Building Health Equity through Policy and Power Shifting:

A collection of case studies for charitable food systems stakeholders

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About This Resource:
This resource, "Building Health Equity through Policy and Power Shifting: A collection of case studies for charitable food systems stakeholders" was developed by Marianna Wetherill, Karla Finnell, and Karen Ortiz, of the University of Oklahoma Hudson College of Public Health. This resource is intended for educational purposes to support food banks, food pantries, health care partners, and other community-based organizations working to advance health equity through charitable hunger relief efforts. It was originally used as part of a larger health equity training series for Feeding America National Office staff and its network of food bank partners conducted in the spring of 2021.

Before Using This Resource:
These case studies are a recommended activity as a companion piece to "Identifying and Countering White Supremacy Culture in Food Systems" written by Alison Conrad, MPP, of the Duke Sanford's World Food Policy Center.

READ the Report or LISTEN to the Podcast: Identifying and countering white supremacy culture in food systems before starting the case study exercise.

Additionally, questions within this guide refer to the terms "Big P" and "little p" policy. Big P policy refers to local, state, or federal policies. Little p policy refers to organizational policies, including their practices, procedures, and programs.

How to Complete Case Studies:
Case studies can be completed in small groups over the course of several sessions (e.g., one case study per session), as an independent exercise, or a combination of both. Keep in mind that the "Discussion Guide" at the end of each case study is simply a guide. The answers we provide are not finite and are only intended as a starting place for your group discussion or self-reflection. We challenge you to add more insights and ideas into the discussion guide as you work along.

We also encourage you to establish several ground rules before proceeding with this exercise in a small group or as an individual exercise.

1. **Stay engaged**- be present and invested through active participation
2. **Speak your truth responsibly**- share your thoughts and feelings authentically, and do so in a way that is not destructive
3. **Listen to understand**- listen with respect, empathy, and be open-minded withholding judgement
4. **Be willing to do things differently and experience discomfort**- learning new things can sometimes be uncomfortable, but practice trying something new
5. **Expect and accept non-closure**- answers may not always be available and there is no perfect outcome, but lead with kindness and grace, and aim for continual improvement
6. **Confidentiality**- stories and personal experiences shared in the groups are held with confidentiality

Please Note:
Shifting power to communities and groups served is a process, and is a necessary component for equitable organizational practices in advancing health equity. Although cases incorporate examples of programs and/or approaches found within the charitable food sector, all other details are fictional.

-1- Food Pharmacy Initiative

Building health equity through policy and power shifting: A collection of case studies for charitable systems stakeholders

There was rising controversy as to whether nonprofit hospitals provided enough community benefits. Most benefits were limited to charity care, and little spending led to community health improvement. In response, the Affordable Care Act mandated that nonprofit hospitals conduct a community health needs assessment and implement community health strategies, establish written policy for medically necessary and emergency care, and placed limits on billing and collection requirements. There are no minimum community benefits that a hospital must provide. Nevertheless, there are now incentives to work with community partners to improve community health.

A representative from an internal medicine clinic approaches their regional food bank with the idea to distribute healthy foods to Medicaid patients with hypertension. They believe this type of initiative will improve quality outcomes, including blood pressure control. The community has a primarily high Medicaid participant population, with every 1 in 5 individuals in the area eligible for services. The clinic's patient population is primarily 30% Hispanic/Latino, 40% Black, and 30% white.

Excited to get the project started, the clinic's dietitian works with the food bank to identify Dietary Approaches for Stopping Hypertension (DASH) diet-appropriate foods to include in the medically tailored food boxes. DASH guidelines encourage the consumption of vegetables, fruits, and low-fat dairy foods. There is also an emphasis on moderate consumption of whole grains, fish, poultry, beans, and nuts. The clinic's dietitian creates and develops recipe cards for patients that highlight key ingredients in each box. All eligible patients must have a hypertension diagnosis, receive Medicaid, and be an active patient at the clinic. Patients who enroll in the program will receive one box of pre-selected DASH-appropriate foods each month regardless of household size. Boxes are distributed at the clinic on designated days each week based on clinic staffing availability. The clinic decides that for patients to receive their food box each month, they must attend all scheduled medical appointments as well as comply with prescribed medications and services.

The clinic finds that participants are quick to sign up for their first box, but soon discover that many become ineligible for additional boxes due to violation of rules for program participation (e.g., missed medical appointments, lapsed prescription refills, etc.). For patients who meet participation requirements, they report not consuming all the food for various reasons (e.g., it does not meet their cultural needs, it takes too long to prepare, or food is shared with friends, family, or neighbors). After 12 months, the pilot program is ended due to low program retention and no improvements in the clinic's quality improvement metrics for blood pressure control. The clinical stakeholders conclude that patients are not interested in changing their diets.

DISCUSSION QUESTIONS

Part I: What is the Big P policy at play here? How has the Big P policy influenced little p policy (i.e., programmatic decisions) of the food bank? What stereotypes or damaged narrative frameworks are used to describe the "problem?"

Part II: What white supremacy food narratives appear in the proposed solution to the problem?

Part III: In this scenario, is the food bank an active or passive partner in the initiative? What little "p" policy changes could occur to make the program more equitable? How could the food bank work with this clinical partner to apply equity principles in the redesign of this program, or others like it in the future?

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FACILITATOR'S GUIDE

Building health equity through policy and power shifting: A collection of case studies for charitable systems stakeholders

Part I

What is the Big P policy at play here?

- As mentioned in the first paragraph, the Big P policy at play here is the newly modified Affordable Care Act. Not-for-profits are supposed to be mission driven, fulfill a charitable purpose, and not exist to generate a profit. This new policy requires that not-for-profit hospitals fulfill new community-based initiatives to keep their tax-exempt benefits.

How has the Big P policy influenced little p policy (i.e., programmatic decisions) of the food bank?

- This new requirement resulted in a reactionary partnership between the clinic and the local food bank. Ask your group, "who was involved in that decision to partner?" From what we know with the details given, this decision was not made with any insight from the community (i.e., patient stakeholders; we will discuss paternalism in Part II). [To stimulate additional conversation, you could also invite group members to share any experiences they've had with community partners in the context of this mandate.]
- There is no mention as to whether the community needs assessment has examined structural inequities or explored the context of daily life when living near or in poverty.

What stereotypes or damaged narrative frameworks are used to describe the "problem?"

Note: Participants may need help thinking through these questions to understand it. These probes may help: What narrative frameworks are influencing the Big P policy solution? [advantaged, contenders, dependent, deviant]. What is the underlying assumption or implied narrative that is being made about this group?

- In this scenario, food has become medicalized and the health consequences of food insecurity for hypertension have been reduced to dietary non-compliance.
- In addition, the change promoted does not portend to change any structural determinants of inequity such as low-wage jobs and benefits, access to quality education, or environment safety and exposure.
- The proposed solution does not recognize the role of chronic stress on health. Even if chronic stress were acknowledged, it is unlikely that the limited quantity of food being provided will reduce stress associated with food insecurity or materially reduce food insecurity.
- Hospital systems are politically powerful, meaning they are getting more than their fair share.
- Therefore, Congress must strengthen and make explicit their obligations as a non-profit to serve the larger community. Because they are politically powerful, it is likely that Congress did not create rigorous requirements to maintain their tax-exempt status. The beneficiaries of the policy, the community, are politically weak, and have been likely framed as "damaged or deviant." This policy change does not address the structural inequities that caused the disparity.

Part II

What white supremacy food narratives appear in the proposed solution to the problem?

- In this scenario, the clinic holds the power and is making all the decisions via paternalism. We see elements of this paternalism when the dietitian independently selected the pre-selected food box contents and created the recipes based on his or her opinion of what the patients "need" without soliciting any input from the patients. The physician/clinic also holds the power by only allowing "compliant" patients with access to the food on an

ongoing basis as a reward for a good behavior and/or for only those patients who "prove" they want to play an active role in their health by attending all appointments.
- The program is staffed by existing clinic personnel due to limited staff capacity, which reinforces the sense of urgency as well as quantity over quality (of work) values expressed in white supremacy culture.
- The creation of a standard, pre-selected box that is provided to all participants of this diverse clinic reflects the value of universalism, i.e., there is only one correct way to eat. The food choices do not consider cultural food preferences, household size, or the context of food preparation (time constraints, kitchen equipment, etc.). The recipe cards also reinforce the individualistic viewpoint that people are in control of what they eat, feeding into the "if they only knew" narrative.
- Individualism is reflected in the hospital's decision to invest their dollars into a downstream initiative, rather than tackling structural determinants of healthy food access.

Part III

In this scenario, is the food bank an active or passive partner in the initiative?

- Passive. Overall, the food bank has exerted little to no control in terms of decision making and implementation strategies of this program as designed. The clinic has the most control and holds power in terms of programmatic and implementation strategies (who gets food, how much, under what conditions).

What little "p" policy changes could occur to make the program more equitable?

- This question relates to the current food pharmacy initiative. If your group is struggling, you can ask your group to suggest some alternatives to the current participation requirements. What are some antidotes to paternalism that we could apply? Allow patients to select foods or have a say in what types of foods are provided; allow patients to contribute recipes they have developed for inclusion with the recipe cards shared with other patients; include (and compensate) patient volunteers to provide feedback on the program for evaluation purposes.

How could the food bank work with this clinical partner to apply equity principles in the redesign of this program, or others like it in the future?

- A community health worker (CHW) from the affected population could be employed to help redesign and implement the program. Formative work could be done by the CHW and food bank to better understand barriers to hypertension management in the context of food. The food bank could implement a set of parameters for any food bank-clinic food as medicine initiatives.
- Example parameters might include non-punitive participation requirements that are not used to coerce attendance at medical appointments; utilization of patient advisory committee on the design and final selection of foods provided in the program; evidence the patient population would prefer this model of food assistance over other models, etc.
- Resources could be invested in exploring appropriate and doable improvement in structural determinants. For example, some hospitals have purchased land, built community gardens on this land, and created a youth job corps program for youth that provides on the job training in food production, program management and implementation, and service delivery for patients with hypertension.

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Mobile Food Pantry & Health Screening Van

Building health equity through policy and power shifting: A collection of case studies for charitable systems stakeholders

A regional food bank is awarded a "rapid response" grant from the City to help bring food access to local food deserts. The urban City is highly segregated and an estimated 70% of individuals living in affected areas identify as Black. Area statistics suggest that families are disproportionately led by single-parent households, as well as people with impaired mobility. The food bank uses the money to purchase a mobile food distribution van that will travel to designated locations to distribute fresh produce. The food bank prioritizes distribution sites to locations designated as a food desert that do not have any pantry programs in operation.

The community also has a "Double Up Food Bucks" (DUFB) program that doubles the purchasing power of fresh fruits and vegetable purchases at farmers' markets for Supplemental Nutrition Assistance Program (SNAP) shoppers. Upon review of participating farmers' market sites, mobile market planners realize that there are several DUFB farmers' markets less than 5 miles away from most of the selected distribution sites. The food bank uses the mobile distributions to help educate people about this exciting opportunity to further "stretch your food dollars." To maximize economics of food purchases and number of households that can be served, the mobile market is supplied with whole fruits and whole vegetables, whole frozen chickens, along with dry beans, long-grain brown rice, and shelf-stable milk. Recipe cards are provided with food distributions that illustrate how to wash, prepare, and store fresh produce to teach people how to avoid food waste.

Although response to the mobile van was initially high, distribution sites have lower participation rates after the third month, despite food insecurity rates remaining the same in the area. DUFB participation rates at the nearest farmers' markets remain stagnant all season-long, despite information flyers being provided on how to use the program with every food distribution. A nonprofit local healthcare system (which operates in the affluent, primarily white part of town) has heard of the mobile food initiative. They want to send nurses to conduct blood pressure and diabetes screenings during food distributions since members of the Black community experience higher rates of stroke than whites. The healthcare system feels these health fair outreach activities can be an important first step for raising awareness in the community about the importance of blood pressure and blood sugar control for health. The food bank wonders if this additional health service might attract more people to participate in the mobile food distributions.

DISCUSSION QUESTIONS

Part I: What is the Big P policy at play here? How has the Big P policy influenced little p policy (i.e., programmatic decisions) of the food bank? What stereotypes or damaged narrative frameworks are used to describe the "problem?"

Part II: What white supremacy food narratives appear in the proposed solution to the problem, including the food distribution, DUFB outreach, and newly proposed health screenings?

Part III: In this scenario, is the food bank an active or passive partner in the initiative? What untapped opportunities might there be for the food bank to shift power to the community?

Part I

What is the Big P policy at play here?

- The Rapid-Response grant is a Big P policy action by the City; DUFBs/SNAP are the products of Big P policy from the federal government. Rapid-response grants are typically utilized to enact quick and temporary response to an urgent need.
- The DUFB program incentivizes low-income populations to purchase fresh fruit and vegetables but requires them to use their own money or some of their SNAP benefits. The types of foods that can be purchased are also usually limited to fresh produce. The benefits may only be used at DUFB accepting entities. Few dollars are dedicated to promotion.

How has the Big P policy influenced little p policy (i.e., programmatic decisions) of the food bank?

- You can ask your small group to recall or research the historical formation of food deserts in the context of racial inequity. It is likely the community's food desert is the result of historic Big P policies, such as redlining, and that these policy opportunities do not address the systems of disadvantage that have been created.
- Similar to case study 1, this results in a reactionary response from program implementors. The structural inequities are not considered, and there is no opportunity within this proposed solution to shift power to the community.
- There is an assumption in the DUFB program that the $20.00 matching funds is adequate to subsidize the purchase of more expensive, fresh produce items.

What stereotypes or damaged narrative frameworks are used to describe the "problem?"

Note: Participants may need help thinking through these questions to understand. These probes may help: What narrative frameworks are influencing the Big P policy solution? [advantaged, contenders, dependent, deviant]. What is the underlying assumption or implied narrative for this group?

- The problems (food deserts and stroke rates) are framed as solely lack of access to healthy foods and poor education of healthy consumption of food. While the availability of healthy fresh foods is important, improving community health requires more sustainable practices than temporary mobile markets. You can ask your small group a follow-up question, "How is this affecting the proposed policy?"
- The Big P policy actor is city government. They made a policy decision to use city tax revenue to address inequities and redistributing resources. The solution is favoring the "contenders" because the policy does not disrupt the existing inequitable structure. The beneficiaries of this policy are low-income populations, the narrative frame is that they are dependent, inviting a paternalistic response.
- The DUFB program does expand benefits, but it is conditional. Conditional programming assumes that the population is damaged, and they will not exercise good judgement using the benefits. They are not changing the environment that makes it difficult to eat healthy.

Part II

What white supremacy food narratives appear in the proposed solution to the problem, including the food distribution, DUFB outreach, and newly proposed health screenings?

- Neoliberalism ideal and a focus on food charity: The root cause of the issue comes down to needing structural and systematic change, not just a food distribution program. Which is why we see inequitable practices as the outcome. Once again, we see individualism is reflected in the decision to invest dollars into a downstream initiative.
- In addition, the recipe cards also reinforce the individualistic viewpoint that people are in control of what they eat and assume participants do not know how to wash their produce or prevent food waste in their homes, framing participants as ignorant in how to feed their families, once again reinforcing the "if they only knew" narrative.
- We also see the theme of "build it and they will come." There was no collaboration with the community early-on in discussion of program strategies and objectives. We see this manifest in low community buy-in and ultimately low participation rates. This theme coincides with the paternalistic theme of "communities can't take care of themselves." The food bank sees there is an access issue in a community and assumes the best possible intervention is a mobile food van. In the same vein, they see that the Black community has high rates of stokes and assume the best possible intervention is to send nurses from outside the community to screen and deliver health education. While these initiatives can be beneficial, neither one was designed or implemented with the input of the community nor will these rectify the underlying structural issues. When participation rates decline, community evaluation is not sought, and an "additional" benefit defined by the dominant culture is presumed to resolve the issue.
- Limited variety of food availability in the mobile van reinforces paternalistic and universalistic world views. Remember the market only provides, "whole fruits and whole vegetables, whole frozen chickens, along with dry beans, long-grain brown rice, and shelf-stable milk." By only providing these items and recipe cards, the program is not recognizing the health value of Black foodways and instead is perpetuating white cultural practices and food choices. For example, the vast majority of Black adults and many older Black children are lactose intolerant. Additionally, Black adults are also more likely to have impaired mobility, which can significantly impede their ability to prepare whole foods in the kitchen.
- Failure to listen: DUFB outreach assumes individuals just don't know about the opportunity, they don't consider an individual's need for transportation, availability, funds, etc.

Part III

In this scenario, is the food bank an active or passive partner in the initiative?

- The food bank is an active partner of the initiative. They wrote the grant and are implementing it with other partners (DUFB administrators and an affluent clinic) that they invited to join the initiative.

What little "p" policy changes could occur to make the program more equitable?

- Instead of employing nurses from outside the community to screen participants, the initiative could employ nurses or community health workers within the community to help screen participants. Co-create a list of food items to be made available at the market with community members ensuring diverse representation in foodways and food preparation needs.

What untapped opportunities might there be for the food bank to shift power to the community?

- Increase communication and collaboration between existing and new "network" resources – shifting power to the community, co-create programs that integrate what the community sees as a priority, identify, and address structural issues within the community – do not just assume you know the solution without research and consultation of stakeholders etc.

-3- Healthy Cooking Classes

Building health equity through policy and power shifting: A collection of case studies for charitable systems stakeholders

A well-resourced, high-volume food pantry serves a mixture of clients, including working families and older adults. Roughly half of its clients identify as Black and another 20% identify as Hispanic/Latino. Food pantry staff have noted in the past that many clients, including adults and children, are overweight or obese despite being food insecure. Food pantry managers attended their regional food bank conference for partner agencies. One of the training sessions introduced "Foods to Encourage" (F2E) and stated these voluntary guidelines could be implemented by partner agencies to improve the nutritional profiles of the foods they distribute. Excited with the opportunity to address health needs affecting food pantry clients, the managers consult with a nutrition professional to review their current food inventory and identify and replace foods that do not meet F2E guidelines with healthier alternatives.

After two months, the managers notice that many of the new foods are not being selected by clients when they complete their food request form. They reach out to their food bank for guidance on what to do, and the Community Initiatives Director suggests the pantry offer Cooking Matters® classes to help clients learn how to cook the new food items. The pantry collaborates with the food bank to schedule a time the pantry feels would be most accessible for client families, but response is underwhelming and only a dozen clients attend, and even less complete the series. The pantry's inventory is currently in the position of having a fully stocked warehouse with an assortment of healthy food items that they need to distribute.

DISCUSSION QUESTIONS

Part I: What is the little p policy at play here? Who originated the little p policy and how did it influence programming initiatives within the food bank network? Review the stated purpose of Cooking Matters on the program's website: http://cookingmatters.org/node/2247. Based on what you read here, what stereotypes or damaged narrative frameworks are used to describe the "problem" of nutrition disparities among low-income families?

Part II: What white supremacy food narratives appear in the proposed solution to the problem, including the food pantry's approach to the healthy food pantry redesign and implementation of cooking classes?

Part III: What actions could the food bank take to promote nutrition equity in healthy food access and education resources for its partners? For clients?

Part I

What is the little p policy at play here?

- There are 2 main little p policies enacted by the food pantry in this situation: F2E and Cooking Matters programming.

Who originated the little p policy and how did it influence little p policy initiatives within the food bank network?

- F2E and Cooking Matters were both suggested by food banks in the food pantry's region. Their suggestions to follow F2E guidelines and implement new programming dramatically affected the resources and services available at the food pantry. Keep in mind when discussing with your group, the level of involvement from the community in making these decisions. Ask your group, "who was involved in the decision to adopt new little p policy?" From what we know in this example, the community was not involved. It was a decision made by food pantry staff advised by regional food bank administration. Ask group members to reflect on similar experience they have had in programming. There is a presumption that the obesity is associated with nutrient content of food being consumed by the clients not any other factors that could play a contributing role.

- Review the stated purpose of Cooking Matters on the program's website: http://cookingmatters.org/node/2247. Based on what you read here, what stereotypes or damaged narrative frameworks are used to describe the "problem" of nutrition disparities among low-income families?

  From the website: *"Cooking Matters hands-on courses empower families with the skills to be self-sufficient in the kitchen. Lessons cover meal preparation, grocery shopping, food budgeting and nutrition. Participants practice fundamental food skills, including proper knife techniques, reading ingredient labels, cutting up a whole chicken, and making a healthy meal for a family of four on a $10 budget."*

  - This program assumes that participants do not have the skills to be "self-sufficient" and "dependent" on educational interventions to improve their welfare. We see this type of narrative used to explain justification of the existence of "welfare dependency," exacerbating a damaged frame.

  - Additionally, the "problem," nutrition disparities among low-income families, is simply defined as insufficient knife skills, trouble reading nutrition labels, inability to properly cut up a whole chicken, and budget sufficiently. While these skills can be important in their own right, assuming they should be the main priority for intervention is inaccurate (see white supremacy narrative below). Consider asking the priority population what their needs are instead of assuming.

Part II

What white supremacy food narratives appear in the proposed solution to the problem, including the food pantry's approach to the healthy food pantry redesign and implementation of cooking classes?

- As mentioned previously, both little p policy changes are paternalistic in nature. Paternalism occurs when an individual who holds the majority of power and decision making controls and decides the outcome for those with

little to no power in the situation. We see here that the food pantry (which holds the majority of power) now dictates the types of food available for clients.

- We also see universalism when the food pantry assumes that because there is a high obesity rate every client will benefit from F2E guidelines and if made available we will see a decrease in obesity. Additionally, there is no cultural consideration when providing foods. Ask your group to look up the food suggested when following F2E guidelines if not familiar. The population that these programs serve are culturally diverse, so assuming these foods will fit their cultural narrative in itself is white supremacy. These types of initiatives (while not explicitly stated in the above case study) tend to result in the "good food vs. bad food" narrative.

- Cooking Matters is individualistic in nature. As mentioned previously, the program assumes that the core issues in this community (obesity and food insecurity) can be solved by teaching the individual basic cooking, cleaning, and knife skills. This is an example of the "if they only knew," and "communities can't take care of themselves" narrative. There is no consideration of systemic issues to these problems, therefore placing fault at the individual level. It assumes that all individuals have the same choices and that they are just making them uniformed. This is an example of the "focus on food charity" narrative.

- The program change including both the adoption of F2E guidelines and Cooking Matters programming is an example of the "build it and they will come" and "failure to listen" narrative. From what we can tell in the narrative of the case study, there was no inclusion of community members in decision making.

In this scenario, is the food bank an active or passive partner in the initiative?

- The food bank is a passive partner in this initiative. The food pantry holds most of the power in the scenario.

What actions could the food bank take to promote nutrition equity in healthy food access and education resources for its partners? For clients?

- The food pantry should begin by asking the community what they need, instead of assuming solutions to problems that have not been defined by the population.

- Co-create a list of food items to be made available at the pantry with community members ensuring diverse representation in foodways and food preparation needs.

- Ask the community what types of educational resources they would like if any at all and allocate more funds to programming that they will see as beneficial.

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Weekend School Backpack Program

Building health equity through policy and power shifting: A collection of case studies for charitable systems stakeholders

A group of teachers at a rural elementary school are concerned about the growing number of children who report to school on Mondays stating they are hungry. They google "child hunger" and upon discovery of their regional food bank's website, they discover it offers a School Backpack Program for any elementary school in their service area.

An excerpt from the food bank's website reads,

> "For many low-income students, school-based meal programs provide a reliable source of food during the school day. In response to the gap in meal access during the weekends, we offer a School Backpack Program (SBP) that provides nutritious, non-perishable, easy-to-prepare meals/snacks to prevent childhood hunger. The SBP is designed with the food needs of elementary and middle school-aged children in mind. Foods include those that children can prepare and consume without any parental assistance (e.g., pop-off tops for canned items; individually packaged snack bars; shelf-stable fruit juice boxes). Bags of food are assembled at the food bank, which are then distributed by SBP coordinators who are typically schoolteachers or counselors employed by a participating school. The SBP school program coordinators distribute the bags to the students, typically in a central location every Friday."

The school borders an Indian reservation and serves Native and non-native students. Internal data collected by the school indicates that children who live on the reservation are more likely to miss school, perform lower on standardized tests, and more often participate in the free and reduced-price school lunch programs. The teachers contact the school principal about the program opportunity, who agrees to pilot it in the hopes it will improve school attendance rates and test scores.
At the beginning of the new school year, teachers are oriented to the new program and instructed to refer students to the program who appear particularly "in need." Every Friday, eligible students will receive a blue backpack that contains 2 individual-sized boxes of fruity cereal, a 6-pack of individual shelf-stable milks, 2 granola bars, 2 small cans of Vienna sausages, and 2 individual boxes of raisins. Participating students can pick up their backpack either at the front office or as they climb on the bus to go home. Empty backpacks are returned to the front office on Monday.

DISCUSSION QUESTIONS

Part I: What is the Big P policy at play here? Consider and identify both historical and current-day policies. What stereotypes or damaged narrative frameworks are used to describe the "problem?"

Part II: What white supremacy food narratives appear in the proposed solution to the problem?
Including the school's approach to addressing weekend hunger?

Part III: What little "p" policy changes could occur to make the program more equitable?

Part I

What is the Big P policy at play here? Consider and identify both historical and current-day policies.

- The Big P policy at play here is the School Backpack Program (SBP). As mentioned above, backpacks are assembled at food banks and distributed at schools.
- You can ask your small group to reflect on the location of the rural school inside of a Native reservation and what historic implications this might entail. How might a history of boarding schools (Big P policy) and forced assimilation impact food programming in this area?
- Traditionally these boarding schools were used to mainstream "American life" forcing the acceptance of white values and norms. These initiatives resulted in a major destruction of Native culture. Begin to talk with your group about how these initiatives in the 18th and 19th century may result in distrust of services and the importance of foodways.

What stereotypes or damaged narrative frameworks are used to describe the "problem?"

- The notion that a child is alone to manage his or her food needs even on the weekend reinforces images of a troubled home environment. If the message is not always of the unwilling parent, it is of the inadequate or unavailable one. The damaging answer, then, is not to increase parental purchasing power or access to foods (system change and responsibility) so that parents can better meet children's food needs but rather to give food directly to children who, alone, can feed themselves over the weekends when schools are not there to feed them (individual change and responsibility).
- "Different from others" stigma. Bag distribution may cause stigma for elementary students receiving bag especially given its specific blue color and central location. Teachers subjectively picking out students who are in "need" might cause additional stigma and profiling.

Part II

What white supremacy food narratives appear in the proposed solution to the problem? Including the school's approach to addressing weekend hunger?

- Before identifying the narratives found in this case study, ask your group to identify who holds the power?
- Individualism; Universalism: This program is grounded in an assumption that hungry children must feed themselves over the weekend. The language and food items they provide (pop-off tops for canned items; individually packaged snack bars; shelf-stable fruit juice boxes) place full responsibility on the children. As a result of this, SBPs tend to provide foods that are processed and ready-to-eat. These foods tend to be of limited nutritional quality (e.g., high in fat, sodium, and added sugar; low in dietary fiber).
- Universalism; Paternalism: Instead of inviting Native foodways to shape the resources provided, the program assumes that the foods provided and the process in which they are provided will be beneficial and accommodating for all groups receiving them. The school and food bank hold the power in this case study. They are using it to make decisions without community feedback or involvement. Perhaps a backpack program is not what the community prefers? Including the community in programming is a simple way to begin to shift power and move away from white supremacy in food programming.

Part III

What little "p" policy changes could occur to make the program more equitable?

- One simple policy change is distributing the bags in a less stigmatizing way. Begin to brainstorm with your groups policy changes that might result in less stigma. Instead of distributing bright blue bags in a central location, perhaps distribute food in plain bags or even the student's bag from the school nurse or trusted faculty at times that are suitable for the students.

- Subjective recruitment of services can leave space for indirect or direct discrimination, bias, or stereotyping. It is important to find a balance between connecting students to services and profiling.

- Co-create a backpack program that better fits the needs and foodways of the community served, especially in this rural Native community who may have past historical trauma.

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Community Garden

Building health equity through policy and power shifting: A collection of case studies for charitable systems stakeholders

A local food bank has been awarded a small ($25,000) grant by the local health department to address their community's high prevalence of obesity and food insecurity. Several zip codes within the community currently have combined obesity and overweight rates that exceed 70%, and in a recent telephone survey conducted by the local health department, over half of residents in these zip code areas reported fresh fruits and vegetables are either not affordable or available near their homes. The food bank decides to implement a community garden program to spend the funds. The mission of the program is to teach the community about nutrition to help lower the prevalence of obesity and cardiovascular disease through sustainable efforts to combat food insecurity in the community.

The food bank has selected 5 partner agency locations within these high-risk zip code areas to implement an on-site garden (each with a $5,000 budget for garden bed start-up and maintenance supplies). The program encourages, "our hungry neighbors to participate in growing their own fresh fruits and vegetables within a community garden setting." Participating partner agencies will be required to identify 5-10 clients to help maintain the garden so that the program will be truly "community-based." These clients will receive instructive tips on gardening from experts, as well as information on how SNAP can be used to purchase plant seeds. In fact, the food bank has identified multiple Master Gardeners from the local extension office who will volunteer their time to inform individuals of "pro" gardening tips and explain why healthy foods are important. In addition to supplying fresh produce for the participating partner agency, the Community Garden Program is designed to "empower those in need by teaching them how easy and affordable it can be to grow their own gardens at home." To complement the new program's efforts, the food bank decides to post requests on its social media page inviting home gardeners from all areas of the community to plant extra produce in their gardens and donate the excess to the food bank.

By the end of the summer growing season, food bank staff see small engagement among clients at the selected partner agency sites. At most sites, the weekly maintenance of the gardens has fallen on the shoulders of partner agency volunteers. Additionally, there has been low participation in education classes taught by the Master Gardener volunteers. Although anecdotal, there is no evidence of any clients starting at-home gardens. The food bank does receive about 1,000 pounds of fresh produce donations attributable to their social media campaign. The program eventually loses steam and fades out.

DISCUSSION QUESTIONS

Part I: What is the Big P policy at play here? What little p policy is at play here? Who originated the little p policy and how did it influence little p policy initiative decisions at selected food pantries? What stereotypes or damaged narrative frameworks are used to describe the "problem?"

Part II: What white supremacy food narratives appear in the proposed solution to the problem, including the bank's approach to engaging partner agencies and clients in this healthy food access initiative?

Part III: What alternative actions could the food bank take to promote nutrition equity in healthy food access for clients and communities of partner agency sites?

FACILITATOR'S GUIDE

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Part I

What is the Big P policy at play here?

- A local food bank has been awarded a small ($25,000) grant by the local health department to address their community's high prevalence of obesity and food insecurity. This city grant is considered the Big P policy in this case study.

What little p policy is at play here? Who originated the little p policy and how did it influence little p policy initiative decisions at selected food pantries?

- The little p policy is the decision to implement the grant awarded money on community gardens with partners in the region. The food bank made this decision on its own with no consult from the community or partners from what we can determine in the case study.

What stereotypes or damaged narrative frameworks are used to describe the "problem?"

- The Garden Program's mission statement, "empower those in need by teaching them how easy and affordable it can be to grow their own gardens at home" holds assumptions that ultimately perpetuate stereotypes. This statement assumes those in the community who are obese or food insecure simply just don't know how to plant and maintain a garden and that educating them will improve health outcomes and food security. This stereotype is further exacerbated by their platforming of educational interventions such as "pro" gardening tips from master gardeners. This situates one group as powerful and knowledgeful and one group as dependent and uneducated.

Part II

What white supremacy food narratives appear in the proposed solution to the problem, including the food bank's approach to engaging partner agencies and clients in this healthy food access initiative?

- The program itself is neoliberal and individualistic in nature. The program implies participants are unhealthy because they are uneducated about the benefits of healthy eating and cannot take care of themselves essentially blaming poverty and food insecurity on the individual. There is no systemic assessment of why the community may be food insecure or have poor health outcomes. This is an example of the "focus on food charity" narrative.
- The educational component of the garden program and incorporation of "experts" is an example of the "if they only knew narrative." As previously mentioned, the program assumes that poor outcomes are a direct result of an uneducated population and that by teaching them how to "take care" of themselves they simply will have the resources, time, and support to do so. This "I know what is best for you approach" is a sign of paternalism and is a result of the "failure to listen" and "build it and they will come" narrative.

Part III

What alternative actions could the food bank take to promote nutrition equity in healthy food access for clients and communities of partner agency sites?

- The food bank can redistribute more resources to the County, increase communication and collaboration between community partners; instead of diagnosing the problem. Additionally, community organizers should sit down with community members and discuss the problem to identify how the grant can be used for structural and lasting change (low community walkability, food desert, high crime, no parks, limited public transportation etc.