Food as Harm Reduction

Food as Harm Reduction: Barriers, strategies, and opportunities at the intersection of nutrition and drug-related harm

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Abstract

Research suggests that food insecurity exacerbates the harms experienced by people who use drugs (PWUD). Therefore, improving the food security status can help PWUD reduce drug-related harms. This paper identifies a knowledge gap in public health and harm reduction literatures regarding the relationship between food and harm reduction. We argue that there needs to be a more comprehensive and systematic model of food provision in harm reduction services. Our argument is based on a qualitative case study of 42 people who currently use, or have used drugs in Vancouver, Canada and of staff of 27 programs that provide harm reduction services in the city. The research demonstrates how PWUD experience the effects of drug use on their food consumption, how they access food, and how they practice self-care. It also shows how harm reduction services, while they often provide food, are unable to systematically address the dietary-related harms associated with drug use. This presents an opportunity and a challenge for these organizations and for harm reduction as a public health approach. We call for more research to be done on food as harm reduction and for stable publically funded food provision in harm reduction-oriented services.

**Key Words:** Food Security; Harm Reduction; Public Health; Foodscape; Vancouver, BC

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Introduction

Contemporary societies are marked by food insecurity, characterized by economic and social barriers to accessing healthy, nutritious, sufficient, and culturally appropriate food in ways that are personally acceptable (Davis and Tarasuk, 1994). In Canada, for example, food insecurity is more prevalent among certain groups, such as single mothers, new immigrants, and Aboriginal groups (Tarasuk, Mitchell, and Dachner 2016). It has been well documented that people who use drugs (PWUD) disproportionately experience food insecurity (Himmelgreen et al. 1998; Romero-Daza et al. 1999; Anema et al. 2010, Schmitz et al. 2016). For example, 65% of people who inject drugs (PWID) in urban Canada reported difficulty affording enough food and experiencing hunger (Anema et al. 2010) and 58% of people who inject drugs in Los Angeles and San Francisco reported food insecurity (Schmitz et al. 2016). This is compounded when PWUD have comorbidities, such as HIV (McKay et al. 2017). One study found that 73% of people living with HIV in British Columbia, Canada who used an AIDS Service Organization were food insecure (Anema et al. 2016). The study found that participants were found to also have poor dietary quality.

Drug use can influence the nutritional and health status of PWUD, both physiologically and through behavioral effects. Physiologically, drug use has been found to produce drug-induced anorexia (from using drugs or withdrawal symptoms), which in turn can result in micronutrient deficiencies, malnutrition and becoming underweight (Himmelgreen et al. 1998, Romero-Daza et al. 1999, Saeland et al. 2010). These consequences can, in turn, reduce the ability to fight off infections, leading to increased morbidity and mortality (McIlwraith et al. 2014, Saeland et al. 2014). Food insecurity for people living with HIV has been associated with a number of negative health consequences, including lower rates of Anti-Retroviral Therapy adherence, decreases in physical health, reduced viral suppression, poorer immunologic status, and increased incidence of serious illness and mortality (Weiser et al. 2011, Whittle et al. 2016). Whittle et al. (2016) found that food insecurity affected the ability of individuals to keep clinic appointments due to feelings of hunger and exhaustion. Food insecurity can also lead to macronutrient and micronutrient deficiencies as well as increasing the participation in risky sexual behaviors, which can contribute to the transmission of HIV (Weiser et al. 2011). Finally,
food insecurity has also been associated with depressive symptoms among both people living with HIV and HIV negative PWUD, suggesting a relationship between nutrition and mental health outcomes (Anema et al. 2010, 2016, Davey-Rothwell et al. 2014, Whittle et al. 2016). Drug use may contribute to food insecurity due to a lack of resources to purchase food, the consumption of food that is high in fat and sugar and low in vitamins and minerals, irregular eating habits and engaging in potentially risky behaviors, such as stealing food, trading sex for food or engaging in unprotected sex (Anema et al. 2016, Neale et al. 2012, Saeland et al. 2008, Shannon et al. 2011, Strike et al. 2012, Tarasuk et al. 2005, Vogenthaler et al. 2013). Food insecurity, then, destabilizes people’s lives and can put individuals at greater risk for experiencing violence, incarceration, and exposure to pathogens.

Harm reduction service providers operate low-barrier programs that primarily serve low income PWUD in order to mitigate the negative health, social, and economic consequences of drug use using pragmatic interventions like clean needle provision, methadone treatment, or supervised injection. While not demanding abstinence, harm reduction approaches are successful public health interventions into the lives of people who are often the most marginalized in society (Jozaghi and Andresen 2013, Smith 2012). In more general terms, harm reduction approaches seek to stabilize people’s lives in order for them to develop less harmful relationships with psychoactive substances. Thus, some interventions, like low-barrier housing provision, have also been integrated into harm reduction programs (Katz et al. 2016, Pauly et al. 2013). Yet, food provision has not been systematically included in harm reduction practice and analysis, while uneven attitudes toward the role of food in harm reduction have been found among public health providers (McLean, 2012; McIntosh 2015, 2016).

Through a study of both people with a history of drug use and also of harm reduction service providers in Vancouver, Canada, we argue that there needs to be a more comprehensive and systematic model of food provision within harm reduction approaches to illicit drug use. We demonstrate that service providers who use a harm reduction model often provide food to their participants, yet they are not adequately funded or equipped to address the dietary-related harms associated with drug use. This presents both an opportunity and a challenge for these organizations and for harm reduction as a public health approach. In the
following sections, we present qualitative data that demonstrates the relationships between chronic drug use, food insecurity, and harm reduction using semi-structured interviews with two groups – PWUD and representatives of organizations providing harm reduction-oriented services in Vancouver. We conclude by suggesting that PWUD present a unique challenge to addressing issues of food insecurity. While they are in need of high quality food in order to support their health, PWUD also often have difficulty accessing it because of drug use. While charitable food providers are frequently used by PWUD as part of their geography of survival, these sites also present challenges and risks. Harm reduction service providers offer a unique position within the foodscape to offer healthy food which is provided in a dignified manner.

Harm reduction and food insecurity in Vancouver, BC

Historically, illicit drug use among service-dependent people has been most associated with the Downtown Eastside neighborhood of Vancouver. The neighbourhood includes a concentration of social services, including a number of free or reduced-cost meal programs that are provided through drop-in centres, religious organizations, and shelters. While there are many soup kitchens and other free meal programs in the neighborhood, there are also high rates of malnutrition and food insecurity, creating a paradoxical foodscape of food availability and food security (Miewald and McCann 2014). This foodscape is a geography that encompasses all places where food is obtained such as grocery stores, restaurants, food banks, soup kitchens, and garbage bins as well as the social relations through which food is accessed (Miewald et al. 2010, Miewald and McCann 2014). Food programs are, more generally, part of the daily ‘geographies of survival’ (Mitchell and Heynen 2009) for PWUD, as the availability and accessibility of food resources is a crucial component to their ability live. Geographies of survival encompass the “network of public and private spaces and social services” (Mitchell and Heynen, 2009, p. 611) that provide the necessary resources for systematically marginalized people. Foodscape and geographies of survival conceptually frame our discussion of the relationship between food access and harm reduction, as part of an interlinked landscape of services used by PWUD for their everyday survival.
While the relationship between drug use and poor nutritional outcomes has been well documented, there remains little in the academic or policy literatures addressing the intersection of food security and harm reduction. Our research shows that food provision by service providers who use a harm reduction approach is often *ad hoc* and without adequate funding or resources. This is not unique to Vancouver. For example, a study of a needle exchange program in New York, McLean (2012, p.298) notes, “The importance of food in particular was manifest in both daily and monthly patterns of attendance that followed meal schedules.” Yet, there was also disagreement among staff “about what ‘harm reduction’ should or could involve, and consequently, what the real harms of drug use were” (Ibid.). We address this gap by drawing out how both PWUD and service providers experience and understand the relationship between food and harm reduction, with a particular focus on the urban geographical contexts of the relationship.

**Methods and Data Analysis**

This study is based on semi-structured interviews conducted with 42 current and former PWUD who were participants at a drop-in centre located in the Downtown Eastside, which provides support for PWUD using a harm reduction approach. Additionally, we conducted interviews with 35 staff members at 27 programs that provide harm reduction services in Greater Vancouver. PWUD were recruited by a poster advertising the study at a drop-in centre, with the support and consent of centre staff. This centre was used as both a site for recruitment and interviewing because it was considered a safe and accessible site for PWUD. Participants were given a $10 honorarium. The only inclusion criterion was that the individuals used the drop-in centre. The interview was initially designed to assess the relationship between housing and food insecurity, however drug use emerged as a significant barrier to food access (see Miewald and Ostry 2014). These studies were approved by the office of research ethics at Simon Fraser University.

Interview questions for PWUD included basic demographics (gender and age), chronic health conditions, history of drug use, current and previous housing situation, where individuals
access food and any barriers they experience that might lead to food insecurity. The majority of these interviewees were single Caucasian men, although efforts were made to include women and representatives of other ethnicities. Participants ranged in age from 26 to 65, with a mean age of 41. While the majority reported using several types of drugs, the most common were cocaine/crack (41%) and heroin/morphine (24%). Marijuana (14%) and alcohol (12%) were also reported, but usually as secondary to other drugs. Nine respondents (21%) were no longer using or in drug treatment at the time of their interview. 69% reported having at least one health problem, including Hepatitis C (26%), mental illness (21%), arthritis or other mobility issues (15%), HIV/AIDS (13%), and digestive disorders (13%).

In order to assess the level of food provision for PWUD, representatives of 27 organizations in Greater Vancouver were interviewed. Inclusion criteria were that the organization self-identifies as being harm reduction-oriented, provides services to people who are actively using illicit drugs (a foundational element of harm reduction), provides harm reduction supplies, and/or engages in harm reduction policy advocacy. The organizations included those focused on low-barrier housing and emergency shelters (n=8), drop-in centres and services (n=6); AIDS service organizations providing harm reduction supplies, supports, and advocacy (n=5); health services (n=4); harm reduction and drug policy advocacy (n=2); a needle exchange; and a legal supervised drug consumption site. Interviews with service providers focused on their food provision activities (if any), their observations on the impacts food insecurity may have on service participants, and on the role nutrition might play in addressing drug related harms. These findings highlight both how harm reduction providers view food provision and also the gaps in service that should be addressed through more comprehensive food and harm reduction programs and policies. All interviews were recorded, transcribed and categorized with a priori codes derived from the interview guides and emergent codes derived from the interview content. This process, grounded in critical and feminist research into drug use, provided textual information on food access and consumption patterns by active and former PWUD in a low-income community that would be unavailable through surveying or other quantitative means (Boyd et al. 2008, Clatts et al., 2002).
Everyday Experiences of Food Insecurity among PWUD

A fundamental principle of harm reduction is that PWUD are, can and should be active participants in their own healthcare. There should be no blanket assumption that PWUD are negligent or self-destructive. Indeed, recent studies have highlighted the various ways PWUD are active in maintaining their mental and physical health (Greenspan et al. 2011), including their nutritional status. Drumm et al. (2005) show that, despite significant barriers, PWUD pay attention to the quality and quantity of food they consume and develop strategies to ensure they have enough food to eat. In this section we highlight structural, physiological and spatial themes that emerged in low-income PWUD’s relationships with food, nutrition, health, and their surrounding environments. Following common practices of qualitative data analysis, the quotations here are representative of respondents’ answers (Clatts et al., 2002). We discuss three themes that were derived from the interviews 1) the self-reported effects that drug use has on the diet of participants, 2) the strategies used for accessing food within the Downtown Eastside foodscape and 3) PWUD’s tactics used to avoid some of the nutritional harms of drug use.

“Once I touch it, the food doesn’t matter”: the effects of drug use on food consumption

Despite the relatively abundant foodscape in the Downtown Eastside, PWUD are susceptible to food insecurity due to financial constraints, loss of appetite due to drug use, time constraints caused by the need to focus on generating enough money to buy drugs, lack of ability to store or prepare food where they live, and their concerns about personal safety in public spaces. For some, their meager income was used to pay for drugs in order to avoid withdrawal, leaving food as a secondary concern. This was the case for Belinda who explained, “Every penny’s gotta go to drugs, so until I get over that hump, it’s a matter of eating what I can when I can find it.” Respondents also noted that lack of appetite while using drugs led to missed opportunities to access food from providers. As Karen noted, “once I touch [the drug], the food doesn’t matter ... I missed meals because I didn’t show up at the right time or whatever so I’d go without food a lot longer. When I was doing the dope and that, I wasn’t interested in lining
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up for food.” Martin echoed this sentiment, highlighting the cycle of drug use and the search for money and drugs that often took priority over eating.

“With crack, when you’re chasing, that’s the most important thing to you, while you’re high you can’t eat, and when you come off, you’re jonesing and you’re chasing it while you should be eating and you’re trying to find some way to score ten bucks.”

Jeremy also noted that food was rarely important and was only consumed when it was readily available. “Like, if I’d see stuff, if I’d be passing through and they’d be handing out sandwiches, I’d grab one of those but, actual meat and potatoes stuff? I wouldn’t have the opportunity or I wasn’t hungry or I was sick.” These accounts illustrate that drug use is a barrier to accessing food for PWUD, even when it is available from charitable food providers. These finding suggest that PWUD have unique challenges to accessing food that cannot be remedied by relying on a charitable model of food provision.

“It’s a matter of eating what I can when I can find it”: negotiating the urban foodscape

PWUD have the daily challenge of navigating the foodscape as part of their daily geographies of survival. Belinda, Karen, Jeremy and other respondents indicated that they used a variety of strategies in order to access food, often relying heavily on free or reduced cost meals programs. In fact, all respondents reported using charitable food providers (including soup and community kitchens, and meals provided through supportive housing and rehabilitation facilities) for at least one of their daily meals. Moreover, 60% of respondents reported using free or low-cost food meal programs for the majority of their meals. At the same time, simply accessing food can put individuals at risk from fights and inter-personal conflicts with others accessing the site, stress from dealing with staff who may enforce rules and regulations that bar certain individuals, or encounters with law enforcement. These risks can result in physical or psychological harm or incarceration. Women in particular noted that they did not like to stand in food lines because of harassment from others in the line-up, and preferred “women only” food providers. Cynthia epitomizes this view:
"I don’t have to worry about guys bugging me and it’s a safe place to eat...Not that I’m a priss or anything but there’s a lot of drug addicts and drunks and stuff and even though I’m one of those people I don’t like to be in an enclosed space with a lot of them."

For those who earned money in the underground economy, either through sex work or selling drugs, finding a safe space to eat could also be challenging. For example, although Jack usually had money for food during his stint as a low-level dealer, he often found it difficult to find a safe place to eat where he wouldn’t be threatened by other dealers, customers or the police. He noted that “If [the police] want to pick up someone on a warrant, [they] just go by the free food places.” Convenience and privacy were factors in where and when Jack accessed food. Standing in long food line-ups was viewed as a waste of time and also exposed individuals to both the police and rivals in the neighborhood. “I had to really, really force myself to eat. I would go to [low-cost provider] and pay for my own meals because I wouldn’t have the time or the patience to wait in the food lines. I would always have $2 for the [low-cost provider]. It’s not too hard to put together $2 when you have a pocket full of dope.” Thus, purchasing food rather than relying on charitable meal programs was one strategy to avoid line-ups and other barriers. It was often preferred over accessing charitable food providers due to greater choice and flexibility over what and when to eat (see also Gaetz et al. 2006, Miewald and McCann 2014). Among study participants, 76% said that they sometimes ate at inexpensive or fast-food restaurants when they had the money and 86% reported shopping, at least occasionally, for food if they had money.

“I take a lot of vitamins and drink a lot of Gatorade”: Self-care strategies to avoid nutritional harms

Acknowledging the negative consequences of drug use on food intake, some respondents said they were aware of the problems of weight loss and dehydration and reported developing strategies to avoid these effects. These included taking vitamins, drinking sports drinks to avoid dehydration, smoking marijuana to stimulate appetite or buying food in advance of using drugs to guarantee that they had something to eat if they were unable to access food providers. Tony
described some of the strategies he used to avoid negative effects on food access that can result from drug use.

“I take a lot of vitamins myself too and drink a lot of Gatorade if I’m on a long jag smoking crack. You’ve got to keep your body hydrated. You gotta make sure, even if you’re losing the weight, that you’re getting essential vitamins and stuff you need ‘cause that’s what will cause more long term damage or problems with mental breaks.”

Some respondents said that they “load up” on food before using drugs to have enough energy to last several days without eating. Belinda described her strategy to ensure she has at least some food available: “I try every month I go and do my groceries first-off for stuff for the month, like powered milk and canned stuff and peanut butter.” Jack described a cycle of bingeing on food when he was not using and then forcing himself to eat and drink nutritional supplements while he was:

“I would try to eat once a day and I was drinking a lot of Ensure...But it was really difficult to make myself eat because I was never really hungry... I would binge [on drugs] for a day or two and then afterwards I would eat non-stop as much as I could for a few days to replenish what I’d lost.”

Our study suggests that self-care strategies are important to low income PWUDs effective use of food resources. Yet, these strategies are reliant on individuals’ resources and the knowledge they have gained through their lived experience.

Food and Harm Reduction Service Provision: Perceptions, Practices, and Barriers

Because of the critical role that harm reduction service providers play in supporting and maintaining the health of PWUD, it is important to address how these providers perceive the role of food in their programs and how they enact strategies to support their participants’ nutrition. In Vancouver, harm reduction takes varied forms, from low-barrier housing and drop-in centres that offer supplies like needles and pipes to supervised drug consumption sites. Despite the ad hoc nature of funding for food, we found food provision to be ubiquitous in
these sites. Of the 27 sites and programs interviewed, only 2 did not provide food or food preparation spaces. The type of food provided and the character of provision varied dramatically – from granola bars, to full meal programming, community kitchens, and take-home food bags.

Service providers revealed that they provided food primarily because they saw acute nutrition needs in their participants. For instance, when asked about the motivation for food provision, the director of an HIV-specific health support program argued,

“the healthier a person is, the better they are [able] to fight off opportunistic infections and such. Secondly... we know that if we didn’t offer, there would be people who [would] not have food.”

Most harm reduction service providers shared this rationale. At the same time, while food was viewed as important to maintaining health, it was also seen as a means of attracting participants, opening lines of communication, and as a gateway to other services. For example, as well as providing full meal services at their main facility, a drop-in centre and outreach program for street-involved youth provided granola bars and juice boxes as part of their outreach. One of their staff, noted that, “The idea [of providing food] was just to start giving it to them, and then [asking], “hey how are you doing?” This contact would, they hoped, lead the participant to stay around the centre longer. “And then, half an hour later, it might [be] that [we find] they have to go to the hospital because they had a throbbing pain in their leg that they hadn’t gone taken care of.”

Food provision, for this organization and others, is both a nutritional intervention and also a caring social gesture that could prompt connection to other health services and resources. Other commonly stated benefits of providing food included its ability to improve participants’ mood and behaviour, promote socializing among participants, encourage healthier nutritional choices, and, in programs using community kitchens or support workers to teach cooking skills, increase independence and skills-building.

Despite attention to food, harm reduction service providers generally struggle to fund their food programs. In British Columbia, service providers’ operating funds can rarely be used
to fund food programs. Providers typically rely on combinations of funding from multiple sources, such as Provincial and Federal governments, health authorities, food banks, and reallocated general program budgets (see also Slater et al. 2015, Pettes et al. 2016). Additionally, despite the prevalence of some form of food distribution in nearly every harm reduction program surveyed, most service providers did not immediately express clear or direct links between food provision and their harm reduction goals. Nevertheless, given the opportunity to talk through the issue in an interview setting, most began to actively make those connections. For instance, the director of a drop-in centre for PWUD explained that food security is,

“one of the foundational tenets of harm reduction, because harm reduction seeks to increase safety and dignity for people, and reduce harm. And so, helping someone to have a healthy physical body and a well-fuelled physical body and teaching people about nutrition is a huge part of that.”

Service providers repeatedly emphasized that good nutrition supported their efforts to reduce drug related harms. For example, a representative of a supervised consumption site described how their broader harm reduction goals would be supported if participants had some measure of food security, saying,

“if you look at harm reduction as needle distribution, crack pipe distribution, and [the consumption site], it’s really a one-dimensional vision... It’s in society’s best interest, from a cost-benefit perspective, from a humanist perspective, to be able to provide ... food.”

Although many were entirely reliant on government funding streams, service providers were critical of the charity model of food provision. They argued that funders have not recognized the vital role of food in the wellbeing of participants, that stagnant funding rates were inadequate for providing nutritious food, and that constantly applying for funding and donations created a sense of competition among service providers and took up too much staff time. The coordinator of a drop-in centre for people with mental health barriers explained, “it’s like the super capitalist way of dealing with social problems”.
Some service providers did indicate that food security was increasingly on the radar of some funders, but that their funding was still insufficient and inflexible. The acting executive director at a housing and shelter organization said,

“‘They must be getting fed.’ That’s what people assume... Shelters come with food funding, right? But housing doesn’t, and even transitional housing typically doesn’t... so it’s staff, and you know, friendly neighbours basically supporting the food needs of people, which is not how it should be.”

Organizations with food budgets reported that their funding for food programming had remained stagnant, or had increased at rates far below those of the cost of food. The Executive Director of an AIDS Service Organization for women explained that “food costs go up, membership goes up, rates of pay for staff go up. The rate of what they [funders] contribute to us doesn’t go up.”

Thus, our interviews suggest that harm reduction service providers, like the PWUD who participate in their programs, understand the importance of nutrition in promoting health. These interviews emphasize that while PWUDs negotiate many barriers to nutrition, service providers are also challenged in ensuring food security for their participants, largely due to insufficient funding, and other systemic barriers. These findings, which focus on harm reduction services, are largely in line with existing critiques of other forms of charitable food provision (e.g., Dachner et al. 2009, Slater et al. 2015, Tarasuk et al. 2005).

**Discussion and Conclusion**

Examining the lived experience of food access for PWUD and the realities of food provision for harm reduction service providers reveals several salient issues. While charitable food providers are important food resources, accessing these services can place individuals at risk, either through low quality food or exposure to stigma and violence. Additionally, because of the effects of drugs on suppressing appetite, PWUD have a unique set of barriers when it comes to accessing food. The creation of safe spaces that protect against these harms is one means of improving food security for PWUD. Harm reduction service providers are uniquely situated to
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provided such spaces, yet they often lack the resources and funding to fully support their participants’ food needs.

More specifically, there are three findings that emerged from this research. First, food insecurity for PWUD is affected by various and interrelated elements that constitute and often exacerbate the harmful aspects of urban foodscapes. While PWUD suffer from some of the same issues that other low-income groups do, such as low welfare rates, they also experience food insecurity due to drug use itself. In order to construct effective public health programs and policies to address food insecurity among PWUD, more research needs to be done on the ways in which PWUD navigate the foodscape as part of their geography of survival and the risks they encounter in accessing both nutritious food and health services.

Second, it is necessary to create nutritional programs and services that address the unique challenges that PWUD face when it comes to accessing food. To date, much of the focus on food security among PWUD has been on nutritional interventions “including nutritional status assessments, advice on healthy diets, referral to nutritionists and food programs and the prescription of meal replacements or dietary supplements” (Neale et al. 2012, p. 636, see also McIlwraith et al. 2014). These types of interventions may not take into account the lived experiences of PWUD in their daily interactions with food, including issues of poverty, inadequate housing and reliance on charitable food, however (see also Nettleton et al., 2012). As Gustafsson et al. (2011, p. 388) note, within public health, “there is a ‘disconnect’ between healthy eating guidelines, that assume an ‘idealised, individualised world’, and actual practices in everyday life.”

This emphasis on individualized responsibility fails to address underlying structural causes of food insecurity and ignores the ways in which PWUD understand their own dietary practices. Critical harm reduction literature (Chen 2011, Moore and Fraser 2006, Mcclean 2011, 2015, Smith 2012, Temenos and Johnston 2016) critiques mainstream “intervention” approaches that focus on individual behavior change. Instead, this literature suggests the need to examine larger ‘risk environments’ (Rhodes 2002), and political economic conditions when assessing the harms associated with drug use. Similarly, a foodscape approach recognizes the structural causes of food insecurity as well as personal agency in navigating the food landscape
(Miewald and McCann 2014) and therefore provides a lens through which to understand food as part of a harm reduction framework that goes beyond simply providing food through a charitable model. Issues such as current drug laws and lack of affordable housing also contribute to food insecurity for PWUD. Thus, our interviews emphasize that strategies to improve food access for PWUD should be designed with the realities of drug use, poverty and social marginalization in mind. Food programs should be spaces where PWUD feel safe and supported, provide a buffer from the risks of drug use and be integrated with other harm reduction services.

Third, improving the food security of PWUD should be viewed as central to public health and harm reduction and should, therefore, be supported by the state, rather than left to *ad hoc* charitable providers. Given the impacts of drugs on appetite and food choice, our interviews show that the experience of food insecurity among low income PWUD is qualitatively different from other low-income groups (see also Schmitz et al. 2016). Simply improving access does not address physiological or structural issues of lack of appetite, housing instability, and the risks that PWUD, in particular, face when accessing food programs. Therefore, specific strategies need to be developed for and with PWUD. For example, the interviewees in this study used a variety of self-care strategies to mitigate the nutritional harms of drug use, exhibiting strong agency in achieving their nutritional goals. These strategies may provide a basis for public health messages that are appropriate for PWUD.

Charitable food and harm reduction service providers comprise important spaces in the foodscapes of PWUD in Vancouver. Yet, despite the abundance of charitable food providers, food insecurity continues to be part of the lived experience of PWUD. Targeted approaches to addressing the barriers to food access as well as better integration of food and harm reduction programming are ways of addressing this issue. Future research should investigate the lived experience of food insecurity for PWUD in order to create strategies that fully meet their needs.

1 Names and other identifiers have been altered to protect the identity of interviewees.
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