5%) were food insecure over the past year and 57% indicated food insecurity over the past month (McIntyre et al. 2002). More than half of the respondents reported maternal food insecurity over one month, which indicates that the mothers regularly experience food insecurity, and child hunger was reported in a quarter of the households over the past month (McIntyre et al. 2002). This study further supports that lone parent households are at an increased risk for food insecurity.

There were also differences in food insecurity depending on province (McIntyre et al., 2002). Respondents from New Brunswick were more food secure then those from Nova Scotia. This indicates that provincial social policies may affect food security and that differing provincial social policies may mean that a family in the same situation in one province may be food secure but not so in a neighbouring province (McIntyre et al. 2002). This further exemplifies the relationship between the social safety net and food security.

Toddlers are affected by adult food security. Hernandez and Jaknowitz (2009) used the first and second wave of the Early Childhood Longitudinal Study – Birth Cohort (ECLS-B) to study characteristics associated with the likelihood of adults experiencing persistent and transitional food insecurity and how these patterns can influence toddler health status, cognitive development and motor development. Findings showed that similar characteristics are associated with transitional and persistent food insecurity (Hernandez and Jaknowitz, 2009). Transitional food insecurity is when families are food secure much of the time but have times where they are food insecure and persistent food insecurity is when families are food insecure much of the time. Being economically disadvantaged is associated with experiencing transitional or persistent food insecurity. Toddlers had lower cognitive scores and worse health status in households where mothers experienced temporary or persistent food insecurity, compared to food secure families (Hernandez and Jaknowitz, 2009). This may be due to food insecure adults having less energy to engage with their toddlers to provide stimulating activities or the adult may be experiencing depression or anxiety that influences children's outcomes. Persistent food insecurity seemed to affect toddlers' health and cognitive score less then transitional food insecurity (Hernandez and Jaknowitz, 2009). This may be because those who have persistent food insecurity have developed coping strategies, such as the ability to navigate the social system (Hernandez and Jaknowitz, 2009).

In 2006, Cook and colleagues found an association between household food insecurity and increased reported fair to poor health. Cook and colleagues (2006) examined families with toddlers 36 months old or less to see if food insecure households have different odds of negative health outcomes compared to similar children in food secure households. The study also looked at whether identifiable child food insecurity in the household leads to even greater negative

health outcomes. Using interview surveys and medical record audits, Cook and colleagues (2006) found that children living in food insecure households had significantly greater odds of fair to poor health and more hospitalizations since birth compared to food secure households with similar children. The study also showed greater odds between children in households with both identifiable child food insecurity and household food insecurity to have fair to poor health and increased hospitalizations compared with food secure households. There was no association between the households with both identifiable child food insecurity and household food insecurity than those with only household food insecurity. The study also found that Food Stamp Program participation reduced the positive association with food insecurity and adverse health outcomes, but did not eliminate the association. This study suggests that household food insecurity with or without identifiable child food insecurity is associated with adverse health outcomes. This may be due to overall family stress associated with food insecurity affecting the health of the children.

Casey, Szeto, Lensing, Bogle and Weber (2001) noted differences in several anthropometric and nutrition measures between low-income families that are food-insufficient and higher-income families that are food-sufficient. The authors found no difference between low-income families that are food-insufficient and food-sufficient (Casey et al., 2001). Data from the Continuing Survey of Food Intakes by Individuals (CSFII) was used to look at physical inactivity and exercise, nutrient, fruit and vegetable consumption, and underweight and overweight. Low-income food-insufficient families had higher protein and cholesterol intakes and lower energy and carbohydrate intakes then higher-income food-sufficient families. Low-income food-insufficient families also had less fruit, yogurt, and nonwhole grains and more dried peas and beans then higher-income food-sufficient families. Low-income children regardless of

food sufficiency were more overweight and watched more T.V. then their higher-income counterparts.

Bhattacharya, Currie and Haider (2004) examined the extent in which food insecurity and poverty are predictive of nutritional status. The study used the data from the third National Health and Nutrition Examination Survey (NHANES III) (Bhattacharya et al., 2004). The authors found that poverty is predictive of poor nutritional outcomes among adults and preschoolers (Bhattacharya et al., 2004). Poverty was associated with lower serum nutrient levels and lower scores on the healthy eating index (Bhattacharya et al., 2004). There was no association with poverty and nutrition outcomes among school aged children (Bhattacharya et al., 2004). This could be due to access to food through school nutrition programs and friends (Bhattacharya et al., 2004).

Bhattacharya and colleagues also (2004) found that food insecurity measures have little predictive power of nutritional outcomes in children once poverty is controlled for, but food insecurity is associated with adult nutritional outcomes. Food insecure adults were shown to have less healthy diets and lower serum nutrients then their food secure counterparts (Bhattacharya et al., 2004). The study also showed that food insecure elderly were more likely to have a low BMI and less healthy diets.

Alaimo, Olson, Frongillo and Briefel (2001) examined the relationships between food-insufficiency, family income and health measures in children. Data from the third National Health and Nutrition Examination Survey (NHANES III) was used (Alaimo et al., 2001). Data was collected from caregivers or 6154 1-5 year olds and 5667 6-16 year olds in the U.S. (Alaimo et al., 2001). Fifteen percent of low-income families and 2% of middle-income families were food-insufficient (Alaimo et al., 2001). Low-income children were significantly more likely to

have reported fair to poor health than high-income children (Alaimo et al., 2001). Also food-insufficient children were more likely to have reported fair to poor health than food-sufficient children (Alaimo et al., 2001). These associations continued to be significant after adjusting for confounding factors such as soiciodemographic factors and income (Alaimo et al., 2001).

Broughton, Janssen, Hertzman, Innis and Frankish (2006) examined the relationship of food security and preschool children's nutritional status. The study consisted of a convenience sample of 142 households with children 2-5 years old in low-income Vancouver neighbourhoods (Broughton et al., 2006). Of this sample 50% were food insecure, which is higher then the rate of 10.4% in Vancouver overall. Children from food insecure households had significantly lower zinc levels then those from food secure households which may indicate that these children have lower intakes of zinc containing foods such as meat and meat alternatives and milk and milk alternatives. Also children in food insecure households were almost twice as likely to be overweight or obese. Supplementary food programs may be insufficient to meet the needs of food insecure households because only half of the food insecure households were involved in supplementary food programs. Broughton and colleagues also found that cooking skills and availability of cooking appliances play a role in control and choice of food in households.

An association has been shown between food insecurity and developmental risk among young children less than 3 years of age (Rose-Jacobs et al., 2008). Rose-Jacobs and colleagues (2008) conducted interviews with 2010 caregivers in low-income households with young children aged 4-36 months. Twenty-one percent of households were food insecure with 6% reporting hunger with food insecurity. The food insecure households were more likely to receive public health insurance and infants were more likely to be breastfed. The food insecure caregivers were more likely to report depressive symptoms (almost half of respondents) and have

less education then the food secure caregivers. After controlling for confounding variables such as birth weight, there was an association between food insecurity and developmental risk among the children even when food insecurity was less severe. This could be because food insecure household may have a limited quality of food which leads to micronutrient deficiency. Also increased stress and anxiety of food insecure households could have increased the risk for depressive symptoms that may lead to increased developmental risk.

Casey and colleagues (2005) found an independent association between food insecurity and child health related quality of life (CHRQOL). A cross-sectional telephone survey was completed with parents regarding 399 children between the ages of 3-17 in 36 Delta counties in rural U.S. in which twenty-five percent of the households were food insecure. In the food insecure households, children scored significantly lower on psychosocial, physical and total CHRQOL. The youngest age group (3-8 year olds) scored lowest on physical function and the teenage age group (12-17 year olds) scored lowest on psychosocial function. Both the youngest and teenage groups scored significantly lower in total CHRQOL than their food secure counterparts. There was no difference between food secure and food insecure middle aged children (9-11 year olds). When controlling for child's income, gender, race and age, food insecurity was associated with total CHRQOL and physical function, with the association between food insecurity and psychosocial function approaching significance. According to this study food insecurity is associated with children's quality of life and health status.

Behaviour problems in pre-school aged children are associated with maternal food insecurity (Whitaker, Phillips & Orzol, 2008). A cross-sectional survey was completed to determine if prevalence of behaviour problems in 3 year olds is more common when mothers are food insecure. The study was completed with 2870 mothers in 18 U.S. cities and found

increased behaviour problems in 3 year olds with food insecurity after adjusting for confounding factors such as prenatal factors, mother's physical health and substance abuse, and sociodemographic factors. Whitaker and colleagues also looked at whether maternal food insecurity is associated with depression and anxiety. They found that maternal depression and anxiety increased with the increase of food insecurity. There was also a lesser association between child behaviour problems and maternal depression and anxiety. Maternal food insecurity is associated with both child behaviour (in 3 year olds) and maternal depression and anxiety.

Casey and colleagues (2004) also examined the association of positive depression scores with food insecurity. They completed a survey with a convenience sample of 5306 mothers with children 3 years and under in 5 U.S. states. Positive scores on a maternal depression screens were found in 35% of mothers interviewed. There was a strong association between positive maternal depression scores and food insecurity, changes in financial benefits, and food stamp support. Almost 53% of those with positive maternal depression were food insecure. High maternal depression scores were associated with fair to poor reported child health status and children were more likely to have been hospitalized. All of the above results are significant after adjusting for confounding variables.

Food security can also differ between members of the same household. A case study by Power (2006), showed how economic abuse can cause or coincide with food insecurity. The study participant's ability to feed herself and her children was constrained by her husband's demand for certain foods and her lack of financial resources. The mother sometimes ate less in order for her children to have sufficient food. She and her children ate foods of lower quality sometimes even though she had developed good coping skills. This case study shows how food

security can differ between members of the same household and how economic abuse can cause food insecurity.

Similar programs to Families First positively impact infant early development. Lyons-Ruth, Connell, Grunebaum and Boteins (1990) noted that a similar program showed that home visiting services for families with infants had better development and the infants were more likely to be securely attached to their mother than those without services. The results were especially strong for infants with depressed mothers (Lyons-Ruth et al., 1990). The goals of the home visiting program in the study included providing a trustworthy and acceptable relationship, increasing families' competence in accessing resources, modeling and reinforcing positive, interactive, and developmentally appropriate exchanges between infant and mother, and decreasing social isolation (Lyons-Ruth et al., 1990). Geeraert, den Noortgate, Grietns and Onghena (2004) completed a meta-analysis that showed early prevention programs for young children at risk for maltreatment had a significantly positive effect. The program was also associated with a decrease in manifestations of neglectful and abusive acts, increased parent-child interaction, as well as child, adult and family functioning (Geeraert et al., 2004).

Programs like Families First can advocate for their clients and help their clients navigate through the system to reach programming that is meaningful to them. Food security may be an issue for many Families First clients. This study will look at how families in the Family First program maintain mechanisms to stay food secure which will help the Families First program in the Assiniboine Regional Health Authority (ARHA) better meet the needs of their clients.

It is important to understand how and what resources families use to maintain food security, especially those with children at risk. Food insecurity is associated with inadequate nutrition, poorer mental health (including depressive symptoms), childhood behaviour problems,

and childhood quality of life. Childhood overall health is also associated with food security. Many professionals and paraprofessionals play an important role in food security including those not normally associated with food security such as meals on wheels drivers, shopping, and transit services. There are many formal and informal programs that help to decrease food insecurity that are important to those who seek and use these programs. Many families find these programs helpful but they are not sufficient to meet all the needs of Canadians. It is important to continue lobbying for better social safety nets such as higher minimum wage and better access to income and employment insurance.

Definitions

Food Security: "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" (Food and Agriculture Organization of the United Nations [FAO], n. d.)

Food Insecurity: "Limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire foods in socially acceptable ways" (Kennedy, 2003)

Hunger: "The uneasy or painful sensation caused by lack of food. The recurrent and involuntary lack of access to food. Hunger, as the recurrent and involuntary lack of access to food may produce malnutrition over time" (Kennedy, 2003)

Food Secure: "Little or no evidence of food insecurity" (Kennedy, 2003)

Food Insecure Without Hunger: "Food insecurity is shown by households' concern about and adjustments to food management" (Kennedy, 2003).

Food Insecure with Moderate Hunger: "Food intake for adults is reduced, and adults are experiencing hunger owing to resource constraints" (Kennedy, 2003)

Food Insecure with Severe Hunger: "Households with children reduce the children's food intake to an extent that implies that the children experience hunger as a result of inadequate resources within the household, while adults show evidence of more severe hunger (e.g. going entire days with no food)" (Kennedy, 2009).

Project goals/objectives

The purpose of my research is to gain insight into what mechanisms and approaches the Families First families use for ensuring food security and whether families perceive that they obtain enough healthy/acceptable food while also taking into consideration the families' environmental concerns. Also this study will give health care professionals and paraprofessional's insight on how their clients cope day to day with food security issues and in turn be better able to provide meaningful care, education and resources.

Methodology

This study will use individual surveys. Fifteen families in the Families First program within the Assiniboine Regional Health Authority (ARHA) will participate in a 15 minute survey delivered face to face by their home visitor. The interview questions were developed ahead of time and then will be explained to the home visitors prior to the interview process. The interviews will be analyzed and summarized by interview question and participant number. Survey questions were developed using questions contributed by the project supervisor, looking at the resources available throughout the ARHA and Brandon Regional Health Authority (Brandon RHA) areas, as the ARHA geographic area is the rural area surrounding the geographic region of Brandon RHA. Interview questions were also developed by consulting the Families First program and a Healthy Child Coordinator who was a home visitor in a previous position.

The researcher also developed survey questions through her own experience in the ARHA and Brandon RHA as a clinical and community dietitian.

The Families First Food Security Interview consists of a mixture of open and close-ended questions. All of the qualitative questions, questions 1, 2, 5, 7, and 10, will be sorted by hand by question number. This way the researcher can see common themes around the answer to each question between respondents. Also the interviews will be read over several times by the researcher; this helps to evaluate responses in the context of the entire interview. All statistical analyses of demographic information and quantitative data will be placed into computer analyses software for analyses.

The demographic data to be collected include, age, gender, whether the respondents live in town or in the country, whether the child lives in a single, 2-parent or other type of household, number of people per household and where the child lives with extended family. The interview questions were designed to learn how and what mechanisms Families First clients use to maintain food security. From question 1 the researcher will learn the parents' own definition of what is healthy/acceptable food for themselves, the family as a whole, the children, and the baby. From question 2 the researcher will learn whether the caregiver felt that she/he had enough healthy/acceptable food for themselves, the family as a whole, the children, and the baby and in her/his own words the reason whether she/he felt there was access to enough healthy/acceptable food. From the first 2 questions the researcher will learn the respondent's view on what he/she feels is acceptable and whether she/he feels there is enough healthy/acceptable food. Questions 3 and 4 will give the researcher information as to where the families obtain their food and where they usually eat. These questions will show the researcher what kinds of coping strategies the families use to maintain food secure and whether they feel that these strategies are acceptable.

From question 5 the researcher will learn how families' environmental views may affect how they maintain food security. Questions 6 and 7 pertain to gardening; from these questions the researcher will learn whether families garden and whether or not they feel that having access to gardening affects food security. Also from questions 6 and 7 the researcher will learn if families who garden perceive gardening as an important mechanism for maintaining food security and if the perceptions differ between those who have access to a garden and those who do not. From questions 8 and 9 the researcher will learn about difficultly, the distance, and the means of the family to purchase food from different types of venues, how acceptable these venues are and how often they visit these places. Question 10 will show the researcher certain products/items that families may like or want but are unavailable or find too difficult to obtain. From question 11 the researcher will learn how food is prepared and stored in the home, as well as what kinds of appliances or storage is available to the families. Question 12 is a 21 question survey. From question 12 the researcher will learn whether the family has access to enough, acceptable, safe, and nutritionally adequate food. From question 12 the researcher will also learn whether the ways that food is accessed is acceptable and reliable. Question 12 will also show whether families worry about their food and whether at any time this past year the family has run out of food, not gotten enough food or food was not nutritionally adequate. From question 12 the researcher will also learn the context of some of the qualitative questions and vice versa.

Significance of Project to Public Health

This research project is of significance to public health. Food security has been described as an important determinant of health (DC, 2005; McIntyre, 2003). This project can be used to create awareness and understanding so appropriate resources can be identified to the Families First program in order to better help their clients. The project will help us understand the

perceptions of rural Families First clients as to what is healthy/acceptable food and their resource uses and needs for maintaining food security. This project creates an avenue to open up communication, provide education and create awareness to the families. It uses an approach that exhibits a non-judgemental attitude and empathy to public health programs including the Families Fist program and the home visitors that interact with their clients. The lack of anonymity in small communities may be a barrier to the use of certain resources; therefore this project can help us seek, strengthen, and create appropriate resources regarding food security. Regional health authorities and public health programs can also target interventions from the information gathered from the project.

The project will allow us to understand food security issues in a rural prairie environment, especially rural southern Manitoba. There is potential to replicate the project to other study populations such as mental health, home care and aboriginal populations. The project can also be replicated for the growing rural immigrant population as they may be in entry level jobs and/or seeking culturally acceptable foods. This project can be used for program planning and practice for health regions and public health departments and the information collected from the project can also be used to inform public policy.

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Appendices

Appendix 1: Families First Food Security Interview

Families First Food Security Study

Participant # _____

Age: □ < 20 □ 20 – 30 □ 31 – 40 □ > 40

Participant: □ single parent □ 2 parent □ grandparent/s □ other

Do you live with your extended family? □ yes □ no

How many families live in your household? _____

Gender: □ male □ female

Lives: □ in town □ in the country

Interview Questions

1. To you, what is healthy/acceptable food for your baby, children, family and self?

Baby:_____

_____

_____

_____

_____

_____

Children:_____

_____

_____

_____

Family:

Self:

2. Do you feel like you have access to enough healthy/acceptable food for your baby, children, family and self? Please explain why or why not.

Baby:

Children:_____

_____

_____

_____

_____

_____

Family:_____

_____

_____

_____

_____

_____

Self:_____

_____

_____

_____

_____

_____

3. How do you obtain or get your food?

□ grocery store	□ corner store	□ soup kitchen	
□ box store (Wal-Mart™)	□ garden	□ food banks	
□ buy from a farmer	□ own livestock	□ hunting	□
gathering (berries)	□ farmers market	□ Other _____	

4. I am going to go through a list of places that many people eat at, let me know how often you and your family typically eat at these places. On a scale of 1-5, 1 being most acceptable and 5 being least acceptable how acceptable is each place?

Place	Frequency (circle one)	Acceptability (circle one)
Home	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
Other family members' house	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
Friends' house	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
Restaurant	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
School	Never or rarely 1-3 times per month 1-2 times per week Once per day	1 2 3 4 5

	2 times per day or more	
Work	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
Soup kitchen	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
Community meal (fowl supper, church brunch)	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
Other:	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5

5. How do you take into consideration the environment (meaning climate change or global warming) when it comes to making food choices?

_____

_____

_____

_____

_____

6. Do you have access to a garden?

□ no garden □community garden

□family/friends' garden □ own garden

7. How do you feel having access to a garden affects having enough healthy/acceptable food?

8. I'm going to go through a list of places that people typically buy food. Tell me how far each place is, how long it takes to get there, and how you normally get there.

Type of food store	Distance	Time	How you get there (circle one)
Big box store (Wal-Mart™)			Walk Drive Get a ride Taxi Handi-van Other:_____
Grocery store			Walk Drive Get a ride Taxi Handi-van Other:_____
Corner store			Walk Drive Get a ride Taxi Handi-van Other:_____
General store			Walk Drive Get a ride Taxi

			Handi-van Other:_____
Other			Walk Drive Get a ride Taxi Handi-van Other:_____

9. How often do you visit the following stores? On a scale of 1-5, 1 being most acceptable and 5 being least acceptable how acceptable is each food store?

Type of food store	Frequency (circle one)	Acceptability (circle one)
Big box store (Wal-Mart™)	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
Grocery store	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
Corner store	Never or rarely 1-3 times per month 1-2 times per week	1 2 3 4 5

	Once per day 2 times per day or more	
General store	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5
Other:	Never or rarely 1-3 times per month 1-2 times per week Once per day 2 times per day or more	1 2 3 4 5

10. Are there certain foods that you need or would like to eat that are difficult to get, or are not available, in your community?

□ yes □no

If yes, what are those foods - and why are they difficult to get or not available?

11. Which of the following equipment or methods for food storage and preparation are used in your home?

□ gas/electric stove □ hotplate □ wood stove □ gas/electric oven

□ microwave □ open fire □ refrigerator □ freezer

□ food drying/dehydrator □food canning □ rood cellar

□ ice house □ other:_____

12. The following questions ask about your thoughts on the food that you eat. Please listen to each one and indicate whether you strongly disagree, disagree, are neutral, agree, or strongly agree.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I am able to access enough food to meet my needs.	1	2	3	4	5
2. I am able to access the kinds of food that I need.	1	2	3	4	5
3. I have easy access to sources of nutritious food.	1	2	3	4	5
4. Obtaining nutritious food is not a problem for me.	1	2	3	4	5
5. I trust that the ways I access food will continue to be available into the future.	1	2	3	4	5
6. I am able to access nutritious food in ways that are acceptable to me.	1	2	3	4	5
7. The ways that I access food are reliable.	1	2	3	4	5
8. I know several different ways to access food.	1	2	3	4	5
9. I am able to access nutritious food in ways that are acceptable to my culture.	1	2	3	4	5
10. I know how to get enough nutritious food to meet my needs.	1	2	3	4	5
11. The ways that I access food are safe.	1	2	3	4	5
12. I sometimes worry that I will run out of food.	1	2	3	4	5
13. I trust my sources of food.	1	2	3	4	5
14. I am confident in my ability to get the food that I need.	1	2	3	4	5

15. I worry that I will not be able to access enough food to meet my needs.	1	2	3	4	5
16. I am not confident in my sources of food.	1	2	3	4	5
17. I do not have a secure source of food.	1	2	3	4	5
18. In the past year, you or your family have worried that food would run out	1	2	3	4	5
19. In the past year, the food that you and your family had would run out, and there would be no way to get more.	1	2	3	4	5
20. In the past year, you and your family could not access the food you needed to eat balanced meals.	1	2	3	4	5
21. In the past year, you or members of your family did not eat enough because there was not enough food.	1	2	3	4	5

Interviewer's notes:_____

Appendix 2: Ethics Submission to the Lakehead University Research Ethics Board

LAKEHEAD UNIVERSITY
RESEARCH ETHICS BOARD
RESEARCHER'S AGREEMENT FORM

Principal Investigator: Dr. Connie Nelson
(Faculty member supervisor for student research)
Telephone Number: 807-767-0480
Email address: connie.nelson@lakeheadu.ca

Co-Investigator(s):

Student Investigator(s): Chantal Morais
(For graduate student research projects/theses)
Telephone Number: 204-851-2394
Email address: cmorais@lakeheadu.ca

Department: Public Health

Address where correspondence should be directed: Chantal Morais, Box 2218 Virden MB, R0M 2C0

Project Title: Families First Food Security Study

Is this project funded? (Please circle): Yes (No)

If yes, provide Title of Funded Project:

Name of Granting Agency:

Granting Agency Project Number:

Proposed Start and End Dates of Research Involving Human Subjects: October 6, 2009 – December 7, 2009

Preliminary Checklist:

The *Tri-Council Policy Statement* recommends a proportionate review process in which the most intensive scrutiny is reserved for the most ethically challenging research.(see *TCPS*, 1.7). The following questions are designed to aid the Office of Research and the Research Ethics Board in determining which proposals qualify for full-board rather than delegated review, those that qualify as more than minimal risk, those that might require the appointment of *ad hoc* reviewers possessing specific expertise not available from the REB's regular members, and those that require the attention of a biomedical REB:

For each of the following questions, place a mark in the box to indicate "yes":

1. Will your study involve more than minimal physical risk to your participants? ☐

2. Will your study involve more than minimal psychological risk to your participants? ☐

3. Will your study likely lead to the discovery of your participants' involvement in illegal activities? ☐

4. Will your study involve participants who are members of vulnerable populations1? ☐

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1 *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans,* i.5.

If yes, please elaborate briefly:

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5. Will your study involve clinical research, the collection of bodily tissues or fluids, or the administration of drugs or dietary supplements? ☐

6. Will your study involve First Nations communities? ☐

Research Ethics Review Criteria

Please check off each applicable box, and include a summary (either on this form or attached as a separate document) of how you will address each of these items:

[X] **Summary of purpose of research**
Be sure to include sufficient detail, described in terms that do not require extensive field-specific knowledge (similar to the statement you would prepare for a granting agency for public dissemination).

The purpose of this study is to gain insight on how families who have home visitors through the Families First program in the Assiniboine Regional Health Authority work to maintain mechanisms for ensuring food security and how families obtain enough healthy/acceptable food while also taking into consideration the families' environmental concerns.

[X] **Research methodology**
a) Describe required characteristics and number of subjects.
b) Explain the method of data collection and analysis. Explain exactly what will be expected of participants (length of time commitment, etc.) **All questionnaires and research instruments must be included as appendices**, although published instruments may be referenced with a current citation or website.

This study will use individual interviews. 15 families in the Families First program within the Assiniboine Regional Health Authority will participate in a 15 minute interview by their home visitor. The interview questions will be developed ahead of time (see appendix C) and explained to the home visitors prior to the interview process. Researcher will analyze and summarize the interviews by interview question and participant number.

[X] **Recruitment procedures**
a) Describe how potential participants will be selected and contacted. Include a copy of any advertisements used to recruit participants.

Families First Home Visitors will invite their clients to participate in an interview during a home visit.

[X] **Harm and/or potential risks to participants**
a) State clearly any potential harm or risks – physical, psychological, injury to reputation or privacy, and breach of any relevant law - for participants or for third parties (those affected by the research but who are not active research subjects).
b) If there is any apparent harm or risk, clearly explain all steps that are being taken to reduce this.

This study is of minimal physical and psychological harm. See appendix A and B for cover letters and consent forms.

[X] **Deception**

If deception is part of the research program, the researcher must:
a) State clearly why no alternative methodology, which does not involve deception, can fruitfully be used to answer the research question.
b) Provide evidence that the participant is not put at risk by the deception (or, in some cases, the failure to fully disclose the research procedure to participants because of fear of contamination of results).

No deception is used in this study.

[X] **Benefits to subjects and/or society**

Describe in detail the potential benefits of the research.

This study can benefit participants by helping the Families First home visitors find resources for those in need regarding food security. This study will help Families First programs better understand the needs of their clients and empower the participants and other Families First clients to be able to seek and find resources that they would find useful.

This study may lead to future studies on what resources would benefit and be meaningful to those who are food insecure.

[X] **Informed consent**

a) Clearly outline the measures that will be used to ensure the informed consent of all research participants.
b) **Cover letters and consent forms must be attached as appendices on Lakehead University letterhead.***
c) When phone surveys are conducted, a statement of introduction must be included as an appendix.
d) If subjects are incapable of providing consent or are legally under the age of consent, the researcher must state why this vulnerable group is necessary to the study and provide consent forms specific to legal guardians. S/he must outline procedures that will be used to inform such participants, to the best of their ability, about the nature of the research and to allow them, not only their guardians, choice with regard to participation. Children under 18 are not normally considered to be emancipated minors and parental consent is required. Consent forms are also required for children and others who, while legally incompetent, should nonetheless be informed about and consent to their own participation.
e) The researcher must illustrate that participants will be informed of their right to withdraw from the study at any time without penalty of any kind, and that they may choose not to answer any question asked as part of the research.

* In preparing cover letters and consent forms, please use the Informed Consent Checklist attached to this form.

All of the participating Families First home visitors will also be required to consent to participate in the study. A consent form and cover letter will be used (See appendix A).

All individuals invited to participate in the study will be given a brief overview of the study verbally. A consent form and cover letter will be used (See appendix B). All participants will be required to sign the consent form in order to participate in the study.

[X] **Anonymity and confidentiality**

The researcher must clearly outline the procedures that will be used to guarantee confidentiality and anonymity for individual participants. This is particularly important with regard to populations, such as students, who may be concerned about the power of the researcher in a context related

to, but not part of, the research itself. Participants who wish to be named and to waive their right to privacy and confidentiality must provide written evidence, witnessed by a third party, to this effect.

All participants will be given a participant number. Names and medical information will not be recorded on the participant's interview sheet. Home visitors will not disclose who participated in the study to any other party including the researcher.

[X] **Storage of data**
Provide evidence that the data will be securely stored for 5 years, as per Lakehead University policy.

All data including informed consents will be stored and locked at Lakehead University for 5 years with Dr. Connie Nelson after the study is completed.

[X] **Peer review**
Clearly state the intention to have the proposal peer reviewed by an external granting agency or thesis committee. Once approved by such a body, confirmation of approval must be forwarded to the Research Ethics Board. Please note that if the Research Ethics Board determines the project to be of more than minimal risk, peer review may be required by the addition of ad-hoc members to the Board, even if the granting agency for the project does not require this, or if the project is not funded.

This study will be peer reviewed by Chantal Morais' supervisor Dr. Connie Nelson and a second reader in the MPH program.

[X] **Research partners and graduate students**
Clearly state whether or not the research will involve graduate students and/or researchers at another university or institution. If graduate students research assistants will be participating, provide evidence, including a letter of confirmation from the student(s), indicating that ethics procedures have been thoroughly discussed and understood by the student(s). If you are involved in multi-site research, provide evidence that ethical approval is also being sought at any other institution where direct research with human participants will be undertaken. Ethical approval from another institution, while essential in a multi-site project, is not itself sufficient for the commencement of research with human participants at Lakehead.

Additional approval will be sought by the Assiniboine Regional Health Authority once approval is granted by the Lakehead University Research Ethics Board as this research is being done in Manitoba.

As a graduate student participating in the research Chantal Morais has completed the *Tutorial for the Tri-Council Policy Statement* (see attached), and all of the course requirements for Lakehead University's MPH program.

[X] **Conflict of Interest**
The researcher(s) shall disclose actual, perceived or potential conflicts of interest to the Research Ethics Board.

No actual, perceived or potential conflicts of interest in this study

[X] **Dissemination of research results**
Clearly state the means by which research will both be disseminated in the academic community and by which research participants may be made aware of the findings of the study.

A summary of the research results will be given to the Families First Home visitors to share with all their clients.
Publication in a peer reviewed journal will be sought.

[X] **I have completed the *Introductory Tutorial for the Tri-Council Policy Statement*** (http://www.pre.ethics.gc.ca/english/tutorial/) **and have attached a copy of my certificate of completion to this form.** *Please note that all investigators listed on this form must submit their certificates.

I am familiar with the Lakehead University ***Ethics Procedures and Guidelines for Research Involving Humans***, the current ***Tri-Council MOU*** (www.nserc.ca/institution/mou_e.htm), and the ***Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*** http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm and I agree to comply with these guidelines, and the procedures approved by the Research Ethics Board, in carrying out this proposed research.

I attest that all information submitted to the REB is complete and truthful. I understand the consequences, for myself and for the institution, of failure to comply with Tri-Council and MOU procedures.

Researchers are required to report to the REB any changes in research design, procedures, sample characteristics, and so forth that are contemplated after REB approval has been granted. Changes may not be implemented until approved by the REB. If any unforeseen incident occurs during the course of research that may indicate risk to participants, I will immediately cease research and inform the REB.

I understand that my protocol will be subject to random review for compliance by the Office of Research.

I will inform the REB when the research is complete by completing the Final Report Form.

Signature of Principal Investigator (or supervisor if graduate student research) Date

Signature of Co-Investigator(s) (if applicable) Date

Signature of Student Investigator(s) (if applicable) Date

Signature of Chair/Director Date

Please note that no one signature may be placed in two separate signature areas above.

To submit your application for ethical approval you must submit eight (8) copies this form, along with eight (8) copies of the information required to address the Research Ethics Review Criteria above (including cover letters, consent forms, and research instruments), and one (1) copy of the certificates of completion for the *Introductory Tutorial for the Tri-Council Policy Statement* to the Research Ethics Board, c/o Office of Research.

Informed Consent Checklist

General

[ ] Cover letters and consent forms are presented on Lakehead University letterhead

[ ] The language level is appropriate to the age and reading level of the subject population

[ ] Contact information for the researcher(s), the supervisor (if it is a graduate student project), and the Research

Ethics Board is always included in the cover letter that the participants will keep after they sign the consent

form.

The Cover Letter/Introductory Information (including electronic letters and consent forms) should include:

[ ] The title of the study

[ ] An explanation of the purpose of the research

[ ] The identity of the researcher and their affiliation with Lakehead University

[ ] The sponsor of the research, if applicable

[ ] A warm, non-coercive invitation to participate, addressed to the "Potential Participant"

[ ] The reason why the potential participant is being invited to participate in the research

[ ] That the individual's participation is voluntary, that they may refuse to participate in any part of the study, and

that they may withdraw from the study at any time

[ ] That participants may decline to answer any question

[ ] A description of the procedures the participants will be involved in and how much of their time will be required

[ ] Information regarding any audio or videotaping and explicit consent to such recording

[ ] Information about any foreseeable risks, harms, or inconveniences

[ ] Potential benefits (including information that there is no direct benefit, if appropriate)

[ ] A mechanism for providing referrals, if appropriate (i.e. if there is the possibility of emotional distress, or physical harm)

[ ] Information regarding who will have access to the data

[ ] Information about the storage of data (during and after completion of the research)

[ ] The degree of confidentiality and/or anonymity that will be provided and how this will be maintained (e.g.

individual participants will not be identified in published results without their explicit consent, data will be

published in aggregate form). For research involving anonymous surveys, it should be stated that the

survey instrument will not be labeled to identify who completed it.

[ ] Limits on confidentiality, if applicable (e.g. confidentiality disclaimer for focus groups)

[ ] A statement indicating the researcher's intent to publish or make public presentations based on the research

and whether or not the participant's identity will remain confidential (e.g., will pseudonymous be used?)

[ ] Offer of a summary of the research results (and a mechanism to provide the summary)

The Consent Form must state each individual's agreement that:

[ ] They have read and understood the cover/information letter for the study

[ ] They agree to participate

[ ] They understand the potential risks and/or benefits of the study, and what those are

[ ] That they are a volunteer and can withdraw from the study at any time, and may choose not to answer any question

[ ] The data they provide will be securely stored at Lakehead University for a period of five years

[ ] If applicable, that they understand that the research findings will be made available to them, and how this will

be communicated

[ ] That they will remain anonymous in any publication/public presentation of research findings.

Participants

must explicitly agree to have their identities revealed.

Other Consent Information

[ ] All participants must sign and date the consent form then return it to the researcher.

[ ] Consent must also be obtained from all agencies, partners, schools, school boards etc. that provide access to

the subject pools. Separate consent forms must be included for all of the above should this apply.

[ ] While inclusive research is important, the researcher must ensure that consent is obtained from vulnerable populations in a sensitive manner. Vulnerable populations include children, and others not competent to give free and informed consent on their own behalf. In cases like this, parent/guardian (or the individual's representative) consent must be obtained. Please note every effort should be made to ensure that participants understand and consent to their own participation as well. In exceptional cases it may be possible to obtain consent from someone under the age of 18. The researcher must explicitly demonstrate why this is necessary and how the research results would be significantly altered if parental consent was required.

Lakehead
UNIVERSITY

Master of Public Health Program
Main Office: SN1005
Ph: (807) 766-7166
Fax: (807) 766-7155

Dear Home Visitor,

I would like to invite you to participate in the Families First Food Security Study I am conducting. Having enough healthy food is important and a struggle for many families.

This study is being done as part of the requirements for my Masters of Public Health Degree at Lakehead University. The intent of this study is to see how and where Families First clients get their food and if they feel they have enough healthy/acceptable food for their families. From this study we hope to gain insight on what resources will be useful and meaningful to Families First clients.

You as a home visitor will be asked to conduct a 15 minute interview with your clients'. You will be asked to review the consent process with your client and place the signed form in an envelope and send to me. You will be asked to give the interview by asking the questions on a form that we provide. You will also be asked to write your client's answers directly on the form provided. Participation in this study is voluntary and confidential. You may withdraw from the study at any time and will in no way affect your job.

I ask that you complete the following consent form to agree to participate in the study. All forms will be kept confidential, by being placed in a sealed envelope. Only aggregate data from your clients will be reported. All information will be shared only with my supervisor and stored and locked at Lakehead University for 5 years after the study is completed. I will be giving a summary of the study findings to you to share with your Families First clients at the end of the study. You will not be identified in any way if the results of this study are published.

If you have any questions or concerns please phone my research supervisor Dr. Connie Nelson at 807-767-0480 or email at connie.nelson@lakeheadu.ca or phone Sue Wright with the Lakehead University Research Ethics Board at 807-343-8283.

Sincerely,

Chantal Morais, MPH candidate

Appendix A

Consent Form
Families First Food Security Study

I _____ agree to participate in the Families First Food Security Study, which examines how and where Families First clients get their food and if they feel they have enough healthy/acceptable food for their family.

The researcher has explained that I am asked to conduct a 15 minute interview about how my clients obtain their food and if they feel they have enough healthy /acceptable food for themselves and their families. I have read the cover letter provided.

I understand that I can withdraw from the study at anytime, even after signing this form, and will in no way affect my job. Any information that is collected about me will be shared only with researchers and will be securely stored at Lakehead University for 5 years. I will not be identified in any way if the results of this study are published.

_____ _____

Signature Date

Appendix A

Lakehead
UNIVERSITY

Master of Public Health Program
Main Office: SN1006
Ph: (807) 766-7166
Fax: (807) 766-7155

Dear potential participant,

I would like to invite you to participate in the Families First Food Security Study I am conducting on food security. Having enough healthy/acceptable food is important and a struggle for many families.

This study is being done as part of the requirements for my Masters of Public Health Degree at Lakehead University. The intent of this study is to see how and where Families First clients get their food and if they feel they have enough healthy/acceptable food for their families. From this study we hope to gain insight on what resources will be useful and meaningful to Families First clients.

You will be interviewed by your Home Visitor, which will take about 15 minutes. This interview is completely confidential and your name and medical information will not be collected. Researchers only have access to your interview with no names attached. Participation in this study is completely voluntary and will not affect any care or resources you receive from the Families First program. You may decline to answer any questions or withdraw from the study at any time.

I ask that you complete the following consent form to agree to participate in the study. All forms will be kept confidential, by being placed in a sealed envelope. All information will be stored and locked at Lakehead University for 5 years after the study is completed. I will be giving a summary of the study findings to the Families First Home Visitors to share with you if you are interested in the results. You will not be identified in any way if the results of this study are published.

If you have any questions or concerns please phone my research supervisor Dr. Connie Nelson at 807-767-0480 or email at connie.nelson@lakeheadu.ca or phone Sue Wright with the Lakehead University Research Ethics Board at 807-343-8283.

Sincerely,

Chantal Morais, MPH candidate

Appendix B

Consent Form
Feelings of food security among Families First clients

I _____ agree to participate in the Families First Food security study, which examines how and where Families First clients get their food and if they feel they have enough healthy/acceptable food for their family.

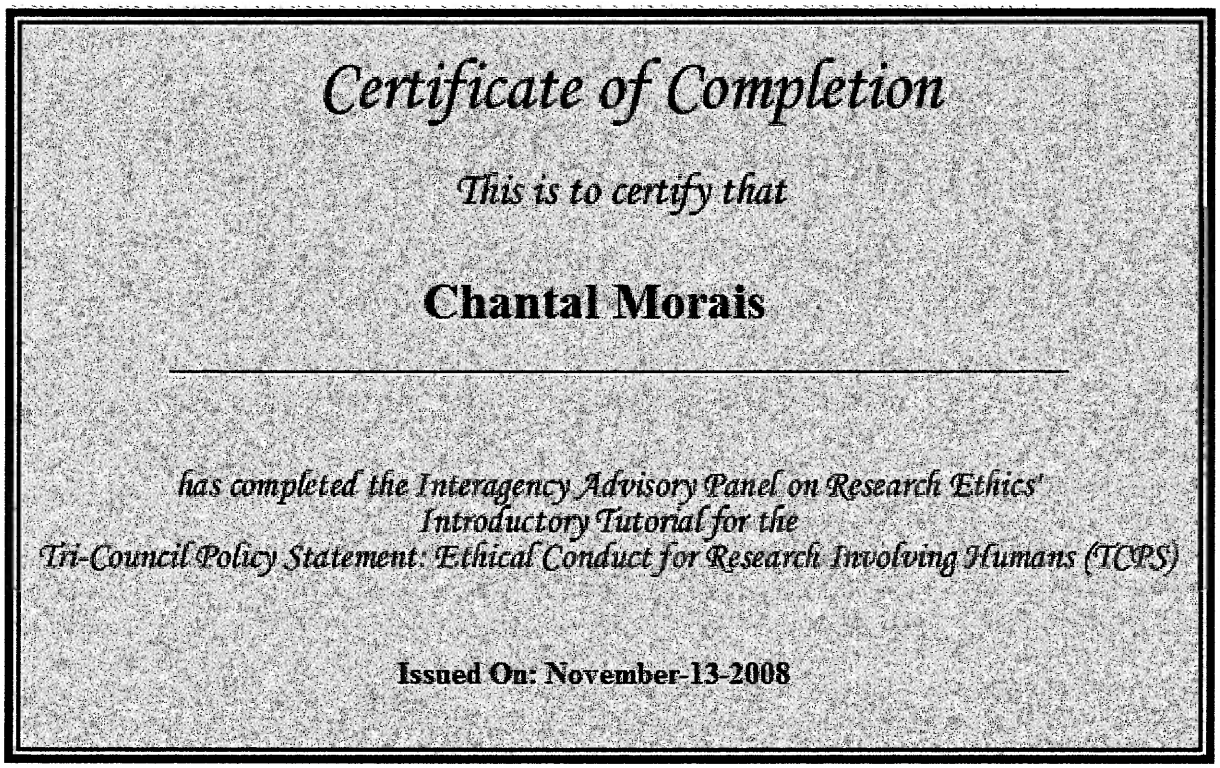
My home visitor has explained that I will participate in a 15 minute interview about how I get my food and if I feel I have enough healthy/acceptable food for myself and my family living in my household. I have read the cover letter provided.

I understand that I can withdraw from the study at anytime, even after signing this form, and will in no way affect the care and resources I receive. I can also decline to answer any questions. Any information that is collected about me will be shared only with researchers and will be securely stored at Lakehead University for 5 years. I will not be identified in any way if the results of this study are published.

_____ _____

Signature Date

Appendix B



Certificate of Completion

This is to certify that

Chantal Morais

has completed the Interagency Advisory Panel on Research Ethics' Introductory Tutorial for the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS)

Issued On: November-13-2008

Note: *Appendix 1: Families First Food Security Interview* was also submitted to the Lakehead University Research Ethics Board as Appendix C