Food Insecurity, Poverty and Homelessness as Key Social Determinants of Health in Northern Ontario

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November, 2015
In 2014, around 4 million individuals in Canada suffered from some level of food insecurity which represents nearly 13% of Canadian households (Collins et al., 2014).

Food Banks Canada (2013) declared that more than 840,000 Canadians went to food banks in March 2013 in order to obtain groceries. This number has not declined over the last five or six years (Desjardins, 2014).
• In 2013, Canada had three to four million people who were living in poverty (Schreiner, 2013).

• Approximately 1.3 million Canadians experienced homelessness or extremely insecure housing at some point during the prior five years.

• At least 200,000 Canadians access homeless emergency services or sleep outside in a given year (Gaetz, Donaldson, Richter, & Gulliver, 2013).
Research Questions

1. What are the patterns and trends in food insecurity, poverty and homelessness amongst women in remote, rural and urban areas of northern Ontario?

2. What are the experiences of poor and homeless women in rural and urban northern Ontario with regard to hunger, poverty and housing challenges, and the impacts on physical and mental perceptions of wellbeing?
Proposed Theoretical Framework

- **Critical theory** blended with intersectionality theory.

- **Critical theory** is built on ideas pertaining to the promotion of critical consciousness and struggles to break down the institutional structures and arrangements that reproduce oppressive ideologies and social inequalities (Evans, 2006).

- **Intersectionality** is defined as a dynamic process of converging systems of relationships that offers an alternative approach for understanding differences in women’s experiences (Yoshida, Hanass-Hancock, Nixon, & Bond, 2014).
Framework for analysis of social determinants of health

- Socioeconomic and political context
  - (culture, religion, social system, human rights, labour market, education system)

- Structural determinants
  - (income, education, gender, ethnicity, ageing)

- Intermediary determinants
  - (living and working conditions; health-related behaviours)

- Biological processes
  - (physical & mental health)

Community Services

Health Systems
Women have reported consistently higher levels of household food insecurity than men in Canada (Matheson & McIntyre, 2014).

Despite efforts made towards poverty reduction, this problem has continued to prevent women and their dependants from living well and contributing to national growth and development (Lopez-Cano & Restrepo-Mesa, 2014; Usman, 2015).

Despite a large number of studies, reports about health-related challenges of homeless women remain sparse (Sarajlija, Jugovic, Zivaljevic, Merdovic, & Sarajlija, 2014).
• Programs and innovations, such as subsidized food and housing are essential, but long-term solutions lie in ameliorating inadequate incomes of women/families (Ionescu-Ittu, Glymour, & Kaufman, 2015).

• Power, Little, and Collins (2015) stressed that food insecurity is an urgent public health problem among women and their dependants in Canada, as it is associated with significant health concerns.

• Exploring the co-occurrence of food insecurity, homelessness, and behavioral health problems among poor and homeless women could improve gender-specific food and homeless services/programs designed for women who are unengaged in traditional services (Ponce, Lawless, & Rowe, 2014).
Study design

The proposed research will use a **sequential exploratory mixed methods design** guided by a **community-based research approach** and adoption of **participant-driven photo-elicitation interviews**.
Setting

- The setting is northeastern Ontario including remote, rural and urban communities. (Sudbury, Timmins, North Bay, Hearst, Cochrane and Moosonee).
- Research conducted on agency premises and sites where services are provided to poor homeless women/families and those at risk of homelessness.
- Areas will be selected that have been shown to have an increased incidence of homelessness and extreme poverty.
Study phases

• **First phase**: a secondary analysis of a database developed by the Poverty, Homelessness and Migration (PHM) project.

• **Second phase**: a qualitative exploration of the experiences of poor and homeless women. Interviews utilizing photo-elicitation with the participants.

• **Knowledge mobilization phase**: the results of the quantitative and qualitative analyses will be presented in a community forum in Sudbury and feedback obtained.
Sampling

• Data from participants for the quantitative component will be retrieved from the PHM project.
  • Approximately 3600 women (and a comparison sample of men) who participated in surveys.

• Participants for the qualitative component will be recruited from community service agencies such as food banks, meal programs, community supported shelters and housing programs.
  • Purposive and snowball sampling techniques will be utilized. Approximately 10 women with experiences of homelessness and food insecurity will be recruited for the photo-elicitation and individual interviews.
Data Collection Procedures

• **First phase (quantitative)**: will begin by determining a preliminary list of specific variables required to conduct a secondary analysis based on the focus of the study.

• Will capture the patterns and trends in food insecurity, poverty and homelessness from homeless women’s perspectives (in comparison to men).
## Quantitative Data Analysis

<table>
<thead>
<tr>
<th>Variables</th>
<th>Level of Measurement</th>
<th>Statistical Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-demographic</td>
<td>Categorical</td>
<td>Descriptive statistics (frequencies, percentages) and cross-tabulations (chi-square)</td>
</tr>
<tr>
<td>Age, gender, ethno/cultural group language, level of education, marital status, number of children or other dependents, custody of or accompanying children, income status, employment status and homelessness status.</td>
<td>Categorical</td>
<td></td>
</tr>
<tr>
<td>Coping strategies</td>
<td>Categorical</td>
<td></td>
</tr>
<tr>
<td>Referral to service provider.</td>
<td>Categorical</td>
<td></td>
</tr>
<tr>
<td>Reason of referral.</td>
<td>Categorical</td>
<td></td>
</tr>
<tr>
<td>Food insecurity</td>
<td>Categorical</td>
<td></td>
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<tr>
<td>Getting enough food to eat every day.</td>
<td>Categorical</td>
<td></td>
</tr>
<tr>
<td>Health and wellbeing</td>
<td>Categorical</td>
<td></td>
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<td>Any mental health problems last year.</td>
<td>Categorical</td>
<td></td>
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<tr>
<td>Any physical health problems last year.</td>
<td>Categorical</td>
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</tbody>
</table>
Second phase (qualitative):

- Recruitment, consent, camera handing and photo training
- Camera return
- Developing photos
- Community forum with photo exhibit
- Photo selection
- Individual interviews
All interviews will be transcribed verbatim (NVIVO 9 software).

This study will follow a **thematic analysis** approach for identifying, analysing and reporting patterns (themes) within data, **formulating codes** and **categories**, **grouping categories into themes**, and presenting the experiences of food insecurity, poverty and homelessness.
Implications/anticipated benefits:

• Views of the participants will enable service providers and community members to identify gaps in resources and devise locally grounded long-term solutions to addressing food insecurity faced by people who are absolutely homeless or at-risk of homelessness.

• Service providers will benefit by learning about the strengths as well as deficiencies of the resources within the community and gain new knowledge/strategies to address the gaps in services and improve the service delivery.

• Generate strategies or solutions to enhance the community’s response to food insecurity encountered by homeless or near homeless individuals.
  • Strategies for improving access to health and social services for poor and homeless people.
References


Thank you

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