Reaching North Dakota’s Food Insecure

SARAH E. COLBY,1 MARSHA PAULSON,2 LUANN JOHNSON,3 and ELIZABETH WALL-BASSETT1

1Department of Nutrition and Dietetics, College of Human Ecology, East Carolina University, Greenville, North Carolina, USA
2Great Plains Food Bank and Daily Bread, Fargo, North Dakota, USA
3Grand Forks Human Nutrition Research Center, Grand Forks, North Dakota, USA

For 1 in 12 North Dakotans the charitable feeding network is the difference between having food on the table and going hungry. The goal of this research was to determine needs, barriers to, and facilitators of optimal access to North Dakota’s charitable feeding programs. Focus groups and interviews with providers and clients were conducted to develop surveys. Surveys were distributed to clients by community liaisons and food assistance providers. Surveys were distributed to partners via mail. Results of the survey indicated that considerable areas were underserved. Clients reported barriers to accessing foods to be embarrassment, transportation, and insufficient amount of food provided. Providers reported increasing demands, insufficient resources, the desires to expand their roles as providers, and wanting to collaborate with existing federal food and nutrition assistance programs.

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Food security has been defined by the United States Department of Agriculture’s (USDA) Economic Research Service (ERS) as the ability to obtain safe and adequate food in socially acceptable ways. The ERS provides guidelines for measuring household food insecurity by 4 levels: high food security, marginal food security, low food security, and very low food security. Households with high food security or marginal food security are defined as food secure, and households with low or very low food security are defined as food insecure. In 2005 and 2006, 11% of households in the United States were food insecure, with 4% classified as having very low food security. As a measure to assist in reducing food insecurity, many food insecure families rely on charitable food providers as well as government food assistance programs. However, on average only 60% of people in the United States and 63% of people in North Dakota who are eligible to receive Supplemental Nutrition Assistance Program (SNAP) benefits (formerly known as the Food Stamp Program) participate in SNAP.

Food insecurity may be primarily a direct outcome of poverty and it also may have multiple and complex negative outcomes. Individuals with low incomes are more likely to have lower diet quality than individuals with higher incomes. Changing food behaviors is difficult for most people and Singleton recognized that the additional psychological and economic barriers experienced by low-income individuals compound the difficulties to make healthy behavior changes. Low-income individuals sometimes prioritize the daily struggle to survive over disease prevention or health promotion. Researchers have found that food insecurity parallels increases in body mass index (BMI). Given similar financial constraints, obese individuals are also more likely than normal weight individuals to fear running out of food and to buy cheaper foods.

Currently, the needs of clients and providers in North Dakota are largely unknown. Additionally, the barriers and facilitators associated with accessing food under food insecure situations in North Dakota are unknown. To improve the food assistance network in North Dakota and to best develop effective interventions to reduce food insecurity, food assistance partners need to increase their knowledge of the needs of the providers and clients and understand the barriers and facilitators associated with accessing food.

A community-based participatory research (CBPR) model can be useful in increasing the effectiveness of intervention efforts. In CBPR, community members are equal partners with academic researchers in defining the problem, developing interventions, collecting information, and interpreting the data in pursuit of socially relevant outcomes. Because community problems are complex, they are unsuited for the outside expert-driven research paradigm. CBPR can improve the reliability and validity of assessment tools, recruitment, retention, cultural sensitivity, and accuracy of data.
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interpretation.\textsuperscript{11,12} A CBPR approach is more likely to be culturally and socially appropriate and thus have relevant and long-lasting positive outcomes.\textsuperscript{11,12}

The goal of this research was to utilize a CBPR model to elucidate the needs, barriers to, and facilitators of optimal access to charitable feeding programs in North Dakota for both food assistance clients and providers. This information can be used to develop effective interventions to help alleviate hunger in North Dakota.

METHODS

This research was initiated from community identified needs and priorities using the CBPR model. A community agency, the Great Plains Food Bank, initiated and acted as the coordinating hub for all the research activities; however, all the community members and researchers were equal partners in all phases of the research process. Partners in this research process included:

- Great Plains Food Bank
- North Dakota State University Cooperative Extension Service
- North Dakota Community Action
- Eight regional Community Actions
- North Dakota’s Department of Commerce Division of Community Service
- Grand Forks Human Nutrition Research Center
- Community members

A steering committee was formed with members from the research partner institution and community organizations listed above. The steering committee identified community members in each of the eight state government defined regions of North Dakota who could act as Regional Points of Contact (RPOC). RPOCs in each region were recruited and completed a community profile. The community profile identified local resources, demographic profiles (total population, age distributions, medium income levels), and pertinent historical information (natural disasters, large company closings, etc). The community profiles may be used when developing future interventions to alleviate hunger in those communities.

The steering committee established the goal of identifying needs and barriers of both food assistance providers and clients. The researchers determined the need for development of a survey with focus groups comprised of providers and clients due to lack of existing survey tools that would assess the specific areas the steering committee had prioritized. Rural and urban providers were recruited by mail and telephone to participate in focus groups and were provided a food item as compensation for participation.

Three focus groups with food assistance providers were conducted over a 2-month survey development period in community locations
throughout the state that were designated by the steering committee as being most conveniently located for providers. Food assistance clients were recruited by RPOCs and provided with a $25.00 gift card as compensation for participation. Five focus groups with food assistance clients were conducted over a 2-month survey development period in community locations throughout the state that were designated by the steering committee and RPOCs as being most conveniently located for clients.

The steering committee used the results of the focus groups to develop a provider and client survey. The surveys were then content validated with 5 experts in the field of food insecurity. Partner surveys were face validated, test/retest reliability assessed, and evaluated with cognitive interviewing with 6 members of the target audience. Client surveys were face validated, test/retest reliability assessed, and evaluated with cognitive interviewing with 12 members of the target audience.

Providers distributed client surveys to current clients. Client surveys were also distributed by RPOCs to potential clients at a variety of community locations including public health departments, housing authorities, and social services. All NSDU (North Dakota State University) extension agents also distributed postcard surveys in rural areas throughout the state to their clients and community members with which they had contact. Of the 15,000 client postcard surveys printed, it is unknown how many surveys were actually distributed. Some RPOCs and providers reported distributing none of the surveys and some reported distributing most of the surveys. No specific number for how many postcard surveys were actually distributed to clients was available. However, it is estimated that there were 13,000 families in hunger in North Dakota during this process and 1854 postcard surveys were returned. It would appear that 15% of the total households in hunger in North Dakota at the time of this survey participated in the survey process.

Partner surveys were distributed by mail using the Great Plains Foods Bank mailing list of current providers. Of 123 provider surveys distributed, 69 (56%) provider surveys were returned. Postcard surveys and partner surveys were entered into a SAS V9.1 (SAS Institute, Inc., Cary, NC) database by trained GFHNRC (Grand Forks Human Nutrition Research Center) staff. Frequency tables were generated.

RESULTS

There were 5 key findings from the analysis of the client and provider surveys.

Key Finding 1: Significant portions of North Dakota are underserved by the charitable feeding network. Bringing all counties up to minimum service levels would require a relatively small increase in food provided (7%); meeting full service levels would require a 35% increase; creating a
hunger-free North Dakota would require almost doubling the current food resources.

Key Finding 2: Clients encounter barriers in accessing food assistance networks. Clients identified the top-3 barriers to using emergency feeding programs as personal embarrassment, transportation challenges, and the amount of food received not meeting the family’s needs. The majority of clients (83%) reported that the food they bought did not last; 76% could not afford to eat balanced meals; and 56% noted that they ate less than they should because there was not enough money. Barriers of access also were reported by clients. Seventy-eight percent of providers are only open during weekday business hours; 50% are not open on a regular (daily/weekly) basis; and 20% are open 4 times a year or less. Most providers believe that people are aware of their program, but only 20% of providers post their contact phone numbers, and only 28% are listed in the phone book. Contrary to providers’ perspectives, clients indicate that they remain unfamiliar with local programs and services.

Key Finding 3: Providers are strained by increased demand and limited resources.

Over 35% of providers report having insufficient food supplies to meet client needs. Fifty-five percent of providers state that clients are using their services more often. Thirty-eight percent of providers cite insufficient funding as a threat to the continued operation of their program. Twenty percent of providers report staffing and volunteer shortages; over 50% of pantries are run by volunteers (often older adults), with no full-time paid employees.

Key Finding 4: Providers expand and adapt their role to meet client needs.

Thirty-eight percent of providers have transitioned to the Client Choice model, giving clients the opportunity to choose their food. Forty-four percent of providers are offering some sort of home delivery service despite rising transportation costs. Twenty percent of providers are supplementing their shelf-stable food items by offering vouchers to purchase meat, produce, and perishables. Providers are interested in offering more services such as supplying recipes (46%), providing nutrition education (33%), and offering referrals to other local services (22%) if resources were available.

Key Finding 5: Opportunities exist for heightened collaboration between the charitable feeding network and federal nutrition programs. Less than one third of households that use charitable feeding programs also receive SNAP benefits. Seventeen percent of providers currently offer SNAP outreach, and an additional 19% are interested in providing this service.

CONCLUSIONS

North Dakota has a strong, viable, charitable feeding network with generally appreciative clients. However, significant gaps in service exist and barriers to accessing services remain a challenge for individuals struggling to
provide food for their families. This research identified existing gaps for clients and providers. With additional donations, providers would be able to better meet the food needs of clients. With additional volunteers, providers would be able to more effectively expand their roles, and as individuals with specific skill sets volunteer their time, providers may be able to provide more recipes, nutrition education, and referrals.

This project elucidated some of the needs of clients and providers and the barriers and facilitators associated with accessing food under food insecure situations in North Dakota that were previously unknown. The identification of clients’ top-3 barriers to using emergency feeding programs (personal embarrassment, transportation challenges, and amount of food received not meeting the family’s needs) was very important new information to North Dakota food assistance program efforts although similar to related studies in other states.13–15 Because clients had low awareness of programs and services, this highlights an additional issue that needs to be addressed. The increased client-perceived barriers for accessing food assistance programs will help improve efforts to strengthen the food assistance network and develop effective interventions to reduce food insecurity in North Dakota.

Based on the results of this study, one possible approach of a social marketing campaign would address many of the identified needs and barriers. A social marketing campaign focused on the food assistance network could affect social norms by redefining the “face” of the food insecure person thereby reducing the barrier of embarrassment; increasing the general public’s awareness of the need for donations (the public may not realize that the food assistance network runs primarily on donations and not government subsidy), thereby increasing the providers’ abilities to meet the needs of the clients; increasing the public’s awareness that the food assistance network is also largely run by volunteers, thereby increasing the human resources of providers; and advertising available food assistance resources (including locations, hours of operation, and contact information), thereby reducing the clients’ barrier of lack of awareness of resources.

Overall, community members and partners were enthusiastically involved in all parts of this research process. They were also eager to share the results of this process with their communities and took great pride and ownership of this collaborative CBPR project. The results of this community-driven process can be used to improve the health and lives of individuals and families living in North Dakota.

REFERENCES


