2: The Health Issue

2.1 Who is being affected & how?

---- *The core issue*

The core issue affecting the target group is a lack of food security, which in turn is strongly related to experienced poverty (refer to Box 1). There are many determinants of poverty & food insecurity, as outlined in the needs assessment (refer to Appendix 1). Poverty and food insecurity can be considered as co-determinants, as the presence of one can directly influence the presence of the other. Hence, poverty can act as both determinant and a continued consequence of impaired nutritional and health status (Kramer-LeBlanc & McMurry, 1998).

Box 1: Definitions

Household food security:

- "Access by all people at all times to sufficient food for an active & healthy life, or more specifically:
- "Access of all members of the household, to a safe and nutritionally adequate diet, such that their nutritional needs are met", and that they may have
- "... the assured ability to acquire acceptable foods in socially acceptable ways."

Poverty:

- *Absolute*: income is inadequate to secure minimum amounts of food, clothing & shelter.
- *Relative*: income is inadequate to provide the resources necessary to have the living conditions & amenities & participate in activities, which are widely encouraged & approved in the society in which they live.

Adapted from: Booth & Smith, 2001; & Kramer-LeBlanc & McMurry, 1998.

---- *Influence of poverty on food security*

On average the incomes of poor Australians are 48% below their poverty lines. In 1999, most of the social security payments were below half the average poverty line and greater than half of the poor live in families whose main source of income is these cash beneficiaries (Harding & Szukalska, 1999; The Smith Family, 2001). In addition to limited disposable income, many experience unaffordable necessity living expenses, including housing, heating and medical expenses. The cost of housing in many inner-city metropolitan areas has increased significantly with escalating demand for housing situated closer to well-paid employment opportunities (The Smith Family, 2001). Housing costs faced by lowest-quintile income earners have previously accounted for, proportionately more than three times that of the average Australian budget (ABS, 2000).

Food is often the sole discretionary or expendable item in the budget of long income

households in Australia, that can be cut back on to meet these other needs (NZNAP, 2000; CDHHCS, 1994; Bernard, 1999). In 1998-99 lowest quintile Australian income earner spent approximately three times less on food and non-alcoholic beverages than the highest quintile earners and approximately half the national average (ABS, 2000). People on low incomes spend a greater proportion of their money on food compared to those on higher incomes (Bernard, 1999; Booth & Smith, 2001; CDHHCS, 1994). In 1998-99, this expenditure accounted for over 40% of their average weekly budget ($159.62), as compared with 10% for the highest quintile ($1996.29) and 14% for the national average ($879.22) (ABS, 2000). Low-income earners spent much less of their budget on non-essential food items (1/6 the amount on take-away and restaurant meals) and more of their budget on essential items (including fruit and vegetables in particular) and many do not have enough to cover even the most basic needs (ABS, 2000). Therefore, although Apparent Consumption data (ABS, 1998) suggest that we have an abundant and nutrient rich food supply for the average Australian, individual access may be limited through inequity of income and resources distribution. No amount of careful budgeting, and taking advantage of discounts and specials can negate the lack of necessary income resources (NZNAP, 2000).

2.2 How many people in what area are affected?

----Extent of poverty & food insecurity in Australia

The extent of poverty in Australia is significant, affecting 2.4 million Australians (approximately one in seven people or 13.3% of the population), including 14.9% of dependent children. As expected, the after housing poverty (remaining disposable income after accounting for housing costs) is even higher, at 17.9% (The Smith Family, 2001). Latest data analysis reveals that compared with the national average annual income of $28 074, South Australians have the lowest mean income ($25 029). Additionally, South Australians experienced the highest rate of poverty in Australia, with 23.3% of households below the poverty line, compared with the 17.9 % nationally (SACOSS, 2001; Carson E & Martin S, 2001). This figure represents a more than doubling in the poverty rate over the past 16 years. The groups most vulnerable to experiencing poverty are indicated in the attached Needs Assessment report (Appendix 1); of these South Australian as a state has the second highest number of long-term unemployed (35.9% compared with the national rate of 27.3%) and the greatest proportion of government income security payment recipients (Carson E & Martin S, 2001).

As a reflection or consequence of poverty and limited resources, the extent of food insecurity in Australia has been estimated as greater than 5% of the general population aged

16 years and over. Higher estimates were obtained for persons with low incomes (first quintile of equivalent income) and those reporting fair or poor health (13%), and youth aged 16-24 yrs with low incomes (17%) (Wood, 2001). However, the National Nutrition Survey data may underestimate the level of food insecurity, as a result of inadequate population representation, particularly with respect to older people, unmarried people, unemployed unmarried people, and particularly, homeless people (Booth & Smith, 2001). Certainly, food insecurity has been estimated as much higher amongst specific groups at risk, including: homeless young people (57%); unemployed (23%); single parent households (23%); street drug users (84%); the disabled and elderly (84%). Additionally, 29% of indigenous Australians aged over 15 worry about going without food (Booth & Smith, 2001). The issue of food insecurity *is* particularly significant for this latter group of indigenous people, who, suffer from considerable poverty risk, with an unemployment rate of 38%, which was almost five times greater than the national 1995 average (BSL, 2001).

2.3 How severe are the health implications?

----Effects of poverty & food insecurity on nutritional status & health

Socioeconomically disadvantaged Australians experience poorer health, have higher rates of mortality and morbidity (including chronic or recent illnesses), are more likely to suffer disability, and experience reduced activity due to illness (AIHW, 2000; National Health Survey, 1992; Podger, 1998). Low income can influence health both directly and indirectly. Poverty adversely affects an individual's ability to purchase goods and services that directly influence health -- such as food and good housing (Podger, 1998). However, poverty can also lead to reduced social participation and participation (or social isolation), and then indirectly, to poor health (Podger, 1998).

Food insecurity (as a consequence of poverty), can adversely affect nutritional status and thereby, health outcome. There remains a misconception that the higher rates of obesity in the socioeconomically disadvantaged indicate excessive nutritional status, whereas the quality of diets of these groups may actually prove less than optimum (ADA, 1998). Poorer intakes of fibre, fruit and vegetables, and whole grain cereals have been found in those with lower socio-economic status, whilst these groups receive more of their intake from meats and refined cereals, (Booth & Smith, 2001; Lester, 1994; Radimer et al, 1997; Rutishauser et al, 1994, Smith & Baghurst, 1993). Consistent with the above findings, micronutrient densities of vitamin C, folate, zinc, iron, magnesium, potassium, beta-carotene and thiamin have previously been found to be higher in high social status groups, and the proportion of energy

derived from fat to be lower (Lester, 1994; Rutishauser, 1994; Smith & Baghurst, 1993). Additionally, intakes of zinc and iron have been reported to be well below 70% of Recommended Dietary Intake in greater than 25% of middle and lower status women (Smith & Baghurst, 1993).

Consistent with above findings of lower micronutrient intake and higher fat intake, lower SES groups also suffer higher rates of diet-related disease throughout the life cycle including: low birth-weight babies, childhood and infant anaemia, and developmental delays; growth stunting; lowered immunity from infectious diseases; dental caries; obesity; hypertension; type 2 diabetes; elderly malnutrition and osteoporosis; cancer; and heart disease and stroke (ADA, 1998; Booth & Smith, 2001; James et al, 1997). Of the chronic diseases directly related to diet, the prevalence of rates of stomach and lung cancer, and stroke and coronary heart disease have been inversely correlated with social status in Australia (Smith & Baghurst, 1993). Population sub-groups that are particularly nutritionally vulnerable include pregnant/ lactating women, infants, children and the elderly; food insecurity in these groups could result in significant impairment to health status (ADA, 1998).

In addition to medical problems, food insufficiency and hunger leads to significant educational, psychological, economic and societal costs (ADA, 1998). Children suffer poorer school performance and decreased ability to concentrate, having implications for the child's ability to develop the intellectual, interpersonal, emotional, and social skills he or she will need to function effectively in society (ADA, 1998). Psychological suffering due to food insecurity is also a contributor to poor health and wellbeing, manifested through increased levels of stress, social constraints and social disruptions, and a reduction in physical, mental, spiritual, and social health and wellbeing (Booth & Smith, 2001). Economic costs to individuals and society result from the reduced capacity of those with nutrition-related illness to earn a living and physically access and prepare food, and hence these same individuals are further at risk for continued food insecurity (AIHW, 2000).

4: Rationale

4.1 Existing Knowledge

Literature regarding carefully planned, evaluated and longer-term sustainable Australian (and South Australian) interventions addressing food insecurity and poverty are hard to come by, even despite searching numerous literature databases and the HEAPS database. This overall lack of available information is compounded by the problem of implemented programs not being widely promoted, or their details not accessible via the World Wide Web. However, any intervention involving the issue of food security should consider a means of: fostering community ownership; providing training and support; supporting flexibility; and, working towards accessing funding that is not short-term or only focussed on innovation (Booth & Smith, 2001).

4.2 Previous initiatives addressing this issue

Both nationally and abroad nutrition programs have focussed on improving social, physical and economic access to food, and improving food knowledge and skills, through various approaches including social advocacy, food banks, community gardens, lunch clubs, and communal cooking programs. Many of these programs have provided much needed social support as well as nutritional support. However, these are not without their limitations or criticisms. Many interventions (including numerous projects in South Australia) have placed primary emphasis and importance on educating the poor about appropriate budgeting and cooking skills (Eat Well SA, 1999), and coincidently have failed to acknowledge or address underlying social, political or economic issues surrounding poverty and food insecurity. Such issues include the needs of welfare payments to meet the poverty line, improved availability of jobs and transport, and equitably accessible education and training for all persons in the community, including the disabled, poor and single mothers (Booth & Smith, 2001; also refer to Appendix 1).

Educational and behaviour change strategies have been the focus of The Food Cent$ program, a joint initiative of the Foodbank of WA Inc. and the Health Department of Western Australia (Foley, 1998). This initiative aims to improve welfare agency clients' healthy eating behaviours, by showing participants how to spend portions of the food money so that foods

chosen make a balanced, nutritious and satiating diet (Foley et al, 1997; Foley & Pollard, 1998). Participants learn how to feed a family of four for $5 per person, are taken on a shopping tour excursion, obtain information about budgeting, and additionally use the Food Cent$ Kilo-Cents Ready Reckoner counter. This tool allows shoppers to compare prices by weight, and provides evidence for the lower cost of nutrient-dense, fresh foods (Foley & Pollard, 1998). Variable levels of project success have been reported, with barriers to continued implementation cited as: lack of time, lack of client interest, limited space and personal problems of trained community advisers (who themselves experience socioeconomic hardship) (Foley & Pollard, 1998; Hollingshead, 2000).

Even food relief programs such as food co-ops and food banks have been criticised as a 'bandaid' solution, with the potential to deflect political attention from the structural causes of food poverty, and thereby limiting the resources available to achieve long-term food security (Coveny, 2000; Booth & Smith, 2001). Frequently, food banks only have poor quality or limited quantity of food donated for distribution (Tarasuk & Reynolds, 1999). However, these concerns do not seem to be equally applicable to the innovative "Community Kitchen" approach, which has been widely embraced in both the United States of America and Canada.

Community kitchens are groups of people who regularly come together to prepare food for themselves and their families; they may then dine in for a meal, or take the food away to freeze, or possibly take advantage of both approaches (Tarasuk & Reynolds, 1999). Whilst a basic objective may be to improve access to adequate food, at the same time many other fundamentals of both health promotion and food security are addressed (Table 1; Crawford & Kalina, 1997). The acquisition of cooking skills is not the primary focus of the kitchen but it can expose members to new foods and different methods of food preparation (Tarasuk & Reynolds, 1999). The primary limitations previously identified were dependence for benefit on the availability of transportation and home freezers (Tarasuk & Reynolds, 1999).

Previous participants comments have included that they were "eating better, more varied diets" since the program started, especially when tired or short of money, "because they could just take a meal out of the freezer" (Crawford & Kalina, 1997). Participants felt that attending a community kitchen was preferable to using food banks and various hand-outs as there wasn't the same extent of stigmatisation or humiliation attached to the community kitchen. The participatory aspect of the community kitchens seems to be the crucial difference (Tarasuk & Reynolds, 1999).

Table: 1 Community Kitchen participant benefits
✳ Receipt of a free or reduced-cost healthy meal
✳ Mechanism to provide social recreation & support
✳ Highly social atmosphere lends itself to the sharing of ideas & information
✳ Encourages mutual aid & problem solving
✳ Allows for learning of strategies to minimise food costs
✳ Budgeting, shopping 'wisely'
✳ Builds a diverse array of skills, increases self-competence & self-efficacy, confidence, empowerment & self-esteem.
✳ Enhances food-related knowledge & skills
✳ Allows for day-care & a break from children
✳ Has influences at the broader community level → renewed visibility & heightened public awareness of food insecurity & rallying of community support & public participation for lobbying for welfare reform to enhance community health
✳ Increased opportunities for, & success in gaining, employment in food-related fields
Adapted from text in: Crawford & Kalina, 1997; Marquis et al, 2001; Tarasuk & Reynolds, 1999.

Community kitchens can be primarily cooking class based (food skills and nutrition education), bulk food preparation based (food security) or social (preparing a meal to have together). Research suggests that the latter two approaches are considered both more beneficial and attractive to participants and hence these aspects should be incorporated into the primary intervention (Crawford & Kalina, 1997). In keeping with the needs and current skills of the target group, community kitchens do not place emphasis on cooking skills. However, cooking components can become an opportunity for those involved to explore ways to increase the variety of different meals that can be created with a limited variety and number of foods, and an introduction to unfamiliar foods and ways that these can be incorporated into the diet.

The extensive benefits (Section 4.2 and Table 1) and amenability to success is supported by previous research (Crawford & Kalina, 1997; Marquis et al, 2001; Tarasuk & Reynolds, 1999). Community kitchens have indeed proven to be successful and sustainable in the longer-term, and can have potential influences at the broader community level with off-shoot groups being able to lobby government regarding welfare issues and provide support for people living in poverty (Crawford & Kalina, 1997). Community kitchen interventions have demonstrated observable evidence of participatory self-competence or empowerment as well as the fostering of not only public awareness but also public participation to enhance community health and endeavours to further support low-income families, through advocacy, food subsidy, provision of equipment and volunteers (Crawford & Kalina, 1997).

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