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CREATING SPACES FOR DIETICIANS TO PROMOTE FOOD SECURITY
Can We Move Beyond the Charity Model?

by

Dayna Roslynn Albert

A thesis submitted in conformity with the requirements for the degree of Master of Arts
Department of Adult Education, Community Development and Counselling Psychology
Ontario Institute for Studies in Education of the University of Toronto

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ABSTRACT

CREATING SPACES FOR DIETICIANS TO PROMOTE FOOD SECURITY
Can We Move Beyond the Charity Model?

Dayna Roslynn Albert
Master of Arts, 1998
Department of Adult Education, Community Development and Counselling Psychology
University of Toronto

The dramatic rise in demand for charitable food assistance in Canada over the past twenty years indicates that a growing segment of society is experiencing some degree of food insecurity. In 1991, The Canadian Dietetic Association published its position that all Canadians have the right to food security and that dieticians have an important role to play. This paper looks at the question of how dieticians are promoting food security within the context of their professional role. A snowball sample was used to invite five dieticians, identified by their colleagues as actively addressing the issue of hunger in the community, to participate in a 90 minute in-depth interview describing their activities and the barriers and supports encountered in relation to their food security work. An analysis of the respondents' experiences illuminates the factors within the context of the workplace and within the professional mandate of dieticians that block attempts to promote food security initiatives. The possibilities and the limitations of the role of dieticians in the promotion of domestic food security are discussed.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>vii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>viii</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td><strong>CHAPTER 1 - BACKGROUND</strong></td>
<td></td>
</tr>
<tr>
<td>I  INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>II FOOD INSECURITY IN CANADA</td>
<td>4</td>
</tr>
<tr>
<td>1. Definition of Food Security</td>
<td>4</td>
</tr>
<tr>
<td>2. Extent and Impact of Food Insecurity</td>
<td>5</td>
</tr>
<tr>
<td>3. Responses to Food Insecurity</td>
<td>6</td>
</tr>
<tr>
<td>III ROLE OF NUTRITION PROFESSIONALS IN ADDRESSING FOOD INSECURITY</td>
<td></td>
</tr>
<tr>
<td>1. The Professional Mandate: Calling or Career?</td>
<td>8</td>
</tr>
<tr>
<td>2. History of the Nutrition Profession's Response to Food Insecurity</td>
<td>10</td>
</tr>
<tr>
<td>a. Introduction to The Canadian Dietetic Association</td>
<td>10</td>
</tr>
<tr>
<td>b. CDA's Attempts to Promote Food Security</td>
<td>13</td>
</tr>
<tr>
<td>IV CURRENT RESEARCH: FOCUS, METHODS, FINDINGS</td>
<td>14</td>
</tr>
<tr>
<td>a. Research Focus</td>
<td>14</td>
</tr>
<tr>
<td>b. Methods</td>
<td>15</td>
</tr>
<tr>
<td>c. Findings</td>
<td>18</td>
</tr>
</tbody>
</table>
CHAPTER 2 - CHARITABLE RESPONSES: TWO EXAMPLES

I INTRODUCTION

II EXAMPLE ONE: HOSPITAL-BASED FOOD RECOVERY AND DONATION 20

1. Introduction and Background of Participant 20
2. Institutional Context 22
3. The Program 22
4. Role of the Dietician 23
5. Pure Charity 24

III EXAMPLE TWO: MULTI-INSTITUTIONAL COMMUNITY DINNER 25

1. Introduction and Background of Participant 25
2. Institutional Context 26
3. The Program 28
4. Role of the Dietician 31
5. Charity Plus 31

CHAPTER 3 - "BEYOND CHARITY" RESPONSES

I INTRODUCTION 33

II EXAMPLE THREE: HOMEMADE BABY FOOD WORKSHOP 33

1. Introduction and Background of Participant 33
2. Institutional Context 35
3. The Program 36
4. Role of the Dietician 38
5. Participatory Food-Based Program I 40
Acknowledgements

This thesis is all about values. It began with following Marian Pitters' "A Values Approach to Defining a Thesis Topic" (thank you Marian!). By happenstance, I found a copy of Marian's paper at the bottom of a filing cabinet in the Department of Adult Education at OISE. Following her process led to my decision to focus the thesis around the response of the dietetic profession to the issue of hunger in the community, a focus which managed to sustain my interest over the eight ensuing years.

The winding down of the thesis journey is bittersweet. Certainly I am elated at having finally expressed, and understood, perhaps for the first time, the concepts and ideas I have been struggling with all these years. Even more powerful is the feeling that something has died; a happy death. It is as if, at the end of my life, I had the opportunity to reflect, with gratitude, upon those who had influenced and supported the course of my journey.

First and foremost, I wish to acknowledge the unwavering support of my husband, Richard Ungar, who provided unlimited emotional, technical, and practical support, especially in the final weeks, days and hours. I thank my advisor, Angela Miles, who managed to balance the yin of her sharp, academic mind with the yang of her gentle delivery and who supported me through the long, dry and the frantic, productive periods of this journey. I thank Valerie Tarasuk, whose critical and valuable comments shaped the direction of the analysis. A special thank you to David Wilson for his willingness to "pitch-hit" at the last moment. I thank the five dietician participants for sharing their experiences and their reflections. I wish to thank my Dad for encouraging me, through his actions and his words, to never give up. I wish to thank my Mom for her practical support and for always believing in me. Finally, and most significantly, I wish to thank my two sons, Rafi and Simon, for whom I persevered.
<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>The Four Foci: A schematic representation of the relationship between institution, target community and the control over program design and implementation.</td>
<td>69</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Key factors across each of the six examples of food security initiatives</td>
<td>73</td>
</tr>
</tbody>
</table>
INTRODUCTION

In response to evidence that poverty and food insecurity in Canada have risen dramatically over the past 20 years, The Canadian Dietetic Association\(^1\) (CDA) has identified the promotion of food security as a high priority for the profession (Canadian Dietetic Association, 1991) and has taken steps to support members' involvement in food security initiatives. What has been the actual experience of dieticians who are actively addressing food security issues within the context of their professional role? What kind of programs are they involved with, what roles are they playing, what are the barriers and supports they encounter in relation to their food security work and how well do they feel supported in their activities by their professional association? The purpose of this thesis is to provide some of the answers to these questions in order to shed light on what, ultimately, are the possibilities and the limitations of a professional response to the complex socio-economic problem of domestic poverty and food insecurity in Canada.

A snowball sample was used to select five dieticians, identified by their colleagues as actively addressing the issue of hunger in the community, to participate in a 90 minute in-depth interview describing their activities and the barriers and supports encountered in relation to their food security work. The respondents were drawn from five different workplace settings; hospital-based food administration, hospital-based outpatient counseling, community-based agency, community health and public health.

This thesis is organized as four chapters. CHAPTER ONE provides background information on food insecurity in Canada, the dietetic profession and the profession's internal tensions which continue to shape the evolution of its mandate. CHAPTERS TWO and THREE describe the experience of the five respondents' involvement in six food security

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\(^1\)Effective 1997, The Canadian Dietetic Association (CDA) and the individual provincial dietetic associations amalgamated to create a new national organization called Dieticians of Canada (DOC) complete with a revised mission statement and revised priorities. This paper covers a time period up until 1996, prior to the inception of the new organization and therefore I continue to refer to CDA instead of DOC.
initiatives. The two Charitable Food Assistance programs are described in CHAPTER TWO. The four "Beyond Charity" programs are described in CHAPTER THREE. CHAPTER FOUR provides an analysis and discussion of the factors which influence the availability of "space" to address food security within the context of the workplace and the dieticians' professional role. Those factors supportive of "beyond charity" spaces are highlighted. Implications of the research are presented, including the possibilities and limitations of food-based responses, recommendations for institution-based dieticians and implications for the professional association.
CHAPTER 1 - BACKGROUND

I INTRODUCTION

Over the past two decades, Canadian society has been increasingly dividing into two camps, the haves and the have-nots. Numerous socio-economic and political factors have played a causative role; the prolonged recessions of the 1970's, early 1980's and the 1990's, the resulting high rates of unemployment, the steady erosion of the Canadian social safety net, the increase in temporary, part-time and low wage jobs resulting in underemployment and a class of individuals labeled as the working poor as well as recently emerging regressive taxation policies which place a relatively increased tax burden on low-income Canadians (Davis & Tarasuk, 1994). As a result, a large proportion of Canadians do not have sufficient income to purchase foods via the normal distribution channels. They are turning in record numbers to charitable food assistance programs such as food banks and soup kitchens. Four categories of responses (Davis and Tarasuk, 1994) to domestic food insecurity have emerged, two of which are food-based; charitable food assistance programs and participatory, community-based food programs, and two of which are income-based; community economic development and advocacy initiatives. For a description of these responses see Page 6.

Since 1990, the Canadian Dietetic Association has been encouraging its members to address the problem of domestic food insecurity. Is the dietetic profession prepared, by virtue of its model of practice and the roles and skills of its members, to make a meaningful contribution? There is a large body of literature which shows that professions in general are not oriented to addressing the concerns of low-income individuals. Instead, professions tend to direct their practices to protecting areas of prestige and income, resulting in greater technological specialization and lesser emphasis on broad, social issues such as the health implications of poverty. The dietetic profession is no exception. Therefore, it should not be surprising to find that many dieticians, despite a personal commitment to addressing the issue
of domestic food insecurity, are mainly involved in charitable responses when employed by traditional institutions.

II FOOD INSECURITY IN CANADA

1. Definition of Food Security

   Hunger has been defined as "the acute physical sensation of discomfort due to lack of food" (Campbell, Katamay, & Connolly, 1988). In Canada, the magnitude of hunger and its effect upon the individual is different from that experienced by those suffering acute and chronic food shortages in third and fourth world countries. Cases of Marasmus and Kwashiorkor arising from prolonged calorie and protein malnutrition, with their obvious array of physical symptoms such as stunted growth, distended abdomens, hair and finger nail abnormalities, impaired wound healing and decreased resistance to disease, are seldom seen. Canada, like most first world nations, is rich enough that even the poorest of the poor can usually, through begging, charitable assistance or other means, find enough food to sustain themselves and their families. Instead of the extreme food shortages referred to above in reference to third world countries, "hunger" in Canada translates as a condition of food insecurity in which people are required to use a disproportionate amount of their personal resources; financial, emotional and intellectual, to obtain food for themselves and their families.

   The term food security has been used over the past decade to encompass a wider scope of factors involved in assuring a secure food supply, such as agricultural sustainability, environmental protection, food safety, food access and as a positive action agenda (Campbell et al, 1988; Davis et al, 1991; CDA, 1991; Sterken, 1991). However, the term has been criticized as being confusing, and imprecise (Power, 1995). An established and widely agreed to definition of food security does not exist. Its precise meaning varies according to
how it is defined and used. The Canadian Dietetic Association (CDA) defines food security as

...a condition in which all people at all times can acquire safe, nutritionally adequate and personally acceptable foods that are accessible in a manner that maintains human dignity (CDA, 1991, p.139).

A discussion paper published by the Ontario Public Health Association Food Security Work Group expands the definition of food security beyond the issue of access to include a sustainable, safe, high quality food supply and food consumption patterns that maximize health and minimize disease (Ontario Public Health Association, 1995). Davis and Tarasuk consider hunger as one component of food security and define the former as, "the inability to obtain sufficient, nutritious, personally acceptable food through normal food channels or the uncertainty that one will be able to do so" (Davis and Tarasuk, 1994, p.50). This definition is similar to the CDA definition of food security but includes the psychological component of uncertainty or insecurity in accessing food which is characteristic of many low income Canadians. Others have used a more quantitative, economic definition of hunger such as, "People are hungry when their regular monthly income is inadequate for the purchase of a sufficient quantity of nutritious food for themselves and members of their family" (Riches, 1989, p.150). In this paper, I will use the CDA definition of food security which focuses on the issue of access to food.

2. Extent and Impact of Food Insecurity

Lack of direct indicators measuring the extent and severity of food insecurity in Canada has led researchers in this field to draw upon secondary data such as utilization statistics from food banks and other charitable food assistance programs as well as economic indicators of poverty. (Davis and Tarasuk, 1994; Riches, 1989) The first food bank in Canada opened in Edmonton, Alberta in 1981 and by 1985 there were 94 food banks across Canada. It is estimated that in 1994, 2.1 million Canadians had sought assistance from food
banks (Davis and Tarasuk, 1994). Currently, food banks exist in 508 communities across Canada. In the month of March, 1997, approximately 669,900 Canadians turned to a food bank for assistance (Canadian Association of Food Banks, 1998). The dramatic rise in documented food bank usage strongly suggests a significant increase in the extent of food insecurity in Canada over the past 18 years.

Food banks are but one example of an ad hoc charitable food assistance system in Canada. A plethora of soup kitchens and food pantries operate year round. School breakfast programs have arisen in low income communities to ensure that classroom learning is not impaired by children beginning their school day without breakfast. (Chu & Mitchell, 1989). A network of hospitals, community centres and hostels operate an Out of the Cold program providing a bed and breakfast service for the homeless during the coldest months of winter.

Data tracking unemployment levels\(^2\), reductions in social security benefits\(^3\), the impact of tax reforms\(^4\) and the percentage of Canadians living in poverty\(^5\) gives further support to the assertion that the current socio-economic climate is pushing more and more Canadians into a condition of poverty and, consequently, food insecurity.

3. Responses to Food Insecurity

Davis and Tarasuk (1994) have identified four basic categories of responses to domestic hunger and food insecurity:

(1) ad hoc charitable food assistance programs,

\(^2\)The unemployment rate had been fairly stable at 5% for almost three decades until fallout from the recession of the 1970's, fueled by the world oil crisis, precipitated a climb in the rate to a high nearing 12% during the recession of the early 1980's. Unemployment remained above 10% for most of the 1990's (Davis & Tarasuk, 1994).

\(^3\)The Canadian system of unemployment insurance and welfare continues to be eroded, piecemeal, in response to shifting social priorities. (Davis & Tarasuk, 1994).

\(^4\)Tax reform measures at both the federal and the provincial level have led to a relative increase in the tax burden of low income Canadians (Davis & Tarasuk, 1994).

\(^5\)The poverty rate was above 15% throughout the 1980's and was 15.1% in 1992. Female-headed single parent homes had a poverty rate of 57.2% and 18.2% of Canadian children are living in poverty (Davis & Tarasuk, 1994).
(2) participatory, food-based programs targeted at low income groups,
(3) community economic development initiatives, and
(4) advocacy and advocacy-based research.
The first two can be classified as food-based responses, the latter two as income-based responses.

Charitable food assistance in Canada consists of an ad hoc array of services, funded largely through private charitable contributions, which have arisen in response to perceived local needs. Examples include food banks, food pantries, soup kitchens and other feeding programs which provide free or low-cost meals and groceries to the persons in need. Charity is a well established and socially acceptable method of providing for the poor. Biblical imperatives to give charity to the less fortunate add legitimacy to the practice and religious institutions frequently organize and administer charitable feeding programs.

Community-based, participatory food programs include community kitchens, community gardens and food cooperatives. A community development approach is often used to introduce these programs into targeted low-income communities. The meaning of the term community development (CD), like the term food security, varies according to how it is defined. In relation to participatory food-based programs, a CD approach generally means to directly involve the community in all phases of a program, from planning to implementation and evaluation (Kalina, 1994) Initially, professional expertise may be involved to facilitate the start up, however, the goal is to build capacity among members of the target community to identify their own needs and to run their own programs (Davis and Tarasuk, 1994).

Community economic development initiatives attempt to facilitate the development of job skills, income and employment opportunities within targeted low-income communities. For example, FoodShare, in conjunction with George Brown College, offers Focus on Food, an 18 month training program targeted at women receiving social assistance.
The primary goal of the program is "to enhance employability" (Food Action, 1995, p.2) in the food industry or to develop one's own food-related business.

Advocacy and advocacy-based research initiatives aim to influence policies at the federal, provincial or municipal level to improve the financial situation of the poor or to alter policies which have a negative impact on food security. Broad-based coalitions of health professionals and community groups join together to lobby for specific goals. (McIntyre, 1996). For example, Nova Scotia nutritionists conducted a food pricing survey which demonstrated that social assistance food rates were inadequate to feed a family of four. A coalition of nutritionists and anti-poverty groups used that information to lobby their provincial government to improve social insurance benefits (Dyer, 1988).

III ROLE OF NUTRITION PROFESSIONALS IN ADDRESSING FOOD INSECURITY

1. The Professional Mandate: Calling or Career?

Are professions a "calling or a career" (Sullivan, 1995)? Are they organized primarily for selfless service to society or for their own self-interest? These questions reveal the intrinsic tensions within the modern professions. Most professions, to some degree, see themselves as both (Perrucci, 1976; Sullivan, 1995). The aspect of "calling" or service to society arises from the 19th century notion of vocation (Larson, 1977) which characterized the three traditional professions of medicine, clergy and law. At that time, entrance to these professions was restricted to the upper classes who had access to the universities. Social status and income were less of a concern as these were already conferred by virtue of class membership. In the early 20th century, members of the middle class viewed the attainment of professional designation as a means of increasing their social status and income (Larson, 1977). Thus, the first half of the twentieth century saw a tremendous rise in the number of occupations which sought and received professional status.
Although the definition and attributes of a profession are debatable (Friedson, 1994), there are basic points of agreement. Generally, professional status entails a university education, a defined body of knowledge, and a recognized certificate or title which signifies admittance to the profession and authority to practice. The benefits of professional designation include (i) autonomy and self-regulation, (ii) a defined area of practice (monopoly) protected by law, (iii) social prestige, and (iv) a career with good income potential (Friedson, 1994; Jackson, 1970; Larson, 1977 & Sullivan, 1995).

The role of the professional association has been more aligned with protecting and enhancing the "career" rather than the "calling" aspect of the professional mandate (Larson, 1977; McKnight, 1977; Perrucci, 1976; Sullivan, 1995). The association acts to maintain a monopoly of practice by influencing government to restrict and restrain "alternative" practitioners who might impinge upon an established profession's turf (Gerstle & Jacobs, 1976). The association is also concerned with maintaining autonomy and the profession's right to self-regulation. Some of these activities, such as setting standards of practice and other procedures to maintain the competency of their members, are generally recognized as benefiting society.

The tension between "calling" and career is played out in each profession's mandate. The mandate is not static but rather is influenced by the members' collective vision of their profession, and by the pressures of the surrounding society (Friedson, 1994; Larson, 1976; Perrucci, 1976; & Sullivan, 1995). Generally, a mandate can be defined broadly or narrowly. A profession which operates from a narrow definition of its mandate tends to focus on narrowly defined technical problems (Perrucci, 1976). Specialization is encouraged and rewarded. Protecting professional privilege, monopoly and power are a high priority. The narrow definition of professional mandate has received much criticism. Specialization is seen to benefit mainly the wealthy and powerful (Perrucci, 1976). It operates from an ideology of individualism (Larson, 1977) and so does not address the broader social ills nor their structural causes or solutions (Larson, 1977 & Sullivan, 1995). A broadly defined
professional mandate moves beyond the narrow questions of professional technique and specialization in its attempt to address the broader questions of how to create a just and healthy society (Perrucci, 1976).

Let us recognize that our most important contemporaneous problems are economic and social and not merely technical and scientific in the narrow sense that we employ the words (Bethune, 1936, p.96).

One illustrative example is the difference between a plastic surgeon operating in a prestigious, upscale clinic who caters to a wealthy clientele and a "barefoot" doctor whose mission is to bring immunization and basic health services to isolated villages.

Contentious issues within a profession often arise out of a clash between the narrow and the broad view of the professional mandate. For example, the question of professional membership is carefully controlled and restricted by a narrow mandate. When a profession moves to embrace a broader mandate, so too does it move to widen its membership base because it wants to be more inclusive rather than exclusive6.

A second contentious issue involves the nature of the strategies employed. Consider the issue of anorexia nervosa. A narrow professional response uses the specialties of psychiatry and medicine to treat the symptoms of the individual. A broad professional response attempts to address the social pressures and media images which are seen to be the root cause of the problem. In the second approach, specialized, highly technical training is not necessary.

2. History of the Nutrition Profession's Response to Food Insecurity

a. Introduction to The Canadian Dietetic Association. The Canadian Dietetic Association (CDA) is "the national voice of members providing world leadership to achieve health through food and nutrition..." (Canadian Dietetic Association, 1995). Qualifications

6The issue of CDA's membership criteria arose when two potential interviewees related how CDA had denied them membership. For further details see Footnote # 10.
for active membership include a university degree in Foods and Nutrition, a dietetic internship or approved practicum experience and/or a Masters' degree. There are approximately 4500 active CDA members who work in a variety of settings such as health institutions, food industry, private practice, education, community health, government and research.

CDA plays a role in the undergraduate and continuing education of its members. It sets the standards for dietetic internship programs and has developed a Standards of Practice Manual. It organizes numerous professional continuing education workshops and a national conference each year. Its quarterly Journal of The Canadian Dietetic Association publishes original research, book reviews and position papers developed by CDA on issues of nutrition and health. Drawing on the expertise of its members, CDA makes submissions to government task forces to ensure adequate consideration of the nutritional implications of health policy initiatives. For example, in 1991 CDA consulted with federal policy advisors on the development of Canada's Guidelines for Healthy Eating and on legislation regarding the sale of unpasteurized and non-fortified milk in Canada (Canadian Dietetic Association, 1992). Since 1993, it has participated in the Health Canada appointed steering committee to develop a National Plan of Action for Nutrition.

In Canada, the early practice of dietetics was grounded in addressing the nutritional consequences of social inequities. At the turn of the century, Lillian Massey-Treble, the acknowledged founder of dietetic practice in Canada (Brownridge & Upton, 1993), worked to educate and feed the poor. In the late 1890's she organized classes for girls and mothers among the working poor in the basement of a mission established by her father. She hoped through education to help them ameliorate their "deplorable working conditions" (p.12). "Hunger became the raison d'etre for dietetics in Canada at the beginning of the twentieth century" (Brownridge & Upton, 1993, p.12).

In 1902, a university course in Household Science was established to prepare young women to carry on Massey-Treble's community work. Soon after, the Lillian Massey School
of Household Science and Art became the training ground for many generations of aspiring dieticians. The original focus on social issues was lost as early practitioners of dietetics shifted their attention towards establishing credibility and defining their scope of practice by developing standards of education and practice. In 1935, The Canadian Dietetic Association was founded "...to be a professional association aimed at improving the status of dietitians7 in Canada and improving standards" (Carrod, 1985 p.244). The issue of membership was a contentious one right from the start. In 1936, some women were excluded because their employment as government rural extension workers, was deemed unacceptable (Brownridge & Upton, 1993). The emphasis upon professionalization pulled dieticians away from their original social concerns. The professional association did "adopt" a child under the Foster Parent Plan in 1955 and provided financial support to UNICEF in the 1960's. Apart from these two initiatives, the profession considered that the best way to contribute to society was to develop a high quality dietetic practice.

During the era of professionalization, roughly 1930's to 1960's, the locus of the dieticians' work shifted from the community to the institutional setting where dieticians struggled to establish their role as legitimate and distinct from the work of nurses and doctors. Next came the era of specialization. The rapid growth in knowledge of nutrition and clinical disease pressured dieticians to specialize in either clinical practice; the tailoring of diets to specific disease states, or food administration; the management of food delivery systems within institutions. This process of specialization and sub-specialization began in earnest in the mid 1970's. Today, in large urban hospitals, most clinical dietitians specialize in specific disease-related areas i.e., renal, oncology, cardiology, etc. Administrative dieticians may also specialize in areas such as purchasing, food service management or computer systems related to food administration. Outside health care institutions, dietitians can specialize in community and/or public health, the food industry, research and education.

7Dietician and dietitian are both accepted spellings of the word. I prefer the former.
Specialization may begin at the undergraduate level, during the post-graduate internship (practicum experience) or at graduate school.

b. **CDA's attempts to promote food security.** What role dieticians should play in addressing the issue of domestic hunger has been and continues to be a matter of debate (Campbell, 1988; Canadian Dietetic Association, 1991; Davis et. al. 1991; Mayer, 1986; Power, 1995). In response to the economic downturn of the 1980's (Brownridge & Upton, 1993) and to pressure from CDA members who strongly believed that the profession needed to recognize and address the nutritional and health consequences of poverty, the CDA Board of Directors agreed to make domestic poverty and hunger a priority issue for the profession.

In 1989, the Ad Hoc Committee on Hunger and Nutrition was struck to research the issue and guide CDA in the development of its position. The Ad Hoc Committee recommended that CDA adopt the positive role of promoting food security, which it defines as "a condition in which all people at all times have access to safe, nutritionally adequate, and personally acceptable foods in a manner which maintains human dignity (Davis et al., 1991, p.141). In 1990, CDA's annual three day conference was organized around the theme of food security. The goal was to introduce food security as a relevant issue for the dietetic profession and to sensitize members about the existence of poverty and its adverse effects on individuals in their own communities. More than one tenth of the CDA membership attended this conference.

In 1991 CDA published its position paper, "Hunger and food security in Canada: Official position of The Canadian Dietetic Association" (CDA, 1991) and entrenched the promotion of food security as a professional responsibility of its members by naming the promotion of food security as a component of its five year strategic plan. Shortly afterwards CDA hired a coordinator of food security activities to facilitate action plans. From 1992-1994 a second Ad Hoc Committee on Hunger and Food Security emerged "to sensitize

---

8In 1996, this commitment was renewed for an additional five year period.
members to the issues of food security and to establish liaison with appropriate partners external to The Canadian Dietetic Association" (Starkey et al., 1995 p.110). In 1993, this committee organized an interactive experience, *Entering the Labyrinth of Poverty*, in which role playing was used to sensitize members to the frustrations and realities of both professionals and clients who are attempting to address issues of poverty and food security. At the 1994 conference, the Ad Hoc Committee organized a process of "mediated debate" (Starkey et al., 1995 p.110) to help members identify their divergent views with respect to food security action plans and to work towards an agreement on options and actions. CDA uses its monthly newsletter, *Communique* to keep members informed of food security activities. It encourages food security research by offering grants through the Canadian Dietetic Research Foundation and by publishing food security related research in *The Journal of the Canadian Dietetic Association*.

The dietetic profession is attempting to broaden its mandate of professional practice. Encouraging its membership to address the issue of domestic poverty and food insecurity is just one activity within a framework of promoting healthy public policy. Dr. Vivian Bruce, past president of the CDA is quoted as saying "We have been an association which has traditionally been ahead of the times, and sometimes the membership" (Brownridge & Upton, 1993, p.85). Contradictions and conflicts inevitably exist within a profession which attempts to marry professional self-interest with a broader social mandate.

III CURRENT RESEARCH: FOCUS, METHODS, FINDINGS

1. Research Focus

Over the past two decades, Canada has seen a significant rise in domestic poverty and food insecurity. What should and could be the role of professional dieticians in addressing this complex socio-economic problem? Since 1991, The Canadian Dietetic Association has taken the position that all Canadians have the right to food security and that dieticians should
play an active role in promoting domestic food security. To support this position, CDA has undertaken numerous activities as outlined above. What is the actual experience of dieticians who are attempting, through their professional practice, to promote food security? What kinds of programs are they involved with and what factors facilitate and hinder their efforts? These were some of the questions that I initially set out to answer. During the course of the present research I became interested in what factors facilitated a charity versus a "beyond charity" approach to food security and so came to focus the research around the challenges involved in creating spaces for dieticians to promote food security.

2. Methods

Research material for this study came from a variety of sources. I thoroughly reviewed the contents of all Journals of The Canadian Dietetic Association from 1985 to 1996, as well as all issues of Communique, CDA's monthly newsletter to its members. Other reference material reviewed included CDA's annual reports, position papers and newsletters of the CDA affiliated Food Security Network, a practice group comprised mainly of dieticians who are interested in and/or involved in food security issues. Finally, I interviewed a select sample of CDA members who were committed to and actively addressing food security issues. As a member of CDA since 1985, I was able to draw upon my own experiences within the profession pertaining to the undergraduate education of dieticians and the role of CDA. Inside knowledge of the profession provided useful contacts, access to documentation and lessened the degree of suspicion that a non-member researching the activities of the association might experience.

A purposive sampling method was employed, whereby I specifically searched for CDA members who were actively addressing issues related to hunger in the community from within a variety of employment settings. Selection criteria included being a member of CDA for at least five years, living within a one hundred mile radius of Toronto,\(^9\) and currently or

\(^9\)This was a logistical consideration arising from personal time and travel constraints.
recently being involved in attempting to promote food security. A preliminary list of potential participants was compiled from the membership list of the CDA Nutrition and Food Security Network and from authors who had published articles related to hunger and/or food security in *The Journal of The Canadian Dietetic Association*. Dieticians on the preliminary list were contacted by phone to determine whether they met the selection criteria, to solicit their interest in participating, to set a mutually convenient time and place for the interview and to ask them to recommend colleagues who were actively involved in addressing the issue of domestic food insecurity. All 12 of the dieticians who were contacted indicated an interest in participating, however one was leaving the country for an overseas posting and several lived outside the 100 mile radius. Two names were frequently suggested as potential participants, however they were not CDA members and had to be excluded. The interviews were conducted during the autumn of 1995.

Qualitative research methods were selected to remain open to and explore whatever issues emerged as the participants reflected on their roles in promoting food security. Five dieticians participated in a ninety minute in-depth, semi-structured interview. A copy of the

**10**These individuals told me they were denied CDA membership because their educational background did not meet CDA criteria. This is an example of how the association's broad mandate of promoting food security conflicts with the narrower self-interest aspects of professionalism. It was with deep regret that I felt compelled to exclude these individuals from this project and thus lose their experiences and their viewpoints in this research. Likewise it is certainly the dietetic profession's loss that CDA's exclusionary membership criteria deprives the association of the influence of people committed to and active in promoting food security. Some CDA members have tried to work around these barriers by setting up Ad Hoc Committees on Food Security ie. the Montreal Ad Hoc Committee and a Food Security Network which are separate from but affiliated with CDA, in which non-CDA members have been invited to participate. However, this solution still limits the potential influence of these individuals upon the larger profession. In 1994, Marsha Sharp, CDA CEO posed the question "Who do we define as members in the future?" (Communique, 1994) acknowledging the loss to the profession of experienced practitioners who do not meet the current CDA membership criteria. One proposed solution was to develop more flexible routes to qualification, but at the time of the interviews for this research, fall 1995, such possibilities did not yet exist.
interview questions can be found in Appendix A. The participants were asked to describe one or two food security-related projects they were currently or had been involved with and were asked to expand upon the goals of the program, the roles they played and the factors which facilitated and inhibited their work. They were also asked to reflect upon what it meant to them to be doing this type of work and to what extent they felt supported by CDA. All five participants agreed to have their interviews tape recorded and transcripts of each interview were made. The transcripts were analyzed inductively following the methodology of constant comparison (Glaser and Strauss, 1967). Issues and themes were identified and a systematic comparison and contrasting of participants' experiences in relation to the content-related themes helped to identify commonalties and differences among the participants.

To enhance the validity and reliability of the results and to ensure that the findings reflect the participants' experiences and not my own, various techniques were employed. A reflexive journal (Guba and Lincoln, 1985) was kept throughout the entire thesis process to track personal opinions, hypotheses and ideas. Thoughts and ideas attributed to the participants were grounded in the data (Glaser and Strauss, 1967) and supported by extensive quotations from the transcripts.

The ethical review protocol described in the Ontario Institute for Studies in Education document entitled Procedures for ethical review of student thesis proposals was followed. These procedures include: full disclosure of the purpose and methods of the study, communicating to participants that they are free to withdraw from the study at any time, written, informed consent. Copies of the disclosure letter to participants and the consent form are found in Appendices B and C respectively. Participants were referred to by a pseudonym in transcripts and in all writings; however, identification by peers may still be possible due to the participants' unique and visible work within the profession and by the unique qualities of their workplaces. In all cases the participants were made aware of this likelihood and elected to participate nonetheless.
3. Findings

Five dieticians, all of whom were selected on the basis of demonstrating a commitment to actively promoting food security through their energetic implementation of innovative programs, described a total of nine separate food security programs. Three of these could be categorized as predominantly charitable food assistance, three as predominantly participatory, food-based and three as predominantly advocacy-based. None of the programs used the strategy of community economic development. The research suggests that three main factors influenced the category of program that these concerned and committed dieticians became involved in:

(1) professional education (model of practice, roles and skills),
(2) awareness and analysis of domestic food security issues, and
(3) the institutional opportunities and constraints of the workplace.

Dieticians who received a traditional, medical model-based education were most likely to be employed within the traditional institutional setting, such as a hospital, and were most likely to implement a charitable response. Those committed dieticians whose education included alternative models of practice such as a community development framework, who had developed a critical perspective on the causes and responses to hunger, and who were employed by institutions that provided opportunities to become involved in broad-based advocacy coalitions outside of the institution were more likely to be involved in programs beyond the charity model such as participatory, food-based programs and/or advocacy-based programs.

Despite the efforts of The Canadian Dietetic Association to promote and support dieticians to become involved in promoting food security, none of the respondents felt that CDA's work directly or indirectly helped them. Several of the dieticians mentioned specific ways in which the professional association actually hindered their work. CDA was criticized for

(1) not clearly and unequivocally promoting an ethical position against poverty,
(ii) generally taking a neutralist stance regarding issues such as the direct marketing of infant formulas, and

(iii) accepting sponsorship from pharmaceutical and multi-national food corporations.

Important roles for CDA identified by the participants include revising the undergraduate curriculum for dieticians and participating in and/or facilitating the creation of broad-based coalitions to undertake specific advocacy campaigns.
CHAPTER 2 - CHARITABLE RESPONSES: TWO EXAMPLES

I INTRODUCTION

Chapter Two describes the experiences of two dieticians who were each involved in a charitable food program to promote food security. The first was a hospital-based Food Recovery and Donation program and the second a Community Dinner and networking event organized by a coalition consisting of mainly health institutions and social service agencies. The description of the program itself is accompanied by information on the education and background of the participant, the institutional context and the dietician's involvement and role(s) within the program.

The term charitable food program is self-explanatory. Charity is the most common response to domestic poverty and food insecurity. However, food security literature does not generally consider charitable food systems to be a part of a desirable food security framework (Campbell, 1988; Canadian Dietetic Association, 1991; Davis & Tarasuk, 1994; Davis et al, 1991; Ontario Public Health Association, 1995; Riches, 1989; Tarasuk & MacLean, 1990) as giving charity is a temporary solution which does not address the root causes of poverty and food insecurity. Nonetheless, charitable food assistance is of utmost importance to sustain people while more permanent solutions are (or should be) sought. Furthermore, an organized charitable response has the potential to be guided into something more than pure charity, as will be shown in Example Two.

II EXAMPLE ONE: HOSPITAL-BASED FOOD RECOVERY AND DONATION

1. Introduction and Background of Participant

Diane is an administrative dietician who graduated in 1979 with a BASc degree in Human Nutrition. During the time period covered by the interview, she was Manager of
Food Production at a large, urban teaching hospital. In the early and mid 1980's, Diane spearheaded two initiatives to address the issue of domestic hunger within her community and as a direct result of these experiences, was asked, in 1990 to join the CDA Ad Hoc Committee on Hunger and Nutrition.

Diane's early years were spent in one of the Maritime provinces, prior to her family's moving to central Canada. She was raised in a middle class family and had no awareness of the existence of poverty within her familial and social environment. "But, you're raised in a middle class environment, middle class is all you see". The issue of domestic poverty and its impact on health and nutrition was not addressed in her undergraduate curriculum, nor was there any consideration of what should or could be the responsibility of health professionals to address these issues.

I can say pretty clearly that university did nothing [towards] spawning a social sense of responsibility. And I think that in the curriculum at that time, uhmm, that was sorely missing.

Diane was influenced by a mentor, a woman who later went into the ministry, who challenged Diane to become aware of the economic and social inequities about her and to think about them in terms of cause and justice.

For me, it was probably exposure to someone I'd known in Guelph who was quite socially responsible and socially aware, and it was probably her influence more than anything else that opened that avenue....she had a very spiritual reason for her social responsibility and I think that spawned a social responsibility seed in me that has since, sort of matured.

Diane believes that it is always possible to create opportunities to promote food security.

I think when you're...aware of the issues, you try to access or create conditions wherever you can.
2. Institutional Context

Diane was head of food production in a large, urban teaching hospital throughout the mid 1980's to early 1990's. She was confident that her department was well managed and that her food and labour costs were within industry standards. The kitchen employed a cook-chill method of food preparation which meant that fresh food was cooked several days before it was needed and preserved via quick chilling. With this method the patient meal count always fluctuates between the time the food is prepared and the time it is served resulting in extra food which is ultimately discarded. According to Diane, the standard waste factor for a cook-chill kitchen is two to five percent and her kitchen operated well within that standard.

The hospital served the needs of the patients who were either admitted or treated as outpatients. It also served the needs of its medical staff and medical students. It did not have in place programs and services targeted specifically towards low income groups.

2. The Program

A colleague of Diane's mentioned reading in a church bulletin that a local charitable agency was in need of food to support its soup kitchen program. Diane recalled her reaction, "...the light just turned on in me....we were throwing [away] food". She called up the charitable agency and said to them; "I've got food. Do you need food?". That was the beginning of a long term relationship between Diane and the agency, a relationship which continued many years after she left the hospital.

The goal of the program was to transfer food that the hospital could no longer use to the charitable agency which was serving hot meals to homeless men. In order to prevent the occurrence of food-borne illness, a staff training program was needed to ensure correct food handling procedures at the receiving end. The hospital wanted to ensure it would not be subject to liability should someone fall ill or die as a result of the donated food. The agency wanted to ensure that the hospital could be counted on to supply food on a regular basis and not suddenly leave them "high and dry". Diane, representing the hospital, worked
collaboratively with the board of directors of the charitable agency to develop a workable food recovery and donation relationship.

3. Role of the Dietician

Diane's first task was to convince the agency that she was prepared to make a long term commitment to supply recovered food and was not calling simply to assuage a middle class guilt that could vanish as quickly as it was provoked.

So that was the first hurdle. Are you really serious about this or are you just another one of those middle class yuppie type people who mean well but don't do anything?

The next step was to obtain approval from the hospital administration. This involved defending the availability of excess food and assuring the hospital administrators that the hospital would not be open to liability should someone suffer ill effects as a result of eating the donated food. Diane had the statistics available to show that despite the existence of food waste, her department was running efficiently and within industry standards in terms of food and labour costs.

We had good food costs. We had good labour costs. They had no reason to doubt that we were operating reasonably well.

Regarding liability, the administration accepted Diane's professional assurance that the food was being shipped reliably and that it was up to the agency to handle it properly at their end. To help ensure that the food would be handled properly, Diane joined the Board of Directors of the agency and helped to institute a training program regarding safe handling procedures for cook-chill food. A formal release and indemnification form was not used, however Diane feels she would go that route should she be involved in a similar program in the future.
Although several other hospitals were operating in the region at that time, Diane's was the only hospital which became involved. In Diane's opinion, the others focused solely on the risk to themselves.

...there are other hospitals in (city) but none of them were prepared to help...They could not see that the need was greater than the risk involved with it.

...it was such an irony than dieticians, who claimed that they were the experts in food and nutrition, were not dealing at all with the marginal class individuals that are certainly at higher risk.

4. Pure Charity.

The Food Recovery and Donation Program which Diane initiated falls within the category of charitable food assistance. Organizing a charitable response within institutions takes initiative, energy and commitment. In order to create space for this program, Diane had to overcome barriers from both the hospital administration and from the charitable agency. To safely transfer the food to the charitable agency she had to initiate new procedures within her own department as well as at the receiving end and take on the additional role as board member of the charitable agency. She took on all of these challenges in addition to her already full administrative duties.

Diane initiated a novel and practical approach to getting food to those in need. It is interesting to note that none of the other hospitals in the area were willing to participate in a similar program despite the existence of food waste in their own institutions. It is not common practice for institutions to create mechanisms for sustained charitable giving. Some institutions will organize charity drives to collect employee donations for the United Way or to raise money for individual charitable causes, but even these occasions are not the norm and they facilitate private donations, not institutional responsibility. Still, there is less institutional resistance to a charitable response than to "beyond charity" responses. Giving charity does not require fundamental changes in social policy or the conditions of the poor
such as income, education and employment opportunities and so it tends to be less politically controversial. In the words of Dom Helder Camara, retired Archbishop of Recife and Olinda in Brazil,

When I give food to the poor, they call me a saint. When I ask why the poor have no food, they call me a communist. (undated poster published by The United Church of Canada)

In this example, a charitable response drew on the hospital's access to excess food. Therefore, despite the absence of a mandate to address the food security needs of the surrounding community, the program was approved, in part, because it did not require the commitment of additional hospital resources but simply redirected what was considered to be waste. Reframing charitable food assistance as an alternative means of waste reduction is a strategy which has been used to increase commitment to participate in commercial food recovery programs (Davis & Tarasuk, 1994).

III EXAMPLE TWO: MULTI-INSTITUTIONALLY SPONSORED COMMUNITY DINNER

1. Introduction and Background of Participant

The social movements of the 60's which struggled against racism, sexism and classism were an early formative influence upon Elaine. They sensitized her to the existence of the many types of oppressive barriers in society. Not wanting to simply accept an oppressive society, in the early 70's she joined an idealistically motivated intentional community which lived communally, recycled long before it was fashionable and generally wanted to make a positive contribution to the world.

...before I went to university, I was part of a group that wanted to make a difference in the world. OK. We were young and ideal I guess. (Elaine)
As part of their positive contribution, they grew produce which they sold cheaply in low income neighbourhoods. In the early 1980's, Elaine participated on the Food Advocacy Coalition of Toronto. Thus, she had a history of active involvement in addressing the issue of access to food for low-income people prior to becoming a dietician.

Elaine graduated with a B.A.A. in food and nutrition in 1986. Unlike the undergraduate curriculum at the various universities where the other participants studied, Elaine did receive some exposure to the issue of food security and domestic hunger. For her fourth year thesis she chose to undertake a nutrition survey of sole support moms living in a low income neighbourhood to determine if their access to healthy food was limited as a result of a knowledge deficit or some other factor. Her research demonstrated that knowledge deficit was not a factor limiting access. Rather, the access problem could be directly related to low income and the high cost of being dependent upon local variety stores. Elaine learned through this research that low income people need higher incomes, not education. She also learned that a dietician would be missing the mark by going into these communities to teach about healthy eating practices because the residents do not have access to affordable, healthy foods.

...our hypothesis was related to whether or not it was a knowledge problem that people couldn't access food. And what we found out, what we proved was that it isn't a knowledge problem. It has nothing to do with knowledge.

Since 1990, she has been employed as an outpatient dietician who mainly provided one-on-one nutrition counseling. At the time of the interview, she was completing a post-graduate M.Ed. degree in adult education.

2. Institutional Context

At the time of the interview, Elaine had been working as an outpatient dietician whose office was housed in the Department of Family Medicine of a large, inner-city hospital. Part of the hospital's mission was to serve its local geographic community, which
was primarily inner-city, low income. According to Elaine, the change in mandate occurred in the early 1990's. The province had asked all hospitals to review their programs and services. The expectation was that duplicated services would be cut and some hospitals would merge or close. Such was the fate of several hospitals in the city, however, Elaine's hospital, with its unique, geographically centered focus on inner-city health, managed to survive the cuts.

This hospital has an emphasized area called inner-city health. This hospital has decided it wants to serve its local geographic community.

The hospital encourages outreach programs through the use of satellite clinics. It allows some staff members to put time and effort into developing links with community-based agencies in order to develop collaborative projects. For example, the hospital runs an Out of the Cold shelter and breakfast program in the winter. In order to receive funding, new programs must involve collaboration with other institutions or community-based agencies.

So, if you're going to start new programs they have to be collaborative and funding has to shift.

Elaine speaks highly of one particular nurse whom she considers to be an excellent community development role model. The nurse has spent many years developing relationships within the community and is trusted and respected by a large group of local agencies and advocacy groups.

Actually, I'm very impressed with this nurse...I've learned a lot from her actually. Uhm, and she also has a lot of community development skills, as I mentioned before, which I don't think we get. You know, we don't get that kind of training.

Elaine feels that her supervisor as well as the highest levels of hospital administration support her work in promoting food security.
our CEO, (name) has done a number of things internally in the hospital that has said to me, you have permission to take a risk.

For example, the hospital sponsors employee self-management training, which gives Elaine the message that she is supported in trying new things, without needing to seek permission before making any and all decisions. The vision statements written by the hospital, the Department of Family Practice and the Department of Nutrition also inspire and give permission to get more actively involved in projects which promote inner-city health. When asked if she thinks the vision statements are sincere or just pieces of paper, Elaine responds,

I'm acting as though they mean what they say and nobody has told me otherwise.

The hospital receives its funding from the provincial government. One could expect a natural reluctance to disturb or antagonize one's source of income. Awareness that the province was considering closing some hospitals, I suspect, may have made them more reluctant than ever to place themselves in the government's bad books. That may explain, in part, the hospital's prohibition against political advocacy which might involve negative political messages.

...they really see themselves as advocates, politically and this hospital cannot be seen that way...We couldn't be part of creating literature that would say, the Harris government is, you know, is this or that or the other whereas one group, I think, wanted to make it a little bit more political.

3. The Program

The hospital worked collaboratively with a variety of health, education, community and church representatives to sponsor an event which included entertainment, dinner, facilitated discussion and information about ways to access low cost or free food to which 220 low-income people were invited, including 50 children.
Elaine credits the hospital's community nurse as being responsible for bringing together the broad coalition of agencies to plan the event. It attests to the years the nurse has spent developing relationships with local community agencies.

Well, one of the nurses at one of our satellite clinics in [community] has been very involved in networking in that local community for several years. And she's really the person who brought all the partners together.

On the surface, the primary goal of the evening was to provide a healthy meal for families and individuals who were struggling to find the resources to put food on the table. However to avoid the stigma associated with a soup kitchen, the planning committee billed it as a community event, with the provision of a complimentary meal as an aside.

And we really de-emphasized the meal. And so, we've invited people, families for an evening of fun and music and entertainment, and somewhere we say, oh, we will be pleased to serve you dinner.

The entertainment consisted of a local high school band, a song leader and The Raging Grannies, a group well known for their entertaining political satire.\(^\text{11}\)

A second goal was to help people bring the issue of food insecurity into the open so that they would not feel so alone in their struggles, and might find support talking with other members of the community who are similarly affected. Participants were seated at tables of ten with a volunteer at each table who facilitated a short discussion of how they were coping in these economically stressful times. Meanwhile, the children participated in activities under the direction of hired baby-sitters.

\(^{11}\text{The hospital insisted that The Raging Grannies be advised not to include any negative references to specific political parties although they could satirize the political process in general.}\)
You know, people may be harbouring this issue internally and think that they're alone and think that they're isolated and so we're trying to get it out of the closet and bring people together around the issue. And we're hoping that some people will feel that they can get involved.

To address the issue of involvement, there were short presentations by local agencies organized around increasing access to food, such as the People's Food Market, food buying clubs, community kitchens and community gardens. After the presentations, posters and representatives from each of the community agencies were available to provide more information about how to get involved. The hospital researched and published a brochure listing the addresses within the local community where one could access free or subsidized meals and groceries. This brochure was also translated into Chinese, the predominant second language of the community and was given to each participant that evening.

A third goal was to receive feedback from the community regarding whether residents wanted programs such as the community dinner repeated or, alternatively, what kinds of programs they would like to see. Included in the goal was having residents more directly involved in the planning.

...we want the community to tell us what it is they want and hopefully get them involved in that. Not doing it for them.

The planning committee for the event consisted of a large group of representatives from health, education and community agencies as well as individual members of the targeted community. The hospital had a representative from each of the departments of Family Medicine and Nutrition. The public health department, a local community health centre and a local community centre were represented as well as a local church, which housed the event, and a local university which provided student chefs to cook the meal. Representatives from community-based service agencies as well as lay community representatives also sat on the planning committee. Each member of the planning committee brought a slightly different vision for the evening to the table and each brought different
resources. For example, the Nutrition Department managed to get all of the food donated from its suppliers and printed the brochures out of its own budget. The university provided student volunteers to help with cooking and clean up. The church, which had large cooking facilities on site, housed the event.

4. Role of the Dietician

Elaine was the liaison between her department and the planning committee regarding such issues as obtaining donations from food suppliers and providing photocopying and translation services out of her department's budget. In group discussions, Elaine likes to play the role of the facilitator, helping each party to understand the others' points of view. Having studied facilitation and small group theory and practice in graduate school, she was able to use her knowledge of how groups operate, and the pitfalls and opportunities available on the road to achieving consensus, to help the group manage itself.

It's a helpful role. If people are trying to get something across and I can see that other people are antagonistic to it, I'll try and reframe it in a way that can be heard. Or, I'll bring it back to the person and say, "it sounds like this is what you're saying", in order to clarify it.

Elaine, who runs a community kitchen out of the hospital's satellite clinic, made a presentation together with some of the participants, about their kitchen and invited members of the community to join them or to get more information on how to start their own community kitchen. Also, Elaine was a member of the volunteer clean-up committee.

5. Charity Plus

The Community Dinner was primarily a charitable food assistance program, however, Elaine described several features of the program which pushed it beyond a pure charitable response. For example, the meal itself was de-emphasized in order to reduce the stigma of charity. The evening was structured to facilitate discussion and mutual support among participants in order to bring the issue of access to food out of the closet. Opportunities to learn about and get involved in alternative, food-based programs aimed at
low-income groups, such as collective kitchens, community gardens and food buying clubs were provided. Thus, the seeds were sewn to encourage the involvement of community members in more participatory, food-based programs. Elaine's hospital, whose mission includes promoting the health of its local inner-city population, was thus able to justify its involvement in an outreach program targeting low-income people.

Although it was a challenge to achieve consensus regarding a common vision for the evening among the multitude of collaborating institutions, which included some advocacy-based community agencies and individuals with community development backgrounds, this process was likely what moved this event beyond a simple one night soup kitchen. The hospital's involvement was a mixed blessing. On the positive side, the hospital's nurse was credited with bringing together the wide group of collaborators as a result of her years of building community relations, which she developed under the support of the hospital administration. As well, the hospital brought many resources to the event such as donated food, photocopying and translation services. On the negative side, the hospital vetoed any criticism of the provincial government which thus inhibited attempts to make visible the link between poverty and socio-economic policies.
CHAPTER 3 - BEYOND CHARITY RESPONSES

I  INTRODUCTION

Chapter Three describes the experiences of three of the participating dieticians in four "beyond charity" programs. The first is a Homemade Baby Food Workshop series, the second a Community Garden at a Shelter for Women, the third a FAX Campaign and the fourth a Discussion Paper by the OPHA Food Security Work Group. The description of each program is accompanied by information on the education and background of the participant, the institutional context and the dietician's involvement and role(s) within the program.

In this paper, a "beyond charity" program is defined as a program to promote food security which does not involve charity, but rather attempts to make a more permanent impact on the food security needs of the target community. This is undertaken either through involving the community in participatory, food programs in order to develop some degree of self-sufficiency and empowerment or through advocacy initiatives that attempt to enact legislation to improve the material conditions of the food insecure.

II  EXAMPLE THREE: HOMEMADE BABY FOOD WORKSHOP

1. Introduction and Background of Participant

Bev was born in Malaysia and came to Canada with her family as a young girl. Her hard working immigrant parents imposed a strict code of behaviour and high expectations for the educational and career achievements of their children. Her mother worked as a cook and Bev attributes to this her interest and practical approach to the preparation of food. In university, Bev became involved with the International Home Economics Association because of their links with home economists in developing nations, a personal interest of hers. At the time of the interview, Bev had been a member of the Canadian Dietetic
Association for five years. She completed her undergraduate nutrition degree in 1988, earning a B.Sc. from a large metropolitan university, followed by a one year general internship program at an urban teaching hospital. In 1991 she was hired as a dietician for a small, northern Ontario hospital serving an extended, primarily rural First Nations population. The position interested Bev as it afforded her the opportunity to develop on-the-job experience in both clinical and administrative functions. Such broad experience, she felt, would enhance her future employability upon leaving the north.

Bev found her experience in the northern community to be personally and professionally transformative. On the personal level, living away from home in such a different community helped her develop greater self-confidence. She found the people of the north to be open and accepting of her and colour blind as to her being a member of a visible minority. She discovered many similarities between the First Nations people and people of her own cultural heritage and this helped her to feel even more comfortable and to develop trusting relationships.

...I didn't really know myself as a person. Then when I got to Moose Factory it was an incredibly welcoming environment where they accepted me for who I was and that started some of the seeds of change, to get to know myself better. (Bev)

She came to recognize the limitations and gaps of her professional education which did not give much consideration to learning and respecting the innate knowledge of traditional people and the material circumstances governing their lives such as the high cost and low availability of fresh produce and the low cost and high availability of "junk" food. She also learned the value of dropping the professional "facade" and dressing according to the prevalent community dress code in order to gain trust and influence.

...from my experiences in First Nations' communities, that's where I learned, really, you have to dress down.
After completing her contract in the north, she was promoted to oversee all provincially administered nutrition programs for First Nations' Communities. While in this job she became involved in a food cost survey of fly-in communities which convinced her that these communities required some form of government subsidy to reduce the price and increase the availability of nutritious foods because without intervention, it was more profitable for food distributors to sell potato chips and candy bars than fresh fruits and vegetables.

2. Institutional Context

FoodShare is a non-profit, charitable, non-governmental organization (NGO) whose mission is "working with communities to end hunger and improve access to affordable, nutritious food". (FoodShare, 1996 p.1). According to its February 1998 "Food Action" newsletter, FoodShare has 10,000 individual donors and over 2000 community members who receive the newsletter and are eligible to vote at the Annual General Meeting. It also seeks corporate donors and grants from numerous private charitable foundations to fund specific programs. Since 1985 it has introduced a wide variety of innovative, community-based programs. Field-to-Table is a program which supports local farmers and local food production by forging direct links between food producers and consumers. The Organic Food Box is a low-cost organic foods distribution network. FoodShare also supports the creation of local community kitchens and community gardens. Its Hunger Hotline volunteers advise callers concerning the location of emergency food services in their neighbourhoods. Bev was involved in FoodShare's program; "Healthy Babies Eat Home-Cooked Food", a baby nutrition program involving community-based workshops.

As a means of stretching its resources and influence, FoodShare forges partnerships with established community and health agencies, and with those advocacy groups that work on behalf of low-income people. It has organized workshops on community gardening in conjunction with the East Toronto Green Community and community kitchen training workshops in conjunction with local public health departments and community health
centres. It has worked in tandem with the Coalition for Student Nutrition to help organize and obtain support for affordable school food programs in low-income neighbourhoods and has lobbied the government to continue and increase financial support for these programs. FoodShare is committed to the benefits of cross-sectorial discussion and collaboration in the food security movement. Thus, in January, 1998, it hosted the Food 2002 Round Table which brought together representatives from health, community and agricultural agencies, government, the food industry and other private sector delegates to seek "possible areas of consensus in answer to the question: 'what would it take to ensure that everyone in Ontario has access to affordable, nutritious food by the year 2000' " (Field, 1998).

3. The Program

Bev was hired in September, 1994 by FoodShare in order to develop and run their infant feeding program. She was chosen for the position above all other applicants because of previous experience working as a cooking demonstrator for a food company. According to Bev, this indicated to the agency that she knew how to take a practical, hands-on approach to food and nutrition. Many of the dieticians FoodShare had encountered were too clinically oriented; e.g. more comfortable talking about nutrients than the everyday language of food.

FoodShare, in conjunction with a local public health department, conducted a needs assessment survey among groups of parents participating in a pre and postnatal support program, asking them what they needed in order to be able to help their families eat more healthily. The participants indicated the greatest level of interest in programs to teach them how to make their own baby food. Funding was obtained from the federal government's CAP-C prenatal nutrition program for a one year contract to hire a Baby Nutrition Program Coordinator. Bev was hired in September 1994 to develop and initiate the workshop series "Healthy Babies Eat Home-Cooked Food".

Prior to joining FoodShare, Bev was a supporter of the charity model of helping the poor. FoodShare's practical approach to helping low income communities develop their own skills and capacities changed Bev's views on helping.
It wasn't so much along the lines of empowerment or self-reliance. And that is something that I've only become more aware of as I've spent my year in FoodShare.

FoodShare wanted to offer free workshops targeting low-income families on how to prepare their own nutritious, low-cost baby food.

...we wanted to offer the course for free and we wanted to go where the parents were. They weren't going to come to me but I was going to go out to them.

FoodShare believed that most people had lost confidence in their ability to make their own baby food and were dependent upon commercial sources which were more expensive and sometimes less healthy in so far as sugar and fillers are sometimes used. Beyond the benefits of reduced cost, was the opportunity to help parents feel empowered and in control of their baby's nutrition. By learning how to make homemade baby food, which can be as simple as mashing a banana with a fork at a cost of 10 cents a serving instead of buying a 59 cent jar of banana baby food, the parent not only can feed h/er baby at less cost, but can also derive a sense of personal satisfaction and confidence in h/er abilities.

One health goal was to lower the incidence of early introduction of solid foods, a practice which can lead to choking, overfeeding, allergic reactions and premature cessation of breast feeding. Other topics included food variety and texture progression, developing a positive feeding relationship as a basis for a lifelong healthy eating pattern and validating an appreciation for family meal times. The cultural foods and practices as well as the practical experiences of the participating parents were to be respected, in so far as they were consistent with current infant health literature.

FoodShare, lacking the resources to pay for workshop locations or the necessary social marketing to attract participants, approached the local public health department to seek their support in integrating the workshop into their pre and postnatal groups. These
groups meet across the city in community centres, hospitals and school activity rooms and are usually attended by groups of between ten and twenty parents. The health department invites all parents of newborns to attend these groups however, according to Bev, approximately 50% of those who do attend could be categorized as low or limited income.

FoodShare has also brought the workshop into local food banks, some of which operate their own programs for low-income parents. At the time of our October, 1995 interview, Bev estimates that approximately one hundred parents had attended in workshop. In order to reach more parents and to more effectively target the multitudinous areas of low-income and culturally diverse neighbourhoods in this large, urban centre, Bev expected to train peer assistants who would take the workshops back to their own communities.

4. Role of the Dietician

The first phase of Bev's work required mostly research during which Bev developed the content of the workshop. This involved collating current infant feeding guidelines and developing simple reference material suitable to a multi-ethnic, and low literacy population. She also tested and chose an inexpensive hand-operated food mill to be used and offered to participants either free or at cost. Then, because she had no direct experience of feeding infants herself, she experimented with using the food mill to make a variety of foods of different consistencies and conducted taste tests with experienced parents in her office who provided valuable feedback.

The second phase involved contacting and convincing the public health nurses who run the pre and postnatal workshops to integrate the baby food workshop into their programs. She had to present the benefits of the program in terms that would convince the nurses of its worth and how it would complement, not duplicate their program. This became easier as word of mouth spread the benefits of the workshop.

\[\text{In order to achieve greater penetration into a variety of communities, FoodShare now trains community-based workers who bring the workshops into their own communities.}\]
The third phase was leading the workshops. Bev wanted to make each workshop a hands-on and fun experience. She wanted participants to feel comfortable and to share their own feeding experiences, problems and solutions. Where logistically possible, the workshops were divided into four separate half-hour segments to be run on consecutive weeks. In the first session, she introduces and demonstrates the operation of the food mill and conducts taste comparisons between commercial baby food and the homemade food which she prepares in front of the participants. Invariably, the parents prefer the taste of the homemade version. She presents a cost comparison which shows homemade food, with the exception of out of season green beans, costing much less. She then shows a segment from a film entitled "Feeding With Love and Good Sense" by Ellen Seder, an expert on the parent-child feeding relationship. After a free-flowing discussion period, parents are asked to bring in their own food to prepare for next week's session. Particularly encouraged are traditional ethnic foods. The following three sessions follow the same format but cover the texture, variety and feeding relationship issues of increasingly older babies, toddlers and preschoolers. One session focuses on fruits and vegetables, another on meats and vegetarian alternates.

Bev encourages the nurses to participate during her workshop in order to be available to handle any medically-related questions which Bev is unable to answer. In an effort to keep the workshop participants feeling comfortable enough to ask questions and share information, she likes to maintain an informal and egalitarian atmosphere. This has meant a conscious decision on Bev's part to drop the professional "facade" by choosing to wear casual clothing and avoid professional jargon. It also means seeking and valuing the experiences of the participants and sharing examples from her own personal experience. She found that it was frequently a challenge to coax the nurses to also drop the professional facade and relate as parent-to-parent rather than as professional to parent.

[I wanted] to draw them out of their professional nursing role and identify with
the parents as parent-to-parent, more especially for those who have their own child. And it was surprisingly difficult to get that started...by getting out of our respective professionals' roles, whether as a dietician or a nurse, I'm asking you to be a human being for a while, and sharing the knowledge that you have gained from your own parenting, and not hiding behind [your role]. And there's always fears and that associated with this, right? Because all of a sudden, uhm, you could be easily judged for your own values as opposed to on a professional value system.

5. **Participatory Food-Based Program I**

This program fits Davis and Tarasuk's model of a *participatory, food-based program* (Davis & Tarasuk, 1994). The program does not involve charity. Instead it teaches participants the skills needed to reduce their dependence upon expensive, commercial baby foods. However, saving money is not the sole goal. The workshop is designed to enhance the participants' sense of self-confidence and empowerment, and to validate and celebrate the importance of every day events such as family meal times and health-appropriate cultural foods and practices.

One of FoodShare's strategies\(^{13}\) is to provide, not charity, but empowerment; the means for low-income people to help themselves through community networking, organizing and skill-building. Poverty can foster learned helplessness and hopelessness (Smillie, 1991) which are demoralizing. Participatory programs can help to re-invigorate participants to develop renewed self-confidence and energy which may spill over into other areas of their life (Kalina, 1995, Smillie, 1991). Other benefits include networking and mutual support which arise when programs are community-driven and community-based (Davis, 1992). Another one of FoodShare's strategies is to encourage locally produced, organic foods as a strategy to build local production for local use and to decrease consumers' dependence upon food giants and agri-business.

\(^{13}\)FoodShare also encourages the use of locally produced, organic foods as part of a strategy to build environmentally friendly local production for local use and to decrease consumers' dependence on food giants and agri-business. Workshop participants were invited to participate in the Organic Food Box and other such FoodShare programs.
Although Bev's participation was limited to the baby food program, FoodShare itself also participates in numerous advocacy programs aimed at influencing government policy in ways to improve the condition of vulnerable low-income groups.

III EXAMPLE FOUR: COMMUNITY GARDEN AT A SHELTER FOR WOMEN

1. Introduction and Background of Participant

Carol grew up in a working class family. Her mother owned a bakery and was a union organizer. Her father was active in socialist politics, first as a member of the CCF and then the NDP party. Community and political organizing were everyday topics of conversation at mealtimes. "So, I come from a very strong community development framework in my family". It did not occur to Carol that her family was somewhat unusual in this respect.

Carol completed her undergraduate nutrition degree in 1988 and was immediately accepted into a general dietetic internship program. In 1990, she was hired by a large teaching hospital as a clinical dietician and worked both in the intensive care unit (ICU) and as an outpatient dietician. ICU work is highly technical, involving the nutritional support of critically ill patients. For this reason it is considered to be a prestigious, high profile position. Carol came to realize that she did not enjoy the nature of ICU work which dealt only with people in the acute stage of their illness. She thought she might prefer working with people to keep them healthy. She decided to return to school to pursue a post-graduate program in the field of wellness.

In 1990 Carol enrolled in the Master of Environmental Studies program at York University and graduated with an M.E.S. in 1994. She took courses in health promotion and community organizing with Trevor Hancock a well-known professor in this field. She also studied principles of adult education and group facilitation. An introductory course in food policy captivated her and she subsequently decided to focus her thesis on the role of healthy
public policy\textsuperscript{14} in promoting food security. She became involved in the university's Community Garden Action Group and later with Grow TO Gether Community Gardeners. She had managed to link food and politics within her career path. This was the direction she now wanted to pursue.

2. \textbf{Institutional Context}

In 1991, Carol was hired by a community health centre serving a multi-ethnic and generally working class neighbourhood of a major city. Carol did not want to work purely as an outpatient dietician doing one-on-one nutritional counseling. She wanted to be involved in community organizing. Thus, she negotiated up front with the health centre that 50% of her time would be for health promotion activities, which in her view is community organizing.

In contrast to public health centres which serve the general population, community health centres have as their mandate to target programs to defined segments of the population. Periodically, the community health centre undertakes a strategic planning process whereby it identifies its target populations. At the time Carol was involved in the community garden project, targets included the homeless and the low-income elderly. Community health centres also serve specific geographic regions known as catchment areas. Thus, for any program to be approved, it must be within the centre's catchment area and linked to a program serving a targeted population.

\begin{quote}
I have a certain catchment area that I can serve. So, uhm, it has to be within this area and it has to be targeted through a program to specific groups. (Carol)
\end{quote}

\textsuperscript{14}"Healthy public policy" is a public health concept referring to the selective use of government policy to further public health goals.
3. The Program

While participating in setting up a study for a nursing clinic at a women's emergency hostel, Carol took note of the environment the residents were living in. The population consisted of a diverse and highly stressed group of women. They were homeless as a result of mental illness, drug abuse, poverty and/or domestic abuse. The shelter provided for their basic needs, but there was no quiet space available; no place for tranquillity or recreation, aside from a television common room.

So, it's sort of a real mishmash of people there and there wasn't really even a quiet space that people could sort of relax in.

Carol noticed an unused third floor patio/rooftop. The shelter was located in a semi-industrialized neighbourhood and the scenery on the patio was quite uninspiring. Nonetheless she thought it had the potential to be transformed into a rooftop garden, into a place of beauty to be created and maintained by the residents for their own enjoyment and pride.

Once approval to pursue the project was received from the community health centre, Carol approached the executive director of the hostel and obtained her approval. She then applied for and received a $1500 grant from the Friends of the Environment Foundation at Canada Trust. Carol hired the landscape architect with whom she had worked the previous year in setting up another community garden and who had experience and good skills in working with marginalized and highly stressed groups around the issue of gardening. He was hired as a consultant for the start-up and the Community Health Centre (CHC) paid his salary for one week. His expertise was essential in helping to choose plants that could survive and thrive in the micro-climate of a rooftop garden. For example, he recommended planting a Siberian Maple Tree which can be successfully grown in a container and survive cold, heat and wind.
That's why it's really great to have horticultural expertise, because...he chose the plants that were specific to containers and very hardy.

Much of the work to create the garden was achieved through donations of labour and materials from volunteers within the community itself. Through contacts in the community, a local Portuguese gentleman donated numerous 45 gallon wine and olive oil barrels which were sawed in half to create half barrels for planting crops. A handyman at the shelter built window boxes out of recycled wood based on the design specifications of the landscape architect. Volunteer labour painted an ugly old brick wall and the architect recommended a hardy, flowering vine to plant at its base. Community leadership was found in the form of a retired couple who were still active in the running of the shelter and who were themselves avid gardeners. Through their efforts, the project is still alive several years after Carol's involvement ended.

The key, I think, to any community organizing is working on the strengths of the people that are excited about the project. In this instance it was primarily this retired [woman] and her husband.

The community garden had several positive outcomes. On a nutritional level, the extra vegetables and herbs supplemented the residents' diet. On a recreational level, the patio was transformed into an appealing and peaceful oasis used by the residents for meditation, BBQ's, picnics and exercise classes. On a therapeutic level, the act of participating in the planning and ongoing maintenance of the garden provided the residents with a much needed source of simple pleasure and sense of accomplishment.

Finally, it was Carol's goal to get the project up and running autonomously, which involved identifying and developing leadership within the community, because without it the project would fold as soon as Carol left.

I am very proud of that project because it has been self-sustaining and it's been a real positive influence.
When the outcome of the project was evaluated, it is interesting to note that what the participants themselves most appreciated was not the availability of fresh vegetables and herbs to supplement their diets but rather the creation of the peaceful oasis that the rooftop garden provided.

4. **Role of the Dietician**

   In general, Carol perceives her major role to be that of a facilitator, to enable the project to get off the ground.

   I guess I'm sort of the facilitator....I would say it's [her role as a dietician] gone from clinician to educator to facilitator.

As a facilitator, Carol does not see herself as the prime moving force. Such a role would be counterproductive because the project would likely fail as soon as she moved on. Instead, she aims to identify and develop the leadership within the community that is necessary to the project's success and longevity.

   ...the leadership. That's the critical piece. Because if you don't have that from within the community then...it won't sustain itself.

   Carol found it easy to introduce the idea of the community garden and to get it off the ground. In Carol's own words:

   Gardening is a pretty non-threatening sort of thing. And so people, I think, can see the merits of it, both from a health / exercise stand point as well as [from a] food / hunger standpoint. So, it sort of merges two things and it's pretty low-key.

Through explaining the rationale, the goals and the potential benefits of the project, Carol gives people a vision to get excited about and to work towards. As interest and excitement about the project grows, it seems to create its own energy which draws in volunteers who want to be associated with it.
Another of Carol's roles is that of resource procurer. She writes up the grant applications to seek funding and writes letters of support to garden centres appealing for gift certificates or in-kind donations of plants and soil. One particularly generous garden centre responds every year to a request for a $50 gift certificate. She also obtained approval for the Community Health Centre to pay the salary of the consulting landscape architect.

But it's really more the organizing, ah, seeing where to get resources, having a handle on writing up grant applications, you know, writing letters of support to get freebies from gardening companies, and those sorts of things.

The day-to-day maintenance of the garden is carried out by the residents of the shelter. Carol and the landscape architect helped to institute a process of weekly meetings where the residents discuss and work out all garden-related concerns. For example, the residents needed to decide how to arrange the patio, how to divide up the chores and how to handle issues of dispute and disagreement. Watering is a critical issue for container gardens and under and over-watering was a frequent problem. Experienced facilitators help the group develop a functioning process whereby all members trust that their concerns will be heard and addressed.

We really set up a really good process in place in terms of having the gardeners meet once a week to discuss their concerns, over-watering, under-watering, who's fertilizing, who's not, (laughs), all of those things... [like] group dynamics that have to get worked out.

Lack of attention to group dynamics can sabotage the project and alienate participants. That is why it is so necessary to take the time to help the group develop a functioning group process.

That's one thing in doing community organizing, like [sic] you sort of keep track of... group dynamics, because they can get out of hand. They're very minisculous (sic) things, but are really important to people.
5. Participatory Food-Based Program II

The Community Garden at a Women's Shelter fits the model of a participatory, food-based program (Davis & Tarasuk, 1994) located within the target community. It is participatory in that the shelter's administrators as well as the residents were involved in the planning, the building and the maintenance of the garden. They were guided in this task through the facilitative efforts of Carol, a dietician who had previous experience in developing community gardens and in facilitating community development projects, work which she refers to as "building capacity within communities". The Community Health Centre supported Carol's involvement in the Community Garden because targeting the homeless for services was part of its strategic plan. Carol's strategy of negotiating the right to use 50% of her time in community development programs lent further justification to her involvement in a Community-Centred, food-based program. The CHC's participation provided the necessary financial support and expertise needed to initiate the program, but in a "hands-off" manner that allowed the garden to be developed to suit the needs of the local community.

IV EXAMPLE FIVE: THE FAX CAMPAIGN

1. Introduction and Background of Participant

Anne comes from a close-knit family and loves children. She has always loved children and describes herself as having been the baby-sitter on the block during her teenage years. Having her own children has served to intensify her belief in the importance of supporting families and children.

I've just always had an interest in families, in children. Uhm, probably has a lot to do with my upbringing too. We have a very close-knit family. (Anne)
Anne completed her B.Sc. in nutrition in 1983 and immediately enrolled in a Masters of Health Sciences program at the University of Toronto, specializing in community nutrition. She has two young children and until 1994 worked on a part-time basis between maternity leaves in order to balance the needs of family and career.

Anne has been an active member of the Society for Nutrition Education and the Ontario Society for Nutritionists in Public Health. She has participated on numerous professional committees, often taking on leadership roles such as chairing committees and planning conferences. She served on the Public Affairs Committee of The Canadian Dietetic Association (CDA) and represented CDA on the National Expert Working Group on Breast Feeding, a group sponsored by Health Canada. She has taught nutrition-related courses at both the university and the college level.

Anne entered directly into a Masters program after her undergraduate studies with the aim of working as a community nutritionist. The issue of poverty and its effect on access to food for families was not on the curriculum and was never even mentioned. At the time (1984-85) the major issue in public health was the potential for HSO's (Health Service Organizations) and managed care to contain escalating health care costs. Health care spending in those days was still expanding at a tremendous rate. The recession of the 80's had not hit the health care system nor its employees.

It [the health care system] was very affluent... nobody talked about poverty. Oh, poverty, nobody talked about that. (Anne)

Graduate school afforded Anne the opportunity to develop a host of generic, management skills which helped her carry out the many leadership roles she later accepted.

Having done the graduate program I also have a huge variety of skills and a body of knowledge around very generic, transferable skills... management, organization, team building, you know, facilitating, that kind of thing. (Anne)
2. Institutional Context

Anne, along with two other public health nutritionists, was hired by the Hamilton health unit in 1990, bringing to five the total number of nutritionists at that location. At that time, the provincial government was increasing funding for health promotion and as a result, public health programs were expanding.

There was this window of opportunity in the Ministry of Health whereby funds were being put into health promotion. (Anne)

The expansion afforded the opportunity for the nutritionists to specialize and Anne chose to work in the area of reproductive health, prenatal, infant and preschool nutrition.

In 1990, when Anne was hired by the Public Health Department, the impact of the recession which began in the early 1980’s was still being felt even as the recession of the 1990’s took hold. Hamilton was particularly hard hit. The issue of food security and access to food became a major focus for the nutritionists in her office.

By the time we were hired here we were into a full crisis. This is one of the poorest communities in all of Ontario. And we all felt that access to food was sort of the reason for our existence in this community anyway. (Anne)

The two senior public health nutritionists were instrumental in focusing much of the department’s resources towards programs related to food security. One dietician has been active on the Food and Shelter Advisory Board. Another works directly with food banks. Anne feels that she, herself, works somewhat peripherally to the issue of hunger and food security. However, she makes the case that the promotion of breast feeding is an access to food issue because the women who are least likely to successfully breast feed, such as low-income and teenage moms, are least able to afford to purchase expensive infant formulas on a regular basis, leading to periodic feeding crises for their babies. The more affluent and more educated groups of the population more often choose to breast feed and when they
don't, they can afford to buy formula. The National Expert Working Group on Breast Feeding has declared the promotion of breast feeding to be an access to food issue and the other nutritionists in Anne's department also see it that way.

And the promotion of breast feeding in this country and the whole issue of breast feeding in this country has been identified as an access to food issue by this national group. (Anne)

Therefore, Anne feels supported in concentrating her efforts on low-income, pregnant women with respect to the promotion of breast feeding. She is not a direct care service provider, but is a supervising consultant for two programs in the community which work directly with this target population.

The group that I'm seeing and that I work with are those most, you know, the vulnerable population in the community. And they're the people who cannot afford to buy formula and they choose not to breast feed. (Anne)

At the time of the interview, in fall of 1995, the Public Health Department, along with most other sectors of the health care field, had been hit with a series of funding cutbacks. Anne's participation on the Regional Lactation Committee (explained below), with which she had worked over the previous five years to promote breast feeding, was cut. The administration said they could no longer justify sending both a nurse and a nutritionist from the health department to participate on one committee.

3. The Program

Upon joining the Public Health Department, Anne was invited to participate on the Regional Lactation Committee, a multidisciplinary group of 12 to 15 people, including representatives from local hospitals, health units, community health centre, La Leche League, doctors offices and the community. The group was becoming aware that infant formula companies were increasing the direct marketing of their products to pregnant and post-partum women; a clear violation of the World Health Organization's (WHO) Code
(World Health Organization, 1981) and a contravention of the industry's own, weaker version of the WHO Code.

[We] were discovering that formula companies were moving very aggressively into direct marketing which violates, totally violates the WHO Code. (Anne)

Direct marketing of infant formulas is a factor known to decrease breast feeding initiation and duration (Campbell, C.E., 1982). This activity, if unchecked, could undermine all efforts to promote breast feeding. Government funded health education campaigns can never compete with the advertising dollars at the disposal of huge, multinational corporations. In response to this perceived public health threat, Anne, through the auspices of the Regional Lactation Committee, chaired a committee to organize a FAX campaign. The goals were two-fold:

(1) to educate health professionals' about the rising incidence of direct marketing and its detrimental effects on the rates of initiation and duration of infant breast feeding and (2) to lobby the then federal Minister of Health, Diane Marleau, about the need to legislate the WHO Code in Canada as a means to control the direct-marketing activities of the formula companies.

4. Role of the Dietician

As chair of the FAX Campaign planning committee, Anne introduced the campaign to a group of between two and three hundred health professionals at a conference organized by the Regional Lactation Committee. She explained the need to legislate the WHO Code in Canada and the committee's intention to lobby the federal Minister of Health. An informational kit was available for distribution to whoever wanted to participate. In addition to background information, the kit contained a form letter and the FAX number for the targeted minister. A columnist for the local press was in attendance and submitted an article about the FAX Campaign which was published in the local paper. The article was then
picked up by Canadian Press and subsequently received national coverage. Press coverage provided free advertising for the campaign.

Anne fielded a huge number of calls from health professionals across the country and sent out hundreds of informational lobby kits. In order to achieve the greatest impact, the campaign chose October 16, corresponding with World Food Day and the Week of the Child to transmit the FAXes.

On the positive side, hundreds if not thousands of health professionals across the country became aware of the threat that direct marketing of infant formulas poses to the rate of breast feeding and that such a practice is in contravention of a code set by the World Health Organization. According to Diane Marleau's office, approximately 1500 FAXes were received on the day of the campaign, which is considered to be an impressive number for such a campaign. On the negative side, the Minister of Health responded that this was not a priority issue for the ministry at the time.

5. Advocacy-Based Initiative I

This program falls within Davis and Tarasuk's (1994) category of Advocacy-Based Initiatives. A traditional health promotion program to promote breast feeding would involve public education campaigns explaining the benefits and the how-to's of breast feeding. Health agencies, however, cannot match the marketing strength of the multinational pharmaceutical companies which produce the formulas (Campbell, 1982; Jeliffe & Jeliffe, 1978). An Advocacy-Based Initiative, by contrast, attempts to use legislation to fix the source of the problem; the direct marketing of infant formulas and its negative impact upon breast feeding success among low-income, post-partum women (Campbell, 1982; Palmer, 1988).

Anne was sent to participate on the Regional Lactation Committee because the promotion of breastfeeding was a public health priority and was also seen as a food security issue for low-income women, as described above. The FAX Campaign received national attention via media coverage. Although the Health Minister declined at the time to take
action, thousands of health professionals became aware of the dangers of direct marketing and would hopefully not become inadvertent participants in the practice.

V  EXAMPLE SIX: DISCUSSION PAPER BY THE OPHA FOOD SECURITY WORK GROUP

1. Introduction and Background

   Carol's personal and educational background and the context of her employment setting are described above in example four, the community garden at a women's emergency shelter. In the summer of 1993, while employed on a part-time basis at the Community Health Centre (CHC) and taking courses towards her Masters degree, Carol wrote a paper for a health policy course at York University in which she examined food security from a municipal policy perspective. She developed a simple Venn diagram describing food security as having three intersecting components; (i) health and nutrition, (ii) agriculture and environment and (iii) social justice. Policies to promote food security, she argued, must be coordinated in order to effectively address all three areas.

2. Institutional Context

   The Ontario Public Health Association (OPHA) is a large coalition of allied health professionals and community members involved in addressing public health related issues. In 1988, the OPHA made a recommendation that a task force be established to address the issue of food security and nutrition policy. In 1993, the OPHA Food Security Work Group was established "to develop an advocacy strategy to ensure food security for all residents of Ontario" (OPHA, 1995, p7.). The OPHA Food Security Work Group consisted of 19 members and, at the time of the interview, had been operating for two years. The members represented a wide diversity of opinions and backgrounds and included nutritionists, policy analysts, environmental health professionals, nurses and representatives from community food organizations. The diversity of backgrounds led to widely varying opinions and wide
ranging debates. There was need for a great deal of consensus building in order to move ahead. This was considered a welcome and worthwhile process which strengthened the ultimate value of the discussion paper. According to Carol, the group did agree on one basic premise, the need to coordinate and address the multiple facets of food security in a comprehensive way.

[They all had] the recognition that there needs to be a more comprehensive policy and looking at redefining the issues.

Carol was invited to join the work group because her experience of researching food security from a municipal policy perspective was thought would be a valuable asset to the work group, whose intention was to discuss food security from a provincial policy perspective. The Community Health Centre, Carol's employer, supported, to a limited degree, Carol's participation on the Food Security Work Group because it was sympathetic to the lack of food security among members of its targeted communities. Carol acknowledged that her participation in the Work Group required a great deal of her personal time because such activities took to eat up more work time than is available.

If you asked people that were involved with writing the paper, it was a real grind to get it out, especially relying on volunteer hours to do it.

3. The Program and the Role of the Dietician

The discussion paper covered three areas of concern; (i) environmental sustainability, (ii) social justice and (iii) health and nutrition. In the first stage of development, committee members selected tasks in which they were most interested and most experienced. Carol chose to work with a group from OPHA's Public Policy and Resolutions Committee to develop the advocacy plan. She was familiar with who some of the key stakeholders were across different sectors of the provincial government, having done a research paper the summer before which involved interviewing fourteen government policy developers. Others elected to write up sections within the discussion paper itself. In general, the dieticians
worked on the sections dealing with food and health, those with environmental and agricultural backgrounds wrote up those sections, and the social policy people wrote the social justice section. In the second stage, drafts for each section were brought back to the work group during a series of monthly meetings and thoroughly rehashed and debated until consensus regarding their content was achieved. According to Carol, the environmental section was the most contentious and the most difficult section in which to achieve consensus.

The environmental section was really contentious for a lot of people, a lot of dieticians. (Carol)

She attributes this to the shift in thinking that is necessary to move from a science-based model of understanding to an environmental model and to be able to grasp concepts such as food production and consumption patterns, environmental sustainability etc. Health professionals are not trained in this kind of macro level of analysis.

It's really overwhelming at times for people to sort of think about those things in that way. (Carol)

Carol, herself, having been immersed in environmental concepts as part of her masters work in environmental sciences, served a useful link in helping the factions to understand each other.

The next stage involved putting the pieces together into a discussion paper, ready to be sent out for comments and feedback. Carol served as the coordinator who synthesized the separate sections into a homogenous document. She was also co-chair of the work group for approximately one year. During the interview she did not elaborate on her role or her individual accomplishments, but preferred to speak of what the committee as a whole achieved. I believe that she understates her own contributions. As Carol herself said, while
discussing the community garden project, "It's not whether I facilitate that or lead it. It's just that it's there".

The discussion paper, published in March, 1995, was entitled Food for Now and the Future: A Food and Nutrition Strategy for Ontario (OPHA, 1995). In order to seek and honour feedback from a wide range of stakeholders, the work group circulated the discussion paper and allowed a six month time span to solicit and review comments before preparation of the final document. A popular education tool, comic book style, was developed for use in low literacy communities to present the concepts and seek feedback.

Rather than make it a resolution and make it all formal and all of that stuff, [in order] to really honour people's feedback [we] have a process set up to sort of say, what are we missing? Do you agree with this? What are some of the priorities that you see? (Carol)

The discussion paper advocates the need for action on both short term and long term goals. For example, food banks may be needed in the short term, but there must simultaneously be action taken toward the long term goal of adequate personal income such that food banks are no longer needed. By promoting action for both short and long term goals, the work group hoped to circumvent the nonproductive debate of pitting one solution against another.

4. Advocacy-Based Initiative II

This program fits the category of Advocacy-Based Initiative. The work group acted as a catalyst to initiate dialogue among a wide range of stakeholders regarding the necessary components of food security and produced a document which could serve as a basis for discussion among government policy makers regarding an integrated policy approach to food security.

The Work Group's Discussion Paper is a "beyond charity" program because it aims to move beyond addressing the symptoms of poverty and food insecurity by identifying and working towards a solution to the basic environmental, social justice and health and nutrition
policies and practices which create food insecurity. No one professional group has the breadth of knowledge needed to adequately consider the many components of food security, as defined by the work group. Therefore, it was important that this advocacy initiative be undertaken by a coalition, like the OPHA Food Security Work Group, whose members bring to the table their various areas of expertise.
CHAPTER 4 - CREATING SPACES: MOVING BEYOND CHARITY

I INTRODUCTION

In reviewing how the dieticians became involved in food security initiatives, it became apparent that in most traditional workplaces i.e. hospitals, or other mainstream institutions, the promotion of food security did not have a niche or a permanent space. It was an extra, an aside, something the dieticians had to justify and advocate in order to be able to proceed, project by project. A second finding is that the professional education and training of the dieticians was seen by the participants themselves as a barrier to the effective promotion of food security. It did not, for example, provide them with the skills needed to participate in lobbying and advocacy initiatives. The dietician's traditional roles of clinician and expert educator were seen as ineffective or counterproductive for community development work. A third finding is related to the locus or forum through which a food security initiative is developed. An institution-based program was more likely to participate in a charitable food assistance initiative whereas an extra-institutional program (defined below) was a more favourable space for developing a "beyond charity" response. Thus, the theme of creating space for the promotion of food security initiatives became the organizing concept through which I analyzed and came to understand the experiences of the dieticians.

Creating space for food security initiatives means identifying and overcoming the barriers to such initiatives. The term "space" in this context is understood very broadly. Space can mean a supportive climate or environment which empowers, an education which provides appropriate tools, availability of appropriate resources earmarked for food security initiatives and institutional policies or mandates which add legitimacy to a more permanent space for food security initiatives. "Space" can also refer to the locus or forum where the food security work is centred.

Initially, I considered all categories of responses to food insecurity to be of equal value. Through reading and reflection, I have come to the personal conclusion that a
charitable response, though useful for meeting an immediate lack of food, is not an adequate response because it does not alter the underlying conditions, like poverty, unemployment, etc. that give rise to food insecurity. Yet, a 1994 survey of dieticians across Canada (Power, 1995) showed that charitable food assistance was their primary response. An analysis of the experiences of the five dieticians in this study revealed many factors within the context of their workplaces and the context of their professional education and training which block responses beyond the charity model. Therefore, it became important to identify which factors, in the experiences of the five dieticians, contributed to creating space for a "beyond charity" response.

II CREATING SPACES: SUPPORTING FACTORS

1. Education

   a. Programs of study. Education is a key component in creating space for dieticians to promote food security. A narrowly based professional education, one which focuses on the clinical aspects of food and nutrition, teaches dieticians to assume roles such as clinician or educator and transmits the skills particular to those roles. A broad-based education, one which considers the impact of socio-economic and political structures on health and nutrition, transmits roles and skills to address these issues and so is more supportive of addressing food security initiatives. Dieticians who feel limited in their repertoire of roles and skills, based on a traditional, narrowly-based undergraduate education, can acquire new skills and roles through a customized post-graduate education or, more practically, through continuing education opportunities and through the example and guidance of experienced, on-the-job mentors (see Context of the Workplace below).

   The participants completed similar undergraduate programs involving a four year bachelors degree in human nutrition. Only Elaine's program included a component related to domestic food security. One of her professors, Jennifer Welsh, had been among the first
academics in Toronto involved in domestic hunger, a factor which may have facilitated the opportunity for Elaine's involvement in a food security-related project. Elaine's own history of involvement in food security activities prior to entering university may have been another factor.

All five participants expressed some dissatisfaction with their undergraduate education with respect to how well it prepared them to participate in the promotion of food security.

I could go on and on about...our inadequate undergraduate training. It is out of date, gone, finished. It will be our demise unless it changes soon. (Anne)

...this specialist training that we end up with. We end up with a micro vision of things. And the world is not a micro place any longer...Give them a broader based training and make damn sure that they understand that they are living in a global village. (Diane)

How they educate dieticians to begin with, I think, is critical. I think there needs to be a real change in education...that they get a very broad sweep of things. (Carol)

The participants agreed that their undergraduate training was too narrowly focused on the medical aspects of food and nutrition, without consideration for the broader social and economic context of nutrition and health. Bev was disappointed that her training did not teach her how to tailor nutrition advice to fit the context of First Nations and northern communities. Elaine regrets not receiving training in the roles and skills effective for community development work. Diane felt the whole issue of professional responsibility towards the poor and awareness of domestic hunger was a big gap in her training. Carol argued that the profession adheres to the medical model to the exclusion of a community development or a healthy public policy model which are, in her view, more appropriate frameworks for designing the promotion of food security initiatives.
Two of the participants, Anne and Carol, pursued masters programs to develop skills beyond the undergraduate level. Anne pursued a Masters of Health Sciences degree in Community Nutrition at the University of Toronto in preparation for a career in public health. During the period of her Masters program (1983-85), public and community health initiatives focused on prevention of disease through public education campaigns aimed to reduce individual high risk behaviours such as smoking, recreational drugs and high fat diets (Labonte, 1987). The switch to a health promotion paradigm focusing on the determinants of health, like poverty, did not take place until the late 1980's, after Anne's graduation. While Anne's program did not address the issue of domestic food insecurity, Carol, whose graduate program spanned the years 1992-94, was able to tailor her program to suit her particular interests which included addressing the basic determinants of health through community development and healthy public policy models of practice. At the time Carol attended graduate school, issues of poverty and food security had become more accepted foci for community and public health practice.

Further education is a resource that can provide committed dieticians with the tools needed to support the promotion of food security. A formal university education is not necessarily the best or the only route for developing these skills. In fact, the process of developing and implementing curriculum changes often results in a significant delay between the time the need for change is acknowledged and the time changes are implemented. The CDA, for example, took over five years to plan and develop revisions to the undergraduate curriculum of dieticians, a process which is still ongoing (Canadian Dietetic Association, 1995; Beaudry, Lilley & Aucoin-Larade, 1991). Skill-based workshops can be developed on a more timely basis and are generally more easily accessed than committing to a post-graduate education. Carol spoke of the group session, "Policy for Change" offered through the Ontario Public Health Association which
talks about how to do coalition building, community development, and it's sort of very pragmatic. It's all on how to facilitate community work.

The CDA, which organizes numerous continuing education programs for its members, can play an important role in developing accessible skill-based workshops and/or in disseminating to its members through its monthly newsletter, Communique, an up-to-date list of such programs offered through other venues.

b. Model of practice, roles and skills. Power (1995) reports that many dieticians feel overwhelmed and helpless in the face of an issue like domestic hunger which is multi-factoral and does not lend itself to the types of solutions traditionally offered by professionals. Part of the problem lies in the scope of the medical model of practice, the predominant model introduced during the undergraduate training of dieticians. The medical model views human problems through a very narrow lens and interprets them in terms of individual deficiencies, whether of nutrients, antibodies or knowledge, that can be corrected through the application of technical expertise or education. It does not attend to the broader determinants of health such as employment, housing, social security, access to food etc. nor to the social, economic and political structures which inhibit equal access to society's goods and services. By contrast, a health promotion model, as described in Health and Welfare Canada's discussion paper Achieving health for all: A framework for health promotion (1986) specifically addresses these determinants of health. A community development model of practice uses a strategy to address the determinants of health by helping to build the capacity within targeted communities to identify and address their own problems. In this model, the professional's role is primarily to facilitate and become resource persons in aid of community defined needs (Labonte, 1987).

Diane and Elaine, whose education focused solely on the medical model, were involved in mainly charitable food assistance programs. They were not exposed to alternative models of practice that would give them the analytic and practical skills to organize a "beyond charity response". Elaine in particular, recognized that she lacked
community development skills when she reflected upon her experience in setting up a community kitchen\(^\text{15}\) for low-income women.

I do have problems with this community kitchen....Because, this is my kitchen. It's not their kitchen. Ah, they see me as the leader. The ladies all see me as the leader. They have not taken ownership. I have not been skilled in making it theirs. (Elaine)

Thus, when Elaine attempted to introduce a participatory, food based response, she lacked the skills to improve the food security of the participants due to her acknowledged "mindset that I was the expert and they were the people who needed the expertise". Had she learned the facilitation and other skills integral to a community development model of practice, she would have been better equipped to help the participants assume control over the management of the community kitchen to meet their own perceived needs, a process which promotes empowerment (Smillie, 1991).

By contrast, Carol's graduate program included a grounding in the roles and skills associated with a community development model of practice. This, plus the skills and experience acquired in facilitating the development of other community gardens, were important factors contributing to her success in introducing a community garden at the women's emergency shelter. Carol had also studied the impact of various levels of governmental policy on food security and thus had the background necessary to participate in the Ontario Public Health Association's (OPHA) advocacy initiative to delineate and promote a comprehensive food and nutrition strategy (OPHA, 1994).

\(^{15}\)Elaine introduced the concept of community kitchens to her hospital and was involved in operating a kitchen for low income women who meet monthly to cook and share one dish together. She acknowledged that her kitchen mainly addressed the issue of social isolation although it also had the unintended health benefit of encouraging some of the participants who were diabetic to make and keep appointments for nutritional counselling, which they might not otherwise have done. I chose not to write about this project because it had a negligible food security component.
Professional education is the primary means by which professionals learn the roles to play and gain the skills available in their repertoire. The traditional, undergraduate education of dieticians, based on the medical model of practice, prepares dieticians to assume the roles of the expert clinician or educator. As a clinician, the dietician can offer an expert opinion regarding dietary diagnosis and prescription, based on dietary histories, food intake questionnaires and knowledge of the relationship between diet and clinical conditions. As an 'expert educator', the dietician teaches the patient what, in the dietician's judgment, the patient needs to know. Whether as clinician or educator, the dietician remains the authority in control of the parameters of the patient-dietician encounter by virtue of her specialized knowledge. Such control is related to the larger issue of the professional's role in society (see Chapter 1).

In the community development model of practice, the primary role of the dietician is as facilitator. Carol described the evolution of her role as moving from clinician to educator to facilitator. She was a clinician while working in a hospital intensive care unit. She was an educator when working as an outpatient dietician and she developed her role as a facilitator in order to carry out community development work. This change, from clinician to educator to facilitator, is not merely a change in role. It represents a significant change in the mandate, scope and paradigm of professional practice. Carol undertook these changes on an individual basis, to fulfill her desire to promote food security initiatives through her professional role. She did this through directing her own education to include broader models of professional practice.

2. Context of the Workplace

The context of the dieticians' work plays a tremendous role in influencing the ease with which food security initiatives are introduced and the category of responses that are employed. When asked what factors facilitated their involvement in programs to promote food security, the five dieticians in this study talked about a supportive work environment. Institutions have supported the development of food security work by:
(i) developing a mandate or focus which targets low income communities (Anne, Bev, Carol, Elaine),

(ii) supporting staff through continuing education opportunities to develop skills in community development and advocacy (Anne, Carol, Elaine),

(iii) hiring staff experienced in community development and advocacy who then act as role models and mentors to other staff (Elaine, Anne, Bev, Carol),

(iv) committing institutional resources towards food security work (all five) and

(v) hiring those in positions of authority and leadership who have a commitment to promoting food security (Anne, Bev, Carol, Elaine).

Four of the five workplaces had targeted low-income groups for service. Elaine credits her hospital's CEO for developing its unique focus on inner-city health. Now programs targeting local, low-income communities can be justified on the basis of the hospital's focus. Debbie Field, founder of FoodShare, is the visionary who developed FoodShare's mission of "working with communities to end hunger and improve access to affordable food" (FoodShare, 1995). Labonte (1987) credits two seminal health promotion publications, the 1986 Ottawa Charter on Health Promotion and Health and Welfare Canada's discussion paper, "Achieving health for all: A framework for health promotion", as fueling a change in the mandate of public and community health. As a result, many Public Health Departments and Community Health Centres have adopted a mandate that aims to reduce health inequities through addressing the basic determinants of health such as shelter, food, income, employment, social justice etc.

There was a window of opportunity in the Ministry of Health whereby funds were being put into health promotion and the government of the day saw that disease prevention and health promotion were so absolutely critical to reducing the health care budget. (Anne)

Individual Public Health Departments and Community Health Centres develop their own regionally based priorities and targets for service. Carol knows of Community Health Centre
dieticians who do only individual nutritional counseling, no community development and others who do nothing but community development work. In these cases, it is likely the dietician's own educational background and repertoire of roles and skills that influence the types of programs developed.

My experience is most of them [Community Health Centres] are reasonably flexible organizations.....I think there are organizational issues but at the same time I think there's also personal issues, that it's [community programming] not their area of interest. (Carol)

The need for ongoing continuing education to develop skills related to advocacy and community development work is great. Anne was supported by her peers and manager

...to go to whatever workshop or whatever I needed to go to to acquire the skills to be able to lobby and advocate and to get out there and, as I've mentioned before, move the cause forward....and what I call that is a supportive environment. (Anne)

Elaine was supported by her workplace to undertake a Masters in Adult Education whereby she is improving her skills in the theory and practice of group facilitation. Continuing education can also happen through the example of on-the-job mentors. When institutions hire employees who have already acquired experience and skills in areas such as community development and advocacy, as did Elaine's hospital, these individuals can teach by example the skills which the dietician may lack. "Actually, I'm very impressed with this nurse....I've learned a lot from her" (Elaine).

Institutions are relatively rich in a number of different types of resources which can be drawn upon to support food security initiatives. The types of resources available through the institution and how they are used influence the category of program developed. For example, the availability of excess food at Diane's hospital made possible the initiation of a food recovery and donation program. The ability to solicit donations from food companies facilitated the implementation of a charity-based community dinner at Elaine's hospital.
Carol's Community Health Centre allocated funds to pay for the consultation services of a landscape architect for the community garden. The Community Health Centre and the Public Health Department allowed Carol and Anne to participate in advocacy initiatives developed by outside organizations.

Finally, demonstration of commitment towards promoting food security by supervisors and higher levels of institutional administration contribute to a supportive environment. Anne's supervisors were personally and professionally committed to promoting food security and had been involved in addressing some of the issues through their public health unit even prior to Anne's being hired. The entire organization of FoodShare is designed to promote food security. Carol's supervisors at the Community Health Centre demonstrated their support for food security initiatives by targeting populations known to have low food security, i.e., the homeless. Elaine describes both the head of her department and the CEO of the hospital as being committed to promoting food security.

Carol was employed by a Community Health Centre whose strategic plan targeted the homeless and low-income seniors for programs and services. When Carol was hired by the CHC, she negotiated up front that 50% of her time be used for health promotion programs, which for Carol meant community development initiatives. These two factors are what gave Carol the space to become involved in facilitating the creation of a community garden at a women's emergency shelter and to obtain funding through the centre to pay the salary of the consulting landscape architect.

3. Locus of Program

The institution and its mandate or mission were major factors in determining the category of food security program initiated. The locus of the program (See Figure 1) refers to both who controls the development of the program as well as the program's ultimate location. **Institution-Centred** programs are ones in which the institution controls the content and the form of the program and which take place within institutional boundaries. Traditional institutions, such as hospitals, tend to develop institution-centred programs which are
charity-based. The Food Recovery and Donation Program is an example of an Institution-Centred program.

**Multi-Institutional** programs are similar to institution-based programs except that they are planned and executed by a coalition of a number of separate institutions, each of which maintain a measure of control over the program. The Community Dinner is an example of a Multi-Institutional program.

**Community-Centred** programs are ones in which the planning and execution of the program occur within the targeted community through the collaborative efforts of the community and an institutional representative, i.e. the dietician. The Community Garden at a Shelter for Women is an example of a Community-Centred program, as are, to a certain degree, the Homemade Baby Food Workshops.

**Extra-Institutional** programs are planned and executed by a coalition of institutional and community representatives who bring to the table the resources of their respective institutions but whose agenda remains independent of those institutions. The FAX Campaign, organized by the Regional Lactation Committee is an example of an Extra-Institutional program, as is the OPHA Food Security Work Group's discussion paper.

Diane and Elaine were both employed by hospitals, the traditional employer of dieticians. Both hospitals are major university teaching hospitals but Elaine's hospital, since 1991, has developed three key areas or foci of leadership (Appendix D), one of which is to serve the health needs of its local, inner-city community. In support of this focus, the hospital has encouraged the development of collaborative ventures with community agencies, such as the community dinner event described in example two, and has participated in an "Out of the Cold" overnight shelter and hot meal program for the homeless in winter. Diane's hospital did not have a similar focus. Both hospitals were involved in food security initiatives primarily categorized as charitable food assistance; the food recovery and donation program and the community dinner.
Figure 1 - The Four Loci: A schematic representation of the relationship between institution, target community and the control over program design and implementation.

<table>
<thead>
<tr>
<th>INSTITUTION-CENTRED</th>
<th>MULTI-INSTITUTION CENTRED</th>
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<tbody>
<tr>
<td>Hospital controls program design and delivery</td>
<td>Coalition of institutions and agencies control program design and delivery</td>
</tr>
<tr>
<td>Community's role is passive.</td>
<td>Community representatives may have a voice</td>
</tr>
<tr>
<td>Favours a charitable response.</td>
<td>Program remains vulnerable to institutions' political and economic constraints.</td>
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- **e.g.. Diane's Food Recovery and Donation Program**
- **e.g.. Elaine’s Community Dinner**

<table>
<thead>
<tr>
<th>COMMUNITY-CENTRED</th>
<th>EXTRA-INSTITUTION CENTRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community controls program design and delivery</td>
<td>Broad-based coalition forms an independent group which controls program.</td>
</tr>
<tr>
<td>Facilitation and resources provided by institution's representative (dietician).</td>
<td>Community may have a voice</td>
</tr>
<tr>
<td><strong>e.g.. Bev’s Homemade Baby Food Workshops</strong></td>
<td>Coalition operates independent of institutions' political constraints.</td>
</tr>
<tr>
<td><strong>Carol’s Community Garden at Women’s Shelter</strong></td>
<td><strong>e.g.. Anne’s FAX Campaign</strong></td>
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<tr>
<td></td>
<td><strong>Carol’s OPHA Food Security Discussion Paper</strong></td>
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Planning for the **Food Recovery and Donation** program was carried out solely by the hospital and the agency which distributes the food. For this reason, I classify this program as an **Institution-Centred** program. Planning for the **Community Dinner** involved a broad coalition of partners, including a hospital, a community health centre, a community centre, a public health department, a local university as well as community representatives. I classify this program as a **Multi-Institutional** program. The Community Dinner, although primarily a charity event, did include elements laying the groundwork for community building and recruitment into participatory, food-based programs. It is likely due to the influence of the diverse members of the multi-institutional planning committee that this event became something more than a simple one night soup kitchen.

The **Community Garden** at a women's emergency shelter fits the category of a **Participatory, Food-Based** program. Its locus is **Community Centred** in that the planning and the execution of the program occur entirely within the targeted community and with the full participation of the community.

Carol was also involved in the **OPHA Food Security Work Group**, a program which fits the category of **Advocacy Initiative**. Carol's employer, the Community Health Centre, agreed that Carol could participate on this committee as part of her employment contract because the goals of the committee complemented the goals of the CHC. The committee consisted of a coalition of health professionals working together as an ad hoc committee of the Ontario Public Health Association. The committee, therefore, was working from an **Extra-Institutional** locus. An Extra-Institutional locus is receptive to "beyond charity" responses because, by definition, it is an independent, privately funded organization, unlike hospitals, individual professional associations or publicly funded health agencies. It is multi-disciplinary which allows a wide range of perspectives and expertise to be brought together and is generally flexible enough in structure to permit inviting whomever is thought to be an asset to the committee, regardless of educational or professional background. Finally, being independent, an extra-institutional committee may have greater freedom than a
public institution to take advocacy positions which may be against the interests of certain corporate or political powers.

Anne was supported by her Public Health Department, to join the Regional Lactation Committee, where she participated in the Fax Campaign to lobby against the practice of direct marketing of infant formulas. The Regional Lactation Committee operates from an Extra-Institutional locus because it consists of representatives from a broad section of health and community agencies who come together to create their own programs and terms of reference. One benefit of participating in an extra-institutional committee through one's place of employment include not having to draw upon personal time which is extremely scarce for women like Anne who have both careers and children. A second benefit is the ability to draw upon resources from one's workplace to support the work of the committee. A third benefit is that Extra-Institutional Committees are usually operate independently of the institutions from where the employees have been seconded. This means that the institution cannot impose its viewpoints upon the Extra-Institutional Committee, as the Committee develops its own terms of reference, and, the Committee, being usually financially independent, is not answerable to political or commercial interests. For example, the power of multinational pharmaceutical corporations over governments and medical institutions is well documented (Jeliffe & Jeliffe, 1978; Palmer, 1988). The weakness of being seconded to an Extra-Institutional Committee through one's workplace becomes apparent in Anne's case when the upper administration of Anne's Health Department removed her from the Regional Lactation Committee, allegedly due to funding cutbacks. Participation is dependent upon the agreement of the workplace.

Bev's employer was FoodShare, a nongovernmental agency whose mission is "working with communities to end hunger and improve access to affordable, nutritious food" (FoodShare, 1995, p.1). The Homemade Baby Food Workshops are a Participatory Food-Based program. Developed through a collaboration between FoodShare and a Public Health Department, it could be described as having a Multi-Institutional locus, particularly
because the workshop locations were not strictly community-based but located in spaces arranged to accommodate Public Health Department-sponsored pre and post-natal support groups. The second phase of the program, currently in place, involves the recruitment and training of community-based peer educators who tailor the workshops to the needs of their communities and who bring them directly into their communities. This changes the locus to one that is community-based.

Figure 2 provides a summary of some of the key factors across each of the six examples of food security initiatives.
Figure 2 - Key factors across each of the six examples of food security initiatives

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>LOCUS</th>
<th>DIETICIAN'S ROLES</th>
<th>DIETICIAN'S EDUCATION</th>
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<tbody>
<tr>
<td>Program</td>
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<tr>
<td>PURE CHARITY</td>
<td>INSTITUTION-CENTRED</td>
<td>Initiator</td>
<td>Traditional</td>
</tr>
<tr>
<td>Food Recovery and Donation</td>
<td>Hospital</td>
<td>Administrator</td>
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<td></td>
<td></td>
<td>Resourcer</td>
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<td></td>
<td></td>
<td>Educator</td>
<td></td>
</tr>
<tr>
<td>CHARITY PLUS</td>
<td>MULTI-INSTITUTIONAL</td>
<td>Facilitator</td>
<td>Traditional</td>
</tr>
<tr>
<td>Community Dinner</td>
<td>Hospital</td>
<td>Resourcer</td>
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<tr>
<td></td>
<td></td>
<td>Educator</td>
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<tr>
<td>PARTICIPATORY FOOD-BASED</td>
<td>COMMUNITY-CENTRED</td>
<td>Researcher</td>
<td>Traditional</td>
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<tr>
<td>Homemade Baby Food Workshop</td>
<td>Non-Profit Community Agency</td>
<td>Educator</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Facilitator</td>
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<tr>
<td>PARTICIPATORY FOOD-BASED</td>
<td>COMMUNITY-CENTRED</td>
<td>Initiator</td>
<td>Traditional &amp; Community Development</td>
</tr>
<tr>
<td>Community Garden at Womens' Shelter</td>
<td>Community Health Centre</td>
<td>Resourcer</td>
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<td></td>
<td></td>
<td>Educator</td>
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</tr>
<tr>
<td>ADVOCACY</td>
<td>EXTRA-INSTITUTIONAL</td>
<td>Lobbyist</td>
<td>Traditional &amp; Masters of Health Science</td>
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<td>FAX Campaign</td>
<td>Public Health Department</td>
<td>Liaison</td>
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<tr>
<td>ADVOCACY</td>
<td>EXTRA-INSTITUTIONAL</td>
<td>Researcher</td>
<td>Traditional &amp; Public Policy Analysis</td>
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<td>OPHA Food Security Work Group Discussion Paper</td>
<td>Community Health Centre</td>
<td>Report Writer</td>
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<td></td>
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<td>Advocate</td>
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III CREATING SPACES FOR "BEYOND CHARITY" INITIATIVES

1. Awareness and Critical Perspective

   Education can play a formative role in a dietician's awareness and analysis of domestic food security issues. Four of the five participants had little or no exposure to the issue of domestic poverty in their undergraduate program and no discussion or debate about the consequences of food insecurity, the pros and cons of possible responses, or what their responsibility or role as professionals could or should be.

   I can say pretty clearly that university did nothing [toward] spawning a social sense of responsibility. And I think that in the curriculum at that time, uhm, that was sorely missing. (Diane)

   Awareness is the first critical step in addressing an issue. In my opinion, awareness should go beyond a dry presentation of facts and figures to sensitizing students to the realities of living with food insecurity. One of the best ways to debunk societal prejudices against marginalized groups such as the poor is to walk a mile in their shoes. For example, at a CDA psychodrama workshop entitled "Entering the labyrinth of poverty" (Murphy, 1994) psychodrama facilitator Tobi Klein used role playing to help dieticians experience how it felt to be the low-income client on the receiving end of professional advice. Using a more direct approach Cotugna and Vickery (1992) designed an assignment to provide their students with a firsthand glimpse of hunger in order to heighten their sensitivity and hopefully their commitment to addressing this problem. The students spent one term volunteering in varying capacities at local food banks and soup kitchens. They were shocked by how widespread the hunger problem appeared to be, by the large numbers of children dependent upon charitable food assistance and by the harsh conditions of their lives. Negative stereotypes about the poor were debunked. As one student said

   I felt "these" people would be bums, derelicts, and mostly men who had
given up on life. Now I realize that they are just ordinary people like me who have had fewer advantages or somehow fallen on hard times (p.298).

More importantly, the students came to see the futility of simply handing out food and began to think about alternative solutions such as the need for professional advocacy and of becoming more politically active. An undergraduate nutrition program which includes a strong domestic hunger awareness component, such as the one described above, could be one of the easiest and powerful ways to create a profession committed to addressing issues of domestic hunger in a meaningful way.

The five participants in this study had become sensitized and aware of the issue of domestic food insecurity through influences beyond their undergraduate education. Diane spoke of an influential mentor who challenged her to recognize and question the economic inequalities around her. Ann described as devastating the experience of seeing first hand the effects of poverty on families and their children as part of her graduate school fieldwork in community nutrition. Elaine's sensitization arose out of awareness of the civil rights movement in the 1960's and 1970's in which issues of classism, racism and sexism were addressed. Bev, despite her first hand knowledge of poverty in developing countries, was unaware of the existence of poverty in Canada until she worked with First Nations communities in northern Ontario. Carol was sensitized early in life as a result of the community-minded work of her working class parents. These sensitizing experiences appeared to be formative in later motivating the dieticians to seek ways to promote domestic food security.

After awareness comes the need to develop a critical analysis of food insecurity, its incidence, impact, causes and possible solutions. Several authors have written about their attempts to introduce a critical perspective in undergraduate programs geared to dieticians and other health professionals (Coates, 1991; Csete, 1992; Eide, 1982; Foster, 1991; & Scheider, 1992). The term "critical" is used to convey the act of questioning the effects of established social and economic norms and structures (Foster, 1991). Eide (1982) was an
early advocate of moving the analysis of hunger from focusing on the individual to focusing on the larger social context. Csete (1992) recommends looking at the broader, social context of hunger by viewing it from a global population perspective, an environmental perspective and a gender, i.e. the feminization of poverty, perspective. Schneider (1992) would focus the curriculum on the socioeconomic and political factors of food production to help nutritionists understand the bigger picture. Coates (1991) believes in guiding students through a process of personal transformation in which they challenge their own thoughts, feelings, ideas and behaviours in order to strengthen their critical skills. He argues that critical analysis and transformation experienced at a personal level facilitates development of a critical perspective at the societal level.

Awareness of the extent and impact of domestic poverty and food insecurity is not sufficient to promote "beyond charity" work. It is the critical analysis process that reveals the structural causes of poverty. Charity alone does nothing to change those conditions. Opportunities to develop awareness and a critical perspective should be essential components of the undergraduate education of nutritional professionals.

2. Facilitating Workplace Factors

Not all institutional supports for food security work are sufficient to create space for "beyond charity" initiatives. Elaine's hospital, for example, had a clear focus to promote health within its local inner-city community, hired a nurse with community development skills, and supported Elaine's need for continuing education to develop her repertoire of skills. Nonetheless, the two food security programs the hospital was involved in were primarily charity-based i.e. the Out of the Cold program and the community dinner. Factors identified as facilitating "beyond charity" work are:

(i) programs developed by broad based coalitions of health professionals working outside of

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16During the cold winter months the hospital administers an over night shelter to give those living on the streets a warm bed and a breakfast the next morning.
individual institutional confines in what I have termed extra-institutional spaces (i.e. FAX Campaign, OPHA Food Security Work Group),

(ii) community-based programs facilitated by dieticians who are well grounded in the principles and skills associated with a community development approach (i.e. Carol’s Community Garden),

(iii) programs initiated through non-traditional institutions which have a strong history of social activism, community development and advocacy (i.e. FoodShare’s homemade baby food workshop),

(iv) knowledge of the gatekeepers and appropriate policy makers in government who can be targeted with a clear message to promote via a planned advocacy strategy (OPHA Food Security Work Group),

(v) allocation of financial and human resources specifically needed to facilitate community-based and/or community driven food security initiatives (CHC’s Community Garden),

(vi) inclusion of community development and community organizing as a legitimate part of one’s role within the institution (Carol’s strategy).

3. Limitations of an Institutional Workplace

Could it be mere coincidence that the two hospital-based dieticians were involved primarily in charitable food assistance programs? Examination of the context of the institutional workplace suggests the presence of a number of factors which inhibit a beyond charity response. In Elaine’s example, the hospital vetoed any messages blaming governmental policies for current problems. Public institutions are by nature conservative and conserving of the status quo. They are reluctant to offend their source of funding, be it the government which controls their operating budgets or corporations such as pharmaceutical companies which provide research dollars, sponsorship and other forms of in-kind support. However, charity is not a politically threatening activity and so there is less institutional resistance to participating in charitable food assistance. Nevertheless, the existence of even charitable institution-based initiatives is rare and requires commitment and
perseverance on behalf of employees who wish to initiate such programs. The availability of institutional resources suitable for charitable purposes, i.e., excess food and suppliers who can be called upon to make charitable food donations, facilitates a charitable response.

Institutions such as hospitals, are mainly peopled by educated, middle class and higher individuals, who, if they hold any level of power, have been educated in the medical model. Thus, those in positions of power and influence almost all hold the same or similar perspectives on health and food security. There is a lack of heterogeneous input to drive the goals of a food security program to a higher level. Hospitals operate with the mentality of the expert: they know what is needed and how to do it. There is not a history of working in partnership with low income communities to discover how they can best support their food security needs.

Charitable responses suit institutional systems of accountability. A charitable response can be quantified and the results measured within a reasonable time frame. One can count the amount of food donated, the number of mouths fed. "Beyond charity" responses, especially advocacy initiatives, require a much greater input of resources and have a much riskier rate of return. An advocacy campaign may not end in a favourable response or the response may be delayed, making it difficult to measure or assess whether the advocacy had any effect.

Finally, institutions, whether hospitals or professional associations, are often beholden to commercial sponsors. Pharmaceutical and food companies support institutions through advertising dollars in professional journals, sponsorship of continuing education programs and provision of free supplies and other resources. Consciously or otherwise, institutions would be reluctant to take a position which might offend sponsors for fear of withdrawal of financial support (Campbell, C.E. 1982). Therefore, a FAX Campaign against the direct marketing practices of infant formula companies is more likely to be undertaken by an independent, extra-institutional committee which is not accountable to third party sponsors.
4. Ethical Education

Jean Mayer (1986) states that nutritionists "have to see their science as one whose goal is the benefit of mankind (sic)" (p.716). Mayer advocates for an ethical and moral foundation to the nutrition profession.

The goal of nutrition is to apply scientific knowledge to feed people, feed them adequately, and feed them all. By its very nature, nutrition is a set of scientific disciplines whose end is action (p.714).

An ethical foundation has been missing from the profession. As a result, explains Mayer, North American nutritionists have not been actively addressing the international hunger and famine crises over the past 40 years and have lagged behind others in addressing issues of domestic poverty and hunger. Foster (1991) also advocates for an action agenda. He calls for professionals to be educated to see themselves as agents of social change "fundamentally committed to creating practices intended for social progress" (p.108).

How does a profession instill a sense of social responsibility within its members? Foster (1991) recommends beginning with problematizing the role of professionals in society. By this he means to critically evaluate the effect of the professional enterprise upon society as a whole. Students should question what role they could and should play and why. The role of education, he states,

is to engage in the active development of agents, individuals working within a moral context to achieve those goals valued by their particular program (p.117).

The profession itself must be seen to take ethical and moral positions on issues which affect the welfare of society. In contrast, Anne notes that CDA does not take a stand on the WHO Code (World Health Organization, 1981) regarding direct marketing of infant formulas. As a result, dieticians enlisted by pharmaceutical companies to distribute samples of infant formula are not sanctioned by the profession.
IV IMPLICATIONS FOR FOOD SECURITY INITIATIVES

1. Possibilities and Limitations of Food-Based Responses

In this study, food security initiatives administered through the dieticians' workplaces were Food-Based programs, whether involving charitable food assistance or participatory food-based programs. All Advocacy Based Initiatives were administered through extra-institutional coalitions. This pattern held true for all nine\textsuperscript{17} of the programs originally described by the participants. Such a pattern is consistent with my analysis of the context of the traditional, hospital-based workplace which inhibits a "beyond charity" response and favours a charitable food assistance response. It is also consistent with the context of the professional role of dieticians who are educated to focus on the clinical aspects of nutrition and not on the underlying factors determining access to food.

If dieticians who manage to create space to promote food security initiatives in the workplace are primarily involved in food-based programs, what then are the possibilities and the limitations of food-based responses and consequently what are the possibilities and the limitations of the role of dieticians in promoting food security within the workplace? Examining these questions involves assessing the benefits and drawbacks of both charitable food assistance and participatory, food-based programs.

a. Drawbacks of charitable food assistance. Although charitable food assistance may temporarily help those who cannot otherwise obtain their next meal, several drawbacks have been identified. Charity does not alter the underlying causes of poverty. To the contrary, it has been argued that the existence of a widespread network of charitable food assistance programs perpetuates poverty by reducing social pressures to develop a political

\textsuperscript{17}Recall that the five participants described their involvement in a total of nine programs to promote food security. Six of these are described in this thesis.
solution to inadequate income (Davis and Tarasuk, 1994; Tarasuk and MacLean, 1990; Riches, 1988).

The proliferation of charitable food assistance programs may thus facilitate an erosion of publicly-funded targeted programs by buffering the impact of policy shifts (Davis & Tarasuk, 1994, p.54).

By addressing only the symptoms of poverty, the conditions leading to poverty and the division of society into more visible groups of have and have nots remains. Charitable food assistance helps to keep the problem of poverty invisible because people are not expiring on the streets due to lack of food and what is not visible is easier to ignore. The nutritional adequacy of a diet which relies heavily on charitable food assistance has been brought into question because the availability of foods depends upon what is donated rather than what is needed (Riches, 1988). The issue of personal and cultural food choices (Tarasuk and MacLean, 1990) and therapeutic dietary requirements are likewise poorly accommodated.

b. Benefits of charitable food assistance. Does this analysis imply that dieticians should stop supporting charitable food assistance programs? This issue of the double edge of charity was raised by Professor Jane Poppendieck (1994), guest editor of a special issue of Agriculture and Human Values, "The Continuing Challenge of Hunger". In her article, entitled Dilemmas of Emergency Food: A Guide for the Perplexed, the following strengths of charitable food systems are cited:

(i) the programs are staffed by caring and concerned volunteers who provide "kinder, gentler help" than the official social service bureaucracy;
(ii) they provide opportunities to socialize among members of marginalized groups who otherwise would lack such opportunities;
(iii) charitable programs are often used as a site to distribute information on eligibility for social services and, in the U.S., a means of providing free medical service; and
(iv) they provide one of the few means to monitor the numbers and the condition of the food
insecure, who otherwise might remain largely invisible or ignored.

Instead of abandoning charitable food assistance programs, Poppendieck outlines a four-pronged guideline for action. First, she recommends "minimizing the damage" by working to ensure that such programs are not allowed to substitute for social service entitlements. Practically, this could mean to concurrently participate in "beyond charity" initiatives such as advocacy-based research to pressure government to ensure that all citizens' basic needs are met. Second, she urges us to "maximize the potential" by building coalitions among groups concerned with promoting food security in order to nurture the potential political power of the combined forces of society who want to see a more equitable distribution of resources. Third, she suggests "transform[ing] relations" by working to replace charitable food systems with participatory, food-based programs such as community kitchens, community gardens etc. Participatory, food-based systems invest more energy and resources into the development of the participants themselves (see benefits of participatory, food-based programs below).

c. Benefits of participatory food programs. Community-based, participatory food programs are believed to have several advantages over charity-based programs as follows (Kalina, 1994):

(i) involvement is thought to foster mutual support and to build a sense of community among participants;
(ii) active involvement and pride in accomplishment is thought to heighten participants' dignity and self-worth; and
(iii) when people are involved in identifying their own problems they may develop more lasting solutions than when the solution is imposed upon them by outsiders.

Davis (1992) explains that the nature of food, the production, preparation and sharing of food provides a natural and a non-threatening locus around which to facilitate community group formation and community organizing. Furthermore, what begins as a community group organized around sharing a meal could develop into something more. Labonte (1987)
describes the case of the single mothers in a low-income neighbourhood of Toronto who worked with the public health department to start a community garden and went on to develop a series of community based programs and to involve the local media in debunking the negative stereotypes of welfare mothers who sit around feeling hopeless and defeated.

d. Second-tier food distribution system. Neither charitable food assistance nor participatory, food-based programs alter the underlying causes of food insecurity. Rather, they both lead to the creation of a second-tier food distribution system in which the first tier is for those with the economic means to purchase food of their choice in locations of their choice. The second tier consists of an ad hoc system of charitable food assistance and a jumble of community based initiatives such as food buying co-ops, community kitchens, community gardens, etc. A two tier food distribution system, argues Davis and Tarasuk (1994) creates a more obvious division between society's haves and have nots, further emphasizing the impoverishment of the poor. However, as enumerated above, participatory, food-based programs, when organized within a framework of personal and community development, can benefit the participants in ways which go beyond the benefit of the food itself. Furthermore, second-tier food systems such as community gardens and food buying clubs which emphasize local, organic produce, benefit the environment, help to support local farmers and thus preserve farmland, and may ultimately serve as a superior model of food production and distribution than the first-tier system. Furthermore, if programs such as these are developed in a more inclusive, cross-class basis, they can contribute to food security for all, not just the poor.

2. Recommendations for Institution-Based Dieticians

The largest subset of dieticians are those who are employed in hospitals, industry and other traditional institutions. However, these are the dieticians the least involved, according to a 1994 survey (Power, 1995), in promoting food security. Community Health and Public Health Dieticians, who are the most involved in food security initiatives, represent only approximately 10% of the population of dieticians. How can institution-based dieticians
become more involved? Firstly, it is important to recognize that promoting food security requires a set of specific skills and roles that are not generally part of the traditional undergraduate preparation of dieticians. An individual should attempt to identify the areas of weakness in one's own skill set and to seek further education. An excellent starting place is The Food Security Network of the dietetic profession. It's newsletter contains a wide range of information regarding food security issues in Canada and profiles examples of programs initiated by dieticians across the country.

Several of the participants in this study have demonstrated that institutions are more flexible vis a vis the promotion of food security than they may at first appear. What this means is that dieticians who want to participate in food security initiatives must be prepared to be committed and very persistent. A first step could be to find allies within the institution who are also committed to promoting food security. Particularly strategic is to recruit allies within upper management. A second step could be to identify the existence of nearby community agencies and community service organizations already involved in targeting low income groups for service and develop possible avenues for collaboration. An alternative approach is to obtain institutional support for participation in an extra-institutional program which may benefit from the institutional resources, be they material or knowledge, that the dietician can bring as an institutional representative.

3. Implications for the Professional Association

The Canadian Dietetic Association (CDA), currently reorganized as Dieticians of Canada, has in recent years shown tremendous leadership and innovation in the programs and endeavours it has developed to encourage its membership to embrace and support the role of promoting domestic food security. This commitment has now spanned a period of ten years, has been twice renewed and has been adopted as a priority for the new national professional association. With all that has been done, are dieticians more involved than ever in promoting food security? Are they better supported in these roles?
The 1994 survey (Power, 1995) reports that 87% of CDA members thought food security should remain a high priority for CDA, however most of them, when questioned about their own food security activities, were mainly involved in traditional charity-based approaches such as Meals on Wheels (47%), food drives (37%) and individual education regarding basic skills (21%). Only 7% reported involvement in advocacy-based programs. The need for educational opportunities to develop skills in areas such as advocacy and community development, in my view, only partly explains the lag between support for food security efforts and involvement in food security efforts. Another factor relates to the tensions inherent in the profession between protecting the interests of the profession and promoting the interests of the larger society. Although the profession "talks the talk" of healthy public policy, community development and coalitions with grassroots organizations, it still arguably saves its highest praise and honours for those dieticians operating within the medical model of practice. Anne stated she felt almost embarrassed and apologetic when talking to members of the profession about her baby nutrition program because she felt the practical approach would not be considered good enough. Carol wondered every year when she renewed her membership in The Canadian Dietetic Association, why she bothered to do so. She felt apart and estranged from the profession.

Sometimes I feel a bit lonely, cause, there's not a whole lot of cohorts around that are doing that work....I wonder if I really should be affiliated at all with the dietetic profession. (Carol)

Some of the positions developed by CDA are the antithesis of her views. For example, CDA's publication of a "Bovine Somatotropin (BST) fact sheet" aimed to explain the issues surrounding the use of hormones to increase dairy cattle milk production, presented mainly the pro-dairy industry side of the BST research, according to CDA members critical of the factsheet, (Canadian Dietetic Association, 1994, p.6).
In my view, there is a pressing need for CDA to look at its own organizational forums. What are the criteria for membership and who is included and excluded by the criteria? In the past, nutrition graduates who did not pursue the traditional routes to professional membership but instead devoted many years to promote food security initiatives through community agencies were excluded by The CDA and consequently their wealth of experience and their viewpoints were lost (see Footnote 10). How connected and in touch is the profession to the larger society? Carol admired the practice of the Ontario Public Health Association (OPHA) to invite non-members onto their Board of Directors as members-at-large to serve the function of keeping the OPHA informed of outside issues and developments. What processes are in place for the development of position papers? What methods are used to evaluate the data? The profession has demonstrated a bias towards purely science-based research. Yet, in areas such as biotechnology, food irradiation and pesticide residues in foods, a pure science-based approach is insensitive to the potential dangers. As Carol states,

If you really honestly feel that science is the only way to inform policy, I think you're sadly, sadly, mistaken.

The use of corporate sponsorship and its potential role as "hush money" is another area The CDA fails to adequately regulate (Bush, 1993). Multinational food manufacturers such as Kraft, Schneiders and other manufacturers of highly processed foods are major sponsors of the annual CDA nutrition month campaigns and their products are often featured in CDA educational materials.

CDA could expand its role in creating space for extra-institutional food security initiatives through facilitating the creation of cross-sectoral collaborative groups to plan innovative programs. Whatever it does, the challenge is to keep the goals tangible, clear and to help CDA members visualize what their role and their contribution can be.
In considering the saying, "If you are not part of the solution then you are part of the problem", the dietetic profession has demonstrated, over the past ten years, its sincere desire to be part of the solution. The blocks that keep it from fulfilling this desire can largely be addressed through education and, more fundamentally, through examining the full implications of what it means to promote a healthy public policy, and how to develop the structures and procedures useful for supporting a broader social mandate for the profession.
Appendix A

List of Interview Questions

As you know, I am interested in talking with you because I understand that, as a nutrition professional, you have been involved in addressing issues related to hunger and food security. I'd like to hear about your experiences. I'd also like to encourage you to reflect on your work; what you've learned, how you feel about it, what it means to you to do this type of work, and ultimately, what you think can and cannot be achieved by a professional response to an issue like hunger.

(1) How did you come to be involved in addressing issues of hunger and food security?

(2) Can you tell me about some of the projects you have worked on?
   - goals, what you hoped to achieve
   - methods / techniques employed to achieve goals
   - roles
   - impact / results
   - supports (experienced vs lacking)
   - roadblocks / barriers / limitations
   - partnerships / collaborators

(3) What does it mean to you to do this kind of work?
   - conflicts
   - feelings
   - values
   - influences

(4) Do you do any volunteer work related to addressing hunger and do you think there are some kinds of activities that can better be accomplished through volunteer work? Why?

(5) What role do you think the profession could/should play re: hunger? What factors shaped your thinking around this issue?

(6) How has your professional association (CDA) influenced the work you do? How? or Why not?
Appendix B

Disclosure Letter to Participants

Dear

I am a member of the Canadian and Ontario Dietetic Associations and have served on numerous professional committees. Currently, I am conducting thesis-related research at the Ontario Institute for Studies in Education. My research involves an analysis of the dietetic profession’s response to the issue of hunger in Canada. The goal is to gain some insight into the possibilities and limits of the profession’s involvement in this issue.

I am writing to inform you about my research and to request your participation in a 60 to 90 minute interview. I am interested to hear your experiences, thoughts and reflections related to work you’ve done as a dietician to address hunger and nutrition and/or to debate what the dietician’s role could or should be. I would like to tape record this interview. The tape will then be transcribed and analyzed to identify important issues and themes. I would then contact you a second time to share my tentative conclusions and to see if they make sense to you. I hope to complete all interviews between October and November 1995.

Your participation would remain confidential. Code names would be used in the transcripts and in any written reports. The purpose is NOT to evaluate you or the profession. Procedures to maintain your anonymity would protect you from any unintentional evaluatory inferences and of course you would be free to withdraw from the study at any time.

An analysis of the dietetic profession’s continually evolving attempts to expand their role to include social activism against hunger could provide useful information regarding the possibilities and limits of a professional response. It could indicate how the association could better foster and support such activity and perhaps serve as an example to other professions. The critical reflections of you and other who have done work in this area are central to the development of such an analysis.

Thank you for considering this request for your participation. I will contact you by phone within the next few weeks to answer any questions you may have and if you are willing, to arrange a mutually convenient time and place for the interview.

Sincerely,

Dayna Albert RPDt
Appendix C
Consent Form

Dayna Albert
Department of Adult Education
The Ontario Institute for Studies in Education
252 Bloor Street West
Toronto, Ontario
M5S 1V6

Dear Dayna:

I have read the attached letter describing your research about the response of the dietetic profession to the issue of hunger and I would like to participate in an interview about my experience related to the above. I give my permission for the meeting to be recorded and understand that I am free to withdraw from the study at any time.

Date                    Signature


90
In November 1996, the opening of our new Victoria wing represented the realization of a dream for many of our staff, physicians and patients. The building was officially opened and dedicated by His Royal Highness Prince Philip, the Duke of Edinburgh. The new wing brings together many departments which were scattered throughout our campus, incorporates new operating rooms with state-of-the-art equipment and offers a full range of features and services that are designed to be welcoming and friendly to our patients and visitors.

Our patients, visitors and community will be able to benefit from the many milestones and key accomplishments recorded by Hospital in 1996/97 in each of our three key areas of leadership: inner city health, heart disease, and trauma. In April, a $1 million donation from the Foundation Baxter and Alma Ricard and a sustaining grant from the Sisters of St. Joseph created a Chair in Inner City Health. This full-time research position, which will be shared with the University of Toronto, will position Hospital as an international leader in inner city health. The concepts and findings learned through this research initiative can be applied to other North American cities.

Other milestones for the inner city health program included the establishment of new Community Advisory Groups to provide feedback and input on issues; a first-ever Community Innovation Conference to provide a forum for our community partners to showcase some of their services to our corporate partners; and the second year of the Out of the Cold program where a warm meal and a place to sleep is provided to the homeless during the winter months.

In the trauma program, the introduction of the world’s first Simulated Automated Mannequin strengthens our role as an international leader in the prevention, rehabilitation and treatment of trauma victims. This state-of-the-art teaching tool allows the trauma team at Hospital to experience the effects of various drug dosages and resuscitation techniques without adding risk to a real-life patient. An additional highlight for the trauma program was a five-year accreditation award recognizing the excellence in patient care, awarded by the Canadian Accreditation Council for Trauma.

Within our heart program, additional funding from the provincial government has allowed us to expand the number of open heart surgeries and other procedures we provided in 1996/97 and we anticipate that this will grow throughout the next fiscal year. The creation of the Terrence Donnelly Heart Centre, made possible through the generous spirit of philanthropy of a Toronto businessman, has brought our services for heart patients together.

Throughout the year, our accomplishments and celebrations - whether they

CONTINUED ON PAGE 4
Bibliography


Canadian Association of Food Banks (personal communication, August 18, 1998).


