



FOOD POVERTY AND POLICY

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Foreword

Introduction

This study on food poverty and policy is an initiative of Combat Poverty, Crosscare and the Society of St Vincent de Paul. It arises from a recommendation in an evaluation of the Dublin City Food Bank, a Crosscare project¹. The evaluation had identified the need to review the wider context for food banking, including the links between low income, food insecurity and diet, and other policy measures for improving access to and affordability of food for low-income households.² Crosscare invited Combat Poverty and the Society of St Vincent de Paul to work with it in undertaking the review. Combat Poverty, the government advisory body on poverty, had previously supported research on low-income families, including studies of food and dietary intake. The Society of St Vincent de Paul, as a charitable organisation working with low-income households, had considerable experience of assisting with the food needs of families, the homeless, older people and children.

The review was undertaken by the Centre for Health Promotion Studies, NUI Galway and the Women's Education Research and Resource Centre, UCD for the three sponsoring organisations. The aims of the study are:

- to apply and quantify the concept of food poverty in an Irish context
- to assess and strengthen policy measures relating to food poverty.

The study draws on a diversity of information sources, including an analysis of secondary data, interviews with key stakeholders and a review of international literature and policy approaches. The preliminary findings and recommendations were discussed at a workshop of key interests involved in food and poverty issues.

Why a study on food poverty?

Food insecurity and inadequate diet are central to the experience of poverty. Various studies, including research by Combat Poverty and other organisations, have highlighted the constraints imposed on food consumption by low income.³ In addition, the 'consistent' poverty measure contains three food-based indicators of deprivation. Despite this evidence, food and nutrition have not figured strongly in policy discussions on poverty. This can be attributed to a range of factors:

- the emphasis on a relative definition of poverty over an absolute definition centred on basic necessities such as food, with the latter seen as more appropriate to the hunger situations in some developing countries
- the pre-dominance of income adequacy concerns in policy debates on poverty, to the detriment of expenditure issues such as food consumption patterns
- the desire to avoid reinforcing the perception of families who are unable to provide adequate food as being inefficient managers of household resources.

1. Crosscare is the CATHolic social service agency for the Dublin archdiocese. The Dublin City Food Bank is part of a wider food programme, encompassing food centres, meals on wheels and homeless shelters.

2. P Faughnan and A Byrne (1998) *Surplus and Scarcity. The Dublin City Food Bank*, Dublin: Crosscare

3. M Daly and M Leonard (2002), *Against All odds. Family life on a low income in Ireland*, Dublin: Institute of Public Administration and Combat Poverty Agency; Vincentian Partnership for Social Justice (2002), *One long struggle. A study of low-income families*. Dublin: author

Reflecting this limited policy awareness, there have been few food-oriented interventions and those that have been undertaken, such as the school meals scheme, EU free beef and 'meals on wheels', have not attracted significant public resources. Nor has food been reflected in the National Anti-Poverty Strategy or in specific policies such as the setting of minimum welfare payments or the reduction of health inequalities. There have, however, been some local anti-poverty initiatives which have incorporated food as a component of their programme design (e.g. school retention, health promotion).

While food has not figured in policies to tackle poverty and social exclusion, it has emerged as a key concern across a range of other policy domains. There is a growing awareness of food and nutrition as determinants of public health. Recent health promotion policy notes that the quality and quantity of food intake is a contributory factor in the main causes of morbidity and mortality. Concern with the social determinants of health has resulted in the development of a national food and nutrition policy, supported by a regional network of community nutritionists. Food has also come under public scrutiny in debates concerning the reform of the Common Agricultural Policy, consumer protection and food safety, and children's diet and exercise patterns. However, the social constraints influencing food consumption have seldom been highlighted in these debates.

Contribution of this study

This study heralds a new awareness about the importance of food and nutrition from a low-income perspective. Central to this is the concept of food poverty, defined as the inability to have a socially adequate and nutritious diet due to cost and access problems. This provides an alternative framework to discuss food and nutrition issues, without the connotation of poor budgeting skills or severe hunger situations.

The main findings of the study are:

- low-income households eat less well and have inferior food intake and lower compliance with dietary recommendations and nutrient intake
- low-income households, while spending a relatively higher share of income on food, have difficulties accessing a variety of good quality, affordable food
- low-income households know what are healthy food options, but are restricted by financial and physical constraints in exercising these choices
- low-income households are restricted socially and culturally in their food consumption patterns due to financial constraints.

In terms of policy responses, the study finds that food poverty is increasingly recognised but that responsive policies are hindered by the lack of a universally agreed definition of the problem. Food poverty is in general peripheral to the work of most policy makers, although they are aware that many of their actions could have

impacts on food poverty, both positively and negatively. This suggests that there is a need for food poverty to be considered as a specific topic at policy level.

The study identifies the following priority issues for tackling food poverty:

- developing a strategic policy framework, encompassing an agreed definition of food poverty and co-ordinated cross-departmental actions
- providing adequate financial resources for food consumption, supplemented by direct food provision where appropriate
- ensuring that good-quality, affordable food is easily accessible
- addressing gaps in dietary knowledge and skills
- supporting bottom-up approaches to food provision and consumption
- improving the quality and extent of food distribution and provision
- strengthening the information base in regard to food poverty.

Towards a co-ordinated food and nutrition strategy for low-income households

The main message of this study is that food insecurity and inadequate diet are central issues for low-income households in contemporary Ireland. Low-income households are the category most at risk of inadequate diet and its negative effects on health and well-being. Barriers to dietary improvement are diverse, ranging from knowledge and skills to financial resources and physical access. The growing public policy awareness of food and nutrition should incorporate specific policies and programmes which focus on low-income groups, especially families, older people, the homeless and ethnic minorities. To achieve this, food poverty should be named as a cross-cutting issue under the National Anti-Poverty Strategy, and therefore be reflected in all mainstream policies pertaining to food and nutrition (e.g. agriculture, retail planning, health promotion, food safety).

In addition, specific measures are required to address dietary deficiencies among low-income groups. These should include practical interventions to improve access to quality food at community-level, in schools and through other social milieux (e.g. hostels, resource centres). An enhanced school meals programme, providing high quality and attractive food as part of a whole-school approach to healthy eating, should be a central component of government action. In addition, a programme of community food initiatives should be established, to address barriers to healthy eating among low-income groups. These initiatives, based on a community development model, could include food cooperatives, food-growing projects, cooking classes and resources, and community cafés.

Action is needed at industry-level to address cost and access issues. The food industry, under the framework of the Common Agricultural Policy and retail planning guidelines, is the key actor in determining the costs of food and in providing access to food. Also, the food industry, in line with corporate social responsibility, can make a vital contribution to food redistribution programmes operated by food banks and other social food outlets which provide food for vulnerable groups.

Finally, income support policies should ensure that payments are, at a minimum, adequate to meet the recommend dietary needs of adults and children, as well as enabling households to participate in the social milieu surrounding food consumption.

Action on food poverty

Combat Poverty, Crosscare and the Society of St Vincent de Paul are committed to promoting the findings of this study with relevant policy interests through structures such as the European Federation of Food Banks, social partnership, the National Anti-Poverty Strategy, pre-Budget submissions, as well as meetings with individual government departments and agencies. In addition, Crosscare and the Society of St Vincent de Paul directly support various local food initiatives, such as school meals, food banking and food centres.

Combat Poverty, meanwhile, is supporting a number of micro studies on food poverty which examine food poverty among vulnerable groups such as the homeless population and asylum-seekers and quantify the costs of a healthy diet. It also convenes an advisory group with the Department of Health and Children and the Department of Social and Family Affairs on food and nutrition initiatives for low-income households. Finally, Combat Poverty is piloting a 'Building Health Communities' programme, which promotes community development approaches to tackling health inequalities. Through these diverse actions, it is hoped that the important recommendations of this study will be promoted among key interests and given concrete effect to the benefit of the food poor.

Section 1:
Food Poverty
in Context

Chapter 1: Introduction

The inability to enjoy an adequate and nutritious diet impacts on both the health and well-being of individuals and households as well as on the social behaviour of food-poor households and their members. To date little work has been done in Ireland examining the existence of food poverty and social inequality in dietary behaviours. The focus of this research is on the relationship between patterns of food consumption, socio-economic circumstance and affordability and access to food. Additionally, policy response options appropriate to addressing food poverty in the Irish context are investigated.

Aims and Objectives

The aim of the research is to develop an understanding of food poverty in the Irish context and to assess and inform policy options to prevent and address food poverty in Ireland.

The specific objectives of the study are as follows:

- to review international literature in relation to food poverty and policy approaches in rich countries
- to document the nature and extent of social inequality in food and food poverty in Ireland, using existing national, regional and local data sources
- to identify and assess current Irish policy responses to food poverty, including statutory, voluntary and business-led initiatives
- to set out strategic co-ordinated policy options for tackling food poverty in the Republic of Ireland

Structure of the Report

In order to assess the policy response to food poverty in Ireland, this study set out to firstly understand the nature and extent of food poverty in Ireland. A preliminary literature review incorporating theoretical perspectives, empirical findings and policy approaches in relation to food poverty revealed the dimensions of the issue and provided a framework that we could apply to measure the nature and extent of food poverty using available Irish data. This material is presented in Chapter 2 'Dietary Inequalities, Food Poverty and Social Disadvantage' and Chapter 3 'Food Poverty in the Republic of Ireland'.

Turning to consider policy issues, we first looked at policies relating to food poverty in place at international level as well as at European level in cognisance of how these shape national policy. Food, nutrition and health policies in place in Britain and the United States were also reviewed to illustrate approaches to tackling food poverty taken in other rich countries. Examples of national level and community-based initiatives to tackle food poverty implemented in both countries are also discussed. A description and assessment of policy and practice relevant to food poverty in Ireland is the final element of the report. This material is presented in

Chapter 4 'Policy Approaches to Food Poverty of International Bodies and Selected Countries' and Chapter 5 'Policy and Practice Relevant to Food Poverty in Ireland'.

In the final chapter, Chapter 6 'Discussion and Recommendations', the research findings are drawn together to identify priority areas and generate a set of recommendations for policy and practice that would facilitate both the prevention of food poverty and the amelioration of on-going food poverty in Ireland.

Chapter 2:
Dietary
Inequalities, Food
Poverty and Social
Disadvantage

National and international literature is reviewed here in order to document the level of social inequalities and poverty that are observed in food and nutrient intake worldwide. The factors contributing to food poverty and social inequalities in dietary behaviour are discussed, leading on to a consideration of how these inequalities are related to low income and other aspects of social disadvantage.

Defining Food Poverty

Within a social exclusion framework, food poverty refers to the inability to have an adequate and nutritious diet due to issues of the affordability of and access to food (Dowler, 1998). In addition hunger, which may be thought of through the concept of food security, is described as the inability to acquire or consume an adequate quality and sufficient quantity of food in socially acceptable ways (Radimer *et al.* 1992).

In nutritional terms food poverty may be defined as the consumption of too little food to meet basic nutritional requirements. Diet plays a very prominent role in premature death from a number of chronic health conditions including cardiovascular disease and some cancers (Block *et al.* 1992). As in many developed countries, Ireland experiences marked social inequalities in health, seen in the variation in health outcomes, especially mortality, across the different social groupings (CSO 2000, Balanda and Wilde 2001, Kelleher *et al.* 2001). It is recognised that some of the inequalities in health may be partly explained by social inequalities in dietary behaviours (James *et al.* 1997, Hupkens *et al.* 1997, Eurodiet 2001) and that the impact of inadequate nutritional intake on health is related to basic social inequity.

Whilst food is clearly very influential on health, a more sociological interpretation of food poverty finds that food-poor households and individuals are at risk of compromised social behaviour (Dowler 1998: 58). Just as income poverty has a constraining effect on the way people live their lives, so related food poverty affects social behaviour and causes or exacerbates social exclusion. As food is a universal need it has the potential to be a site of universal experience, a mark of communal cohesion and a solidifying social force. The effects of food poverty can mark out an individual's social behaviour and contribute to social exclusion.

Social Inequalities in Dietary Behaviour

Diets progressively become more unbalanced with decreasing socio-economic status (Friel 2003). People from socially advantaged positions consume more nutritionally balanced diets in line with dietary recommendations. Population-based studies worldwide have repeatedly shown that individuals from lower socio-economic groups have significantly lower intakes of foodstuffs regularly advocated by health professionals and the media as promoting better health (e.g. James *et al.* 1997, McElduff and Dobson 2000). Similarly, foods often more associated with an affluent

lifestyle, such as wine and cheese, are consumed in smaller quantities among lower socio-economic groups.

These socio-economic gradients in food and nutrient intake are observed throughout Europe, withstanding cultural diversity. The EU-funded FAIR project reviewed dietary intake research carried out in 15 European countries and concluded that, whilst not homogeneous, those adults belonging to lower socio-economic groups exhibited less healthy nutritional behaviour (Irala-Estevez *et al.* 2000, Roos *et al.* 2001). Generally those with higher education consumed more vegetables, fruits and cheese and less fats and oils. Throughout industrialised countries, higher intakes of full-fat milk, higher fat meat products, sugars and potatoes, and lower levels of fresh fruit and vegetables and high-fibre cereal products are much more likely to be reported by individuals from lower socio-economic groups (e.g. Leather 1995, Davey-Smith and Marmot 1991, Milligan *et al.* 1998, Billson *et al.* 1999, Popkin *et al.* 1996). Food and nutritional analyses specifically of the dietary habits of people on low incomes show generally an unbalanced combination of foodstuffs, with greater consumption of foods high in saturated fat, such as full-fat milk, meat products, sugars and preserves and also more potatoes and cereals (Nelson and Leather 1997, Roux *et al.* 2000). Conversely, the consumption of fruit, vegetables and high-fibre products such as brown bread is lower among people on low incomes compared to higher income categories. At the nutrient level, lower fat intake and higher vitamin and mineral intake is generally associated with higher socio-economic status (Hulshof *et al.* 1991, van Rossum *et al.* 2000). The Vincentian Partnership for Social Justice reported that in households dependent on social welfare a 'nutritionally adequate diet appears to be impossible' (2001). Low-income groups have lower intakes of vitamin C, b-carotene and folate (possibly related to low intake of fruit and vegetables) and energy and iron which could place people in a position of reduced reserves for coping in demanding situations (Clarke 1993, Dowler and Calvert 1995, Nelson and Leather 1997, Friel *et al.* 2003).

Research demonstrates that malnutrition in childhood is causally linked to health-related problems later in life such as chronic illnesses, impaired development of children's brains and their capacity to learn, as well as bringing about physical impairments such as blindness caused by vitamin deficiency (Weinreb *et al.* 2002, Gordon 1998, Gabor 1987). In the UK a large proportion of children consume too much fat and sugar and not enough fruit and vegetables and fail to reach recommended nutrient intake levels (Bradshaw 2002). Children from lower social classes, or whose parents are unemployed, consume higher amounts of bread, eggs, potatoes, chips, baked beans and sugar and lower levels of milk, carcass meat, chicken and fruit than children from higher social class households (Nelson 2000). At the other end of the age scale are older adults. Despite the widespread assumption that later life means universal ill health, there are marked socio-

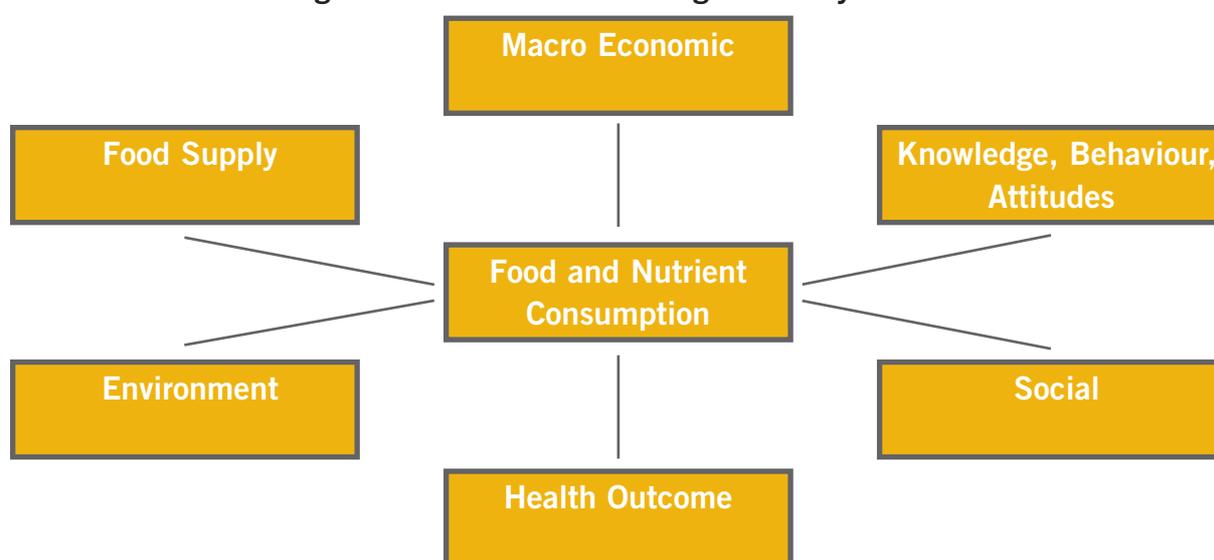
demographic and economic variations in the health and lifestyle behaviours of older age groups (Victor 1989). Whilst the nutritional requirements for older people are mostly similar to those of younger people, they generally need fewer calories. Malnutrition is a concern in this age group and those most at risk are those who lack access to food because of poverty or because of a disability (Roe 1990). Older people on a pension are at risk of having a low income and this income inadequacy may be one of the most important environmental determinants of inadequate nutrition among older people.

Ascertaining the food and nutritional status of the most marginalised groups in society is difficult, partly because of the obstacles in accessing these groups in research. However, it has been identified that nutritional deficiencies are present among groups such as people who are homeless (Derrickson *et al.* 1994, Stitt *et al.* 1994, Power and Hunter 2001). Many homeless people eat fewer meals per day, lack food more often and are more likely to have inadequate diets and poorer nutritional status than housed populations (Wiecha *et al.* 1991). Maintaining a healthy diet also proves difficult for the Traveller community mainly due to low levels of income and constrained physical access to cooking and storage facilities (McNamara 1995).

Determinants of Dietary Intake

Unequal distribution of the material, social and cultural resources in society results in social inequalities in food and nutrient intake and often in food poverty among some population groups. The internationally observed social gradients in dietary behaviour clearly indicate the influence of macro-economic, structural, psychosocial and personal factors on food consumption. It may be such that inequalities at these levels differentially equip people to make healthy food choices (Shaw *et al.* 1999). There are many mediating factors through which social gradients in adequate nutrition may originate (Kelleher and Friel 1996). Figure 1 illustrates the range of factors impacting on food consumption operating at the individual and household levels.

Figure 1: Factors contributing to dietary habits



There are two dominant propositions in the literature, namely material/structural and psychosocial, which may explain the processes by which socio-economic inequity results in inequity in dietary behaviour.

Material and Structural Influences on Food Consumption

The material/structural model identifies policy issues relating to food distribution and supply including food access and price and issues of disposable income, education, employment and housing conditions and how these contribute to the social gradient observed in food and nutrient intake (Milio 1986, Morris *et al.* 2000, Murphy-Lawless 1992).

Access Issues

Access to healthy food is determined primarily by what is available to buy and what people can actually afford. Access affects food consumption in the context of a rich country like Ireland in a variety of ways including: the crops grown by farmers, the availability of a variety of foods, prices of the foodstuffs, control of the market by large multiples and how that may constrain the retailing sector in terms of what foods get into the shops, and placement of retail outlets in out-of-town venues (Department of Health 1996, Watson 2001).

The physical environment can directly affect dietary behaviour. Transport issues in the form of getting food to consumers and consumers to foods arise as an outcome of the domination of the food retail market by large multiples which are often sited on the outskirts of towns. The types of shops that people can reach is based on their physical capabilities and transport options and access to such facilities may be restricted if car use is not an option and adequate public transport is not provided (Department of Health 1996). A high rate of closure of local shops and the dominance of supermarkets twinned with inadequate and/or expensive public transport systems are a key factor in food poverty (Watson 2001). Many people live in areas where there is no supermarket or greengrocer and they only have access to one or two convenience stores that primarily sell expensive canned or processed foods. The term 'food desert' has been used to describe areas of relative isolation where individuals experience physical and economic barriers to accessing healthy food (Reisig and Hobbiss 2000).

Affordability Issues

These factors run in parallel with the amount of money an individual or household allocates to food expenditure as driven by the money available and the relative importance placed on food (Dowler 1998). Compared with households on average or above-average income, low-income households spend a greater proportion of their money on food, but in real terms the amount spent is less (Graham 1992, Hobbiss 1991). However, when household finances are under pressure food spending is seen

as more flexible than other household spending and is therefore likely to be further reduced (Graham 1992, Coakley 2001). The money available and the costs of food are the most important factors when considering food priorities among low-income groups and define the taste, cultural acceptability and healthy eating boundaries (Dobson *et al.* 1994, Coakley 2001).

People on low income strive to follow mainstream dietary habits but financial constraints mean that the range of foods consumed is limited with little flexibility for variation in case of wastage. Basic foodstuffs such as meat, vegetables, fruit, staples and snacks have been identified as essential foods but the costs of food often mean that the less healthy option in these food groups is purchased (Dobson *et al.* 1994, Coakley 2001). A study of food consumption among low-income families in the UK found that shopping for food is carried out in such a way as to maximise savings and get value for money and therefore requires substantial time in shopping around (Dobson *et al.* 1994).

Psychosocial Influences on Food Consumption

From a social psychology perspective there are models that explain gradients in dietary behaviour through social norms and personal expectations, beliefs, values and attitudes (Becker 1974, Ajzen and Fishbein 1980, Bandura 1977). Personal taste, attitudes, nutritional knowledge, peer influences and the availability of food and nutrition related information all play a role in determining food choices (Watt *et al.* 2001, Nic Gabhainn *et al.* 2002). Knowledge about the role of food and nutrients in the causation of disease has been shown to vary by educational attainment and occupational group, with those from higher social categories more likely to correctly identify specific relationships between diet and disease (Crawford and Baghurst 1990). Roos and colleagues identified that higher socio-economic groups are more likely to follow a diet perceived as modern and healthy (1996). More socially disadvantaged groups receive dietary information from several sources, the most popular being television. This often results in a fragmented knowledge of food issues, with the greatest uptake of information being from that which could be personalised to their own situation (Dobson *et al.* 1994).

Social Factors, Food Consumption and Food Poverty

A certain level of social participation is what confers citizenship and food-consumption patterns play an important part in this (Warde 2000). Being forced through lack of resources to forfeit the social pleasures of eating out, eating in other people's homes or having one's guests for a meal, are markers of less participation (Coakley 2001, McCashin 1996, Walker 1995 and Warde 2000). Social behaviour is constrained when income cannot support the additional costs of feeding others so the satisfaction of entertaining guests to a meal must be foregone (Walker 1995). Women report dreading their children bringing their friends home for fear of how

much they will consume (Graham 1992). Likewise due to the demands of mutual reciprocity visiting others for meals is avoided unless with the closest of relatives (Walker 1995).

Within the household the allocation of food and time determines who gets what (Dowler 1998). Gender inequalities in the distribution of resources within the household have been demonstrated and found to include the distribution of food so that women's food intake is less than male household members (Daly 1989, Delphy 1984, Cantillon 1997, Graham 1992, Kerr and Charles 1986). Although women are less likely to control household income, they are more likely to bear the responsibility for day-to-day budgeting, for food shopping and for preparation of food for the family (Cantillon 1997, Carraher *et al.* 1998 and Graham 1994). Cultural norms assume women are carers and act to support the well-being of their children, partners and others, such as dependent older or disabled family members often through food and nutrition (Graham 1992). The role of children within families has a bearing on household food choices as children can act as agents of change. Food produce advertising targeting children adds pressure in low-income households to buy more expensive, brand name goods (National Food Alliance 1997).

Summary and Conclusions

In nutritional terms poverty in relation to food may be defined as the consumption of too little food to meet basic nutritional requirements, with adverse health consequences. It is not just health, however, that is compromised in food-poor households, so too is social behaviour when people cannot eat, shop for, provide or exchange food in the manner that has become the acceptable norm in society due to issues of affordability and access (Dowler 1998). The explanation often given for poor diet and other lifestyle consumption behaviour is that of feckless individual choice. However, it is clear that living in poverty and social disadvantage shapes dietary patterns in terms of affordability of food, access to and availability of food, psychosocial influences and patterns of consumption. Living in poverty and social disadvantage imposes structural constraints on food consumption behaviour in three principal ways. Firstly, affordability in terms of the cost of food and in the context of a low-income household the consequent share of the household budget allocated to food items. Secondly, access to food. This refers to the retail options available and the capacity to shop in terms of transport, time and physical ability. The availability of food storage and cooking facilities are a further constraint on what foods can be accessed. Additionally, within the household how resources including food are distributed is another determinant of who gets what to eat. Thirdly, psychosocial factors also matter in determining food choice among socially disadvantaged groups in such a way as to put them at risk of food poverty. Personal skills and knowledge, social pressure and cultural norms each interact with structural and economic constraints to produce a complex constellation of factors contributing to food poverty.

Chapter 3:
Food Poverty in
the Republic
of Ireland

This chapter draws on a range of data sources to generate a picture of the level of poverty, social inequalities in dietary behaviour and food poverty in Ireland. The material presented is a combination of secondary data analysis of data-sets available to the Centre for Health Promotion Studies, NUI Galway and a collation and review of published research on poverty that provides specific in-sights into food consumption. The chapter starts with an outline of the current situation of poverty in Ireland, including a focus on food-related indicators. Secondary analysis of existing national, regional and local data sources is then undertaken to document the nature and extent of social inequalities in dietary habits and of food poverty in the Republic of Ireland. There are four main research questions driving this analysis:

- What are the dietary patterns in relation to socio-economic circumstance?
- Is this pattern the same at the household expenditure and individual consumption levels?
- What are the social and psychosocial influences and outcomes in dietary behaviour among low-income groups?
- What is the extent of issues relating to access, availability and affordability of food?

Various sources of information are drawn upon to investigate the above questions. Secondary analysis is performed on data sets generated by the Centre for Health Promotion Studies, NUI Galway which contain key information and allow us to build up a picture of the nature and extent of social inequality in food habits in Ireland incorporating the range of factors affecting food poverty. Information is also obtained from published national and regional reports and peer reviewed literature on data relating to the Republic of Ireland. Details of the data sources are referred to under each research question heading below. See Appendix One for a detailed account of the data sources relating to each question.

The measurement of social group differences in dietary behaviour is necessary to obtain a deeper understanding of the underlying contributing factors to the resulting inequality in outcomes and hence facilitate an appropriate response (Murray *et al.* 1999). A range of social status indicators is necessary for population health and nutrition monitoring purposes and the use of a range of indicators, each relating to different aspects of social status, has identified consistent social gradients in dietary behaviour, both in this research and that published internationally (Dubious and Girard 2001). Individual and household measures capture different facets of social inequity in health and dietary habits (Manor *et al.* 1997, Galobardes *et al.* 2001). Each of the different measures of socio-economic status – occupation, education and income – explains different components and contributes differently to health and related risk inequalities (Galobardes *et al.* 2001, Macintyre 1994).

Poverty and Social Exclusion

In the Government's National Anti-Poverty Strategy (NAPS) poverty is defined as follows:

People are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by Irish society generally. As a result of inadequate income and resources people may be excluded from participating in activities which are considered the norm for other people in society.

(Government of Ireland 1997: 3)

One approach to measuring poverty is by reference to income alone. An income-poverty approach defines a poverty line in terms of income and regards those with incomes below that line as poor. A relative-income approach derives poverty line incomes as a proportion of average incomes with thresholds. The Economic and Social Research Institute (ESRI) is engaged in an on-going series of monitoring poverty based on data gathered in the Living in Ireland Surveys. The most recently available results, those from the 2001 survey (Whelan *et al.* 2003) show that the percentage of persons whose weekly income falls below the 50 per cent median income line is 12.9 per cent, while 21.9 per cent are below the 60 per cent line and 29.3 per cent are below the 70 per cent line (Whelan *et al.* 2003: 12).

A second measure of poverty is 'consistent poverty' which takes into account both the level of income and being deprived of basic items because of the inability to afford them. The basic items referred to are considered basic life-style deprivation indicators¹ such as lack of one substantial meal each day or not being able to pay everyday household expenses without falling into debt. 'Consistent poverty' refers to households or individuals who have a relatively low income and are experiencing basic deprivation. Three of the eight 'deprivation items' are food-related. Given the significance of food in the basic deprivation indicators it is reasonable to assume that households living in consistent poverty are at risk of food poverty.

In 2001, 4.9 per cent of people were living in consistent poverty using 70 per cent of median income as the income element of the measure (Whelan *et al.* 2003: 38-39). The risk of living in poverty was significantly higher for those living in households comprising one adult with children, followed by those in families with

1 The measure includes 8 basic life-style deprivation items which people do not have because of lack of money.

These are:

- One substantial meal each day
- Chicken, meat, fish or its equivalent every second day
- A roast or its equivalent once a week
- Two pairs of strong shoes
- A warm, waterproof coat
- New, rather than second hand clothes
- Adequate heating
- Being able to pay everyday household expenses without falling into debt

two adults and four or more children. A higher proportion of women than men are in consistent poverty with women aged 65 or over at a higher risk of poverty than men of that age. As regards labour market status those who are unemployed or ill/disabled are at greatest risk of consistent poverty (Whelan *et al.* 2003).

The proportions of those living in consistent poverty experiencing deprivation in relation to food is high. In 2000 almost half of those living in consistent poverty were lacking in a roast meat joint or its equivalent once a week while 14 per cent were without a meal with meat, chicken or fish every second day (Nolan *et al.* 2003: 50).

Data are also available highlighting the proportion of those going without each of the basic deprivation items. In the case of the three food-related basic deprivation items, the proportion of individuals going without each has declined dramatically between 1994 and 2001. The proportion of individuals going without a meal with meat, chicken or fish every second day has fallen from 5 per cent to just under 1 per cent, the proportion going without a roast or its equivalent once a week has fallen from 8.1 per cent to 0.9 per cent and those going without a substantial meal on at least one day in the last 2 weeks has fallen from 4.2 to 0.9 per cent. All of these are positive trends in the context of food poverty.

Nolan *et al.* (2003) propose that an alternative set of deprivation indicators should be used in measuring consistent poverty. The alternative proposed includes the measure of 'having friends or family for a meal or drink once a month', thereby bringing in the social dimension of food. In 2000 6.3 per cent of the population could not do this (Nolan *et al.* 2003: 57).

More generally, social status refers to the position of people in the social order and is measured using indicators of occupation, social class and education (Mackenbach and Kunst 1997). Each of these socio-economic status (SES) measures is strongly predictive of life chances (Macintyre and Anderson 1997) but the different measures have been shown to be better predictors of inequality in a range of outcomes. Asset-based measures such as income, car ownership and home tenure have become increasingly used as indicators of social stratification in health and are strongly associated with social variations in dietary behaviour.

Individual-Level Food and Nutrition Consumption Patterns

Individual level food and nutrient intake is investigated in a range of population groups including the general adult and children population, rural dwellers, people who are homeless, asylum seekers, the Traveller community, unemployed people and low-income mothers and families.

General Population

Commissioned by the Department of Health and Children, the first national health and lifestyle survey of adults, SLAN, was undertaken in 1998 and contains a sample of 6,539 adults representing a range of socio-economic circumstance. A self-administered questionnaire, comprising eight sections, including one on dietary habits and a semi-quantitative food frequency was used in the survey. The food frequency part of the questionnaire is designed to cover the whole diet and to estimate both food and nutrient intake and includes 149 food items representative of the main food groups consumed in the Irish diet. A number of socio-demographic and socio-economic details pertaining to the respondent were recorded and the analyses now presented relate to age, sex, social class, education, employment status, medical card status and household tenure. Income was not recorded in the 1998 SLAN.

The SLAN data suggest marked social gradients in dietary behaviours, both at the food and nutrient level, with consumption of healthy foodstuffs in line with dietary recommendations positively related to increasing socio-economic status. A summary of the results for each of the three components of dietary intake is reported below.

Food Quantities

Table 1 summarises the social variation observed in the quantities of foodstuffs consumed by the general adult population. Consumption of foodstuffs regularly advocated by health professionals and the media as being health promoting, such as fruits, low-fat milk and white meat, is lower among respondents from lower socio-economic groups. Foods often associated with an affluent lifestyle, such as wine and cheese, are consumed in smaller quantities among lower social groups. The dietary behaviour observed among working class groups in Irish society since 1948 (Friel 2003, Kelleher *et al* 2002) is observed in the 1998 SLAN data among lower socio-economic groups. This includes a greater consumption of full-fat milk, butter, red meat and products, carbohydrate-rich foods like potatoes and baked beans in these strata compared to more socially advantaged groups.

	MALES	FEMALES
Social Class 5/6	<ul style="list-style-type: none"> ▼ Fruit juice, White meat & products, Wine ▲ Red meat & products, Meat alternatives 	<ul style="list-style-type: none"> ▼ Fruits, Cheese, Wine ▲ Potatoes, Rice & Pasta, Full-fat milk, Red meat & products, Meat alternatives
None/Primary Education	<ul style="list-style-type: none"> ▼ Fruits, Fruit juice, Low-fat milk, Cheese, Other dairy products, White meat & products, Beer, Spirits ▲ Full-fat milk, Butter, Red meat & products 	<ul style="list-style-type: none"> ▼ Cheese, Other dairy products, White meat & products, Wine, Beer ▲ Full-fat milk, Red meat & products, Soft drinks, Low-sugar soft drinks
Non Home Owner	<ul style="list-style-type: none"> ▼ Margarine ▲ Fizzy drinks, Beer 	<ul style="list-style-type: none"> ▼ Cereals ▲ Fizzy drinks, Beer
Employment Status	No significant differences	No significant differences
Medical Card Holder	<ul style="list-style-type: none"> ▼ Fruits, Vegetables, Fruit juice, Cheese, Other dairy products, White meat & products, Wine, Beer ▲ Cereals 	<ul style="list-style-type: none"> ▼ Fruit juice, Cheese, Other dairy products, White meat & products, Low-sugar soft drinks, Wine, Beer

Table 1: Summary of social status variations in age-adjusted mean food and drink intake of Irish males and females.

Source: Survey of Lifestyle, Attitudes and Nutrition, SLAN 1998. Centre for Health Promotion Studies, NUI, Galway

▲ = higher mean intake compared to remaining social group categories.

▼ = lower mean intake compared to remaining social group categories



Nutrient Intake

The social variations in nutrient intake mirror to a certain extent those observed in the food consumption data. Although the nutrient variation was less marked, this is possibly due to the contribution of differing food sources in the different social groups and must be borne in mind since important for educational and promotional purposes. Education is the dominant socio-economic factor by which nutrients vary,

the same observation as in other studies (Roos *et al.* 1996, Hulshof *et al.* 1991, Lindstrom *et al.* 2000). As shown in Table 2, those with little or no education have a significantly higher contribution to their total energy intake from protein and fat, and significantly lower mean energy contribution from carbohydrate and also mean fibre intake levels.

MALES			
	None/Primary (n=595)	2nd level (n=1188)	3rd level (n=772)
Energy, MJ	9.02 (0.2)	9.40 (0.1)	9.60 (0.2)
Protein, E%	19.2 (0.2)*	18.0 (0.1)	17.3 (0.2)
Fat, E%	35.2 (0.3)*	35.0 (0.2)	33.2 (0.3)
Carbohydrate, E%	47.1 (0.4)*	47.6 (0.3)	49.3 (0.3)
Fibre, g	20.4 (0.6)*	21.8 (0.3)	22.9 (0.4)
Females			
	None/Primary (n=512)	2nd level (n=1490)	3rd level (n=893)
Energy, MJ	8.42 (0.2)	9.00 (0.1)	8.88 (0.1)
Protein, E%	18.8 (0.2)*	17.8 (0.1)	17.3 (0.2)
Fat, E%	34.9 (0.4)*	34.1 (0.2)	32.6 (0.3)
Carbohydrate, E%	48.4 (0.5)*	49.9 (0.2)	51.2 (0.3)
Fibre, g	20.6 (0.6)*	23.0 (0.3)	23.5 (0.4)

Table 2: Age-adjusted mean (standard deviation) macronutrient and fibre intake levels by education level

Source: Survey of Lifestyle, Attitudes and Nutrition, SLAN 1998. Centre for Health Promotion Studies, NUI, Galway



Food Pyramid

For public health nutrition policy and intervention purposes, identified groups at nutritional risk can be targeted more easily through dietary practice than at nutrient level. Nutrition health education and promotion is based on Recommended Daily Allowances (RDAs) of nutrients that are derived from recommended daily consumption of a number of food groups, and are often visually represented by food pyramids, plates or circles (e.g. NAG 1995, Willett *et al.* 1995, Hermann-Kunz and

Thamm 1999). A food pyramid is used in the Republic of Ireland, in which there are five shelves (Figure 2), each one recommending a daily number of servings from each food group. The bottom shelf relates to cereals, breads and potatoes of which six or more servings per day are recommended. Four or more servings per day of fruit and vegetables are indicated on the next shelf. The third and fourth shelves correspond to dairy products (three servings per day recommended) and meat, fish or poultry (two servings per day recommended). At the top of the pyramid there are foods high in fats and sugar. It is suggested that these foods are eaten sparingly but more specific comments are not given. For most purposes, up to three servings per day from the top shelf has been used as the notional value.

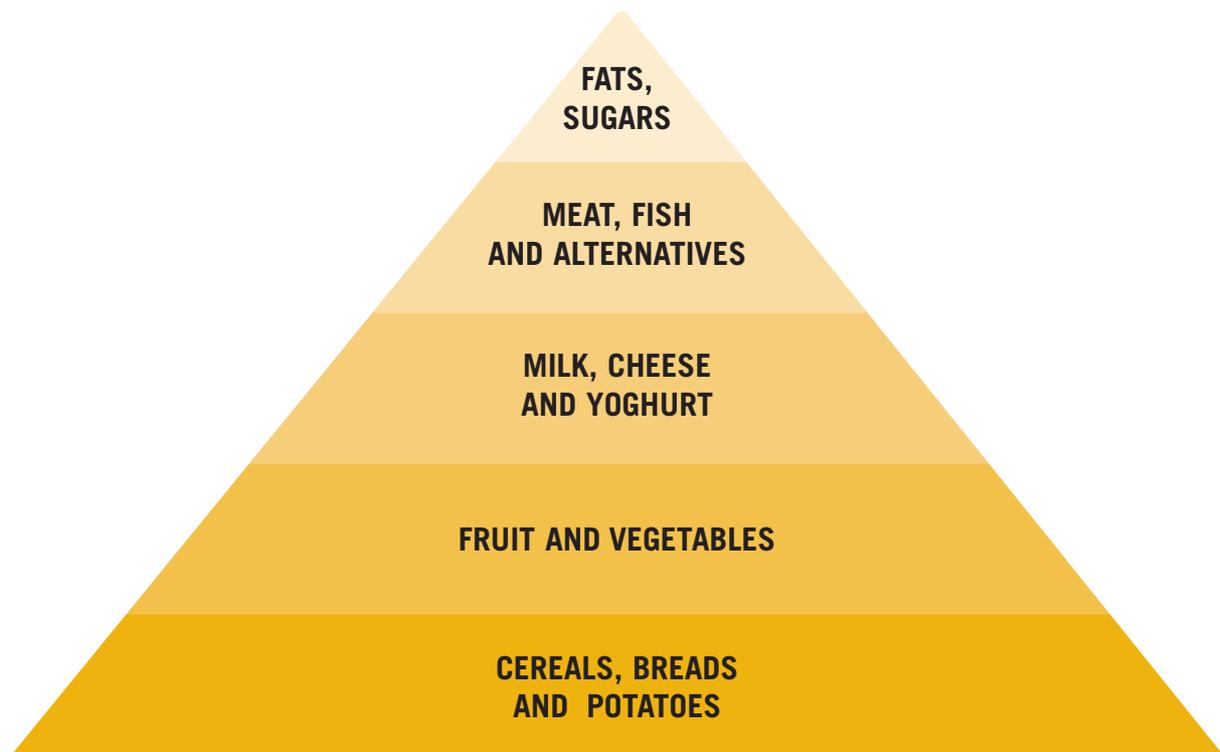


Figure 2: Irish Food Pyramid

Source: Department of Health and Children



As with food and nutrient intake, marked variation is observed in the compliance with daily recommendations from the food pyramid with regards to social class, education, medical card status and household tenure, but not by employment status (Figures 3-5). The most notable social gradient is observed in compliance with the fruit and vegetable recommendations. As seen in Figure 3, close to three quarters of persons in social classes 1 and 2 meet the daily recommendations of four or more servings of fruit and vegetables compared to only half of those from social classes 5 and 6.

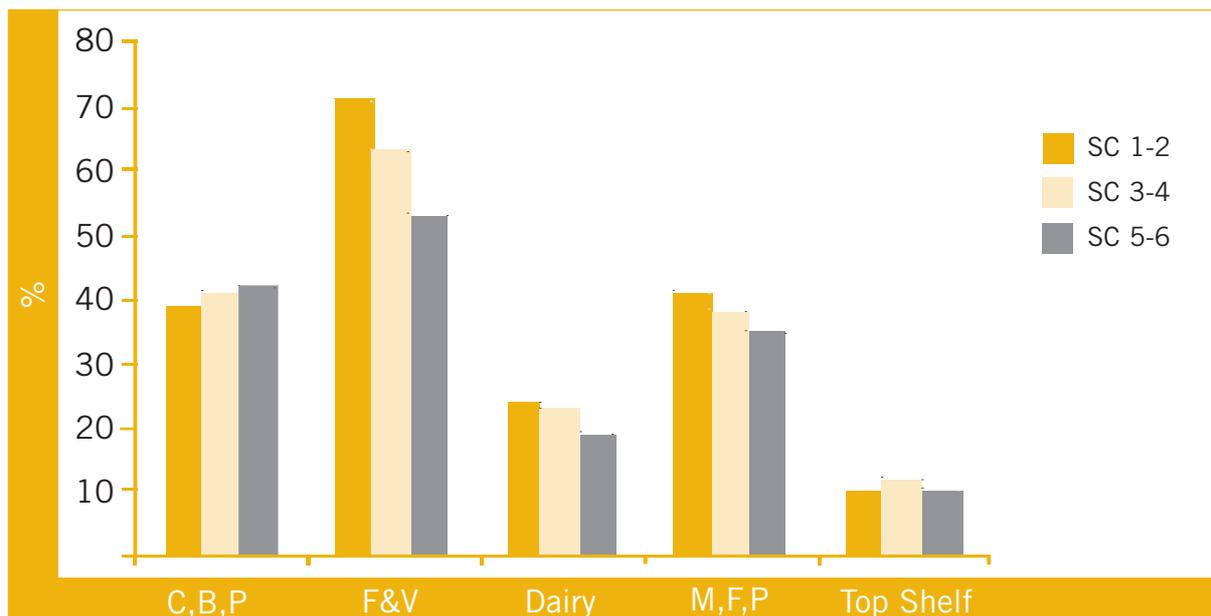


Figure 3: Social class variation in compliance with dietary recommendations

Source: Survey of Lifestyle, Attitudes and Nutrition, SLAN 1998. Centre for Health Promotion Studies, NUI, Galway

Notes:

SC 1-2: Professional, Managerial & Technical

SC 3-4: Non-manual & Skilled Manual

SC 5-6: Semi-skilled & Unskilled

C,B,P: Cereals, Breads and Potatoes

F&V: Fruit and Vegetables

M,F,P: Meat, Fish and Poultry

Top Shelf: Foods high in fat and high in sugar



The same gradients are observed in the compliance with food pyramid recommendations when broken down by level of education attained (Figure 4). Again, a 20 per cent difference exists in the compliance rates of those with higher and lower levels of education. Also, significantly more of those with little formal education consume excess amounts of foods high in fat and sugar.

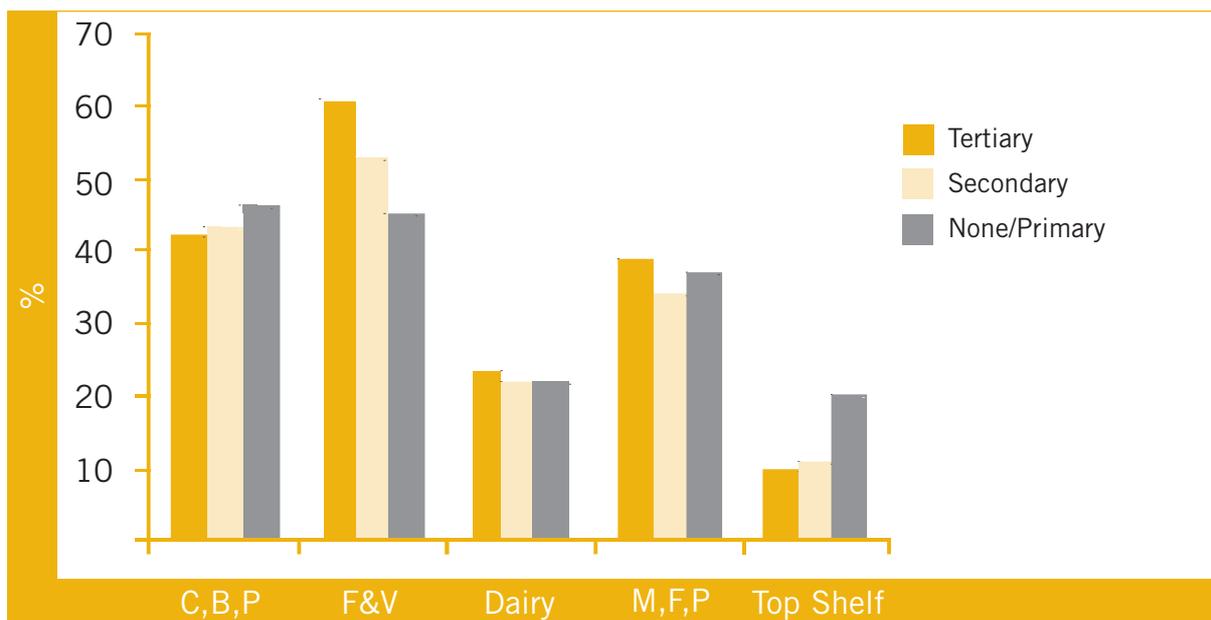


Figure 4: Variation in compliance with dietary recommendations by education level

Source: Survey of Lifestyle, Attitudes and Nutrition, SLAN 1998. Centre for Health Promotion Studies, NUI, Galway

Notes:

C,B,P: Cereals, Breads and Potatoes

F&V: Fruit and Vegetables

M,F,P: Meat, Fish and Poultry

Top Shelf: Foods high in fat and high in sugar



Figure 5 illustrates how having a medical card reflects similar dietary behaviour among persons from social class 5 and 6 or having little formal education. Almost 20 per cent more of those without medical cards complied with the dietary recommendations for fruit and vegetables. As with education, a greater number of people with medical card consumed excess foods from the top shelf of the pyramid, compared to those without medical cards.

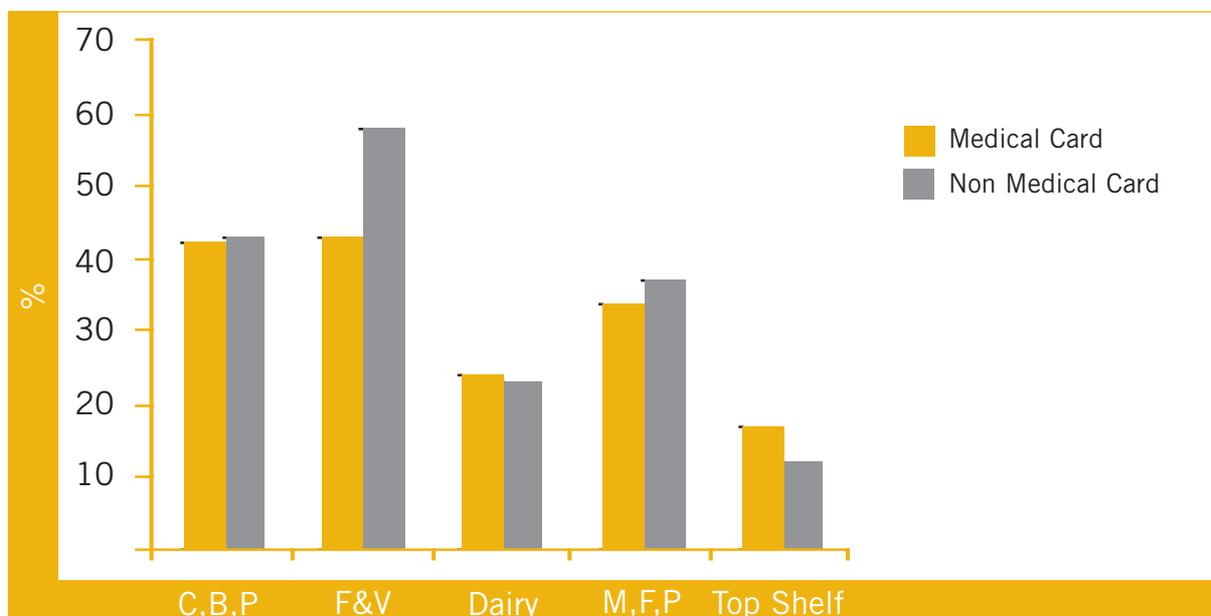


Figure 5: Variation in compliance with dietary recommendations by medical card status

Source: Survey of Lifestyle, Attitudes and Nutrition, SLAN 1998. Centre for Health Promotion Studies, NUI, Galway

Notes:

C,B,P: Cereals, Breads and Potatoes

F&V: Fruit and Vegetables

M,F,P: Meat, Fish and Poultry

Top Shelf: Foods high in fat and high in sugar



Socio-demographic and economic factors are interconnected and may contribute to dietary habits in a complex and indirect manner. Multivariate analyses, using logistic regression models, separately for males and females, were carried out to determine the independent effect of each social status indicator in predicting the percentage energy from fat, protein and carbohydrate. The independent factors – social class, level of education, medical card status, employment status, age, marital status and home tenure – were entered together into each model. Table 3 presents the Odds Ratios and 95 per cent confidence intervals for those independent variables that remain significantly predictive of compliance with the fruit and vegetable recommendations, allowing for all other entered factors. Education level is the strongest predictor of compliance with fruit and vegetable recommendations. For both males and females, those with tertiary level education are more than twice as likely to consume the recommended four or more servings of fruit and vegetables per day compared to those with none or primary level only.

MALES	OR (95% CI)
Social Class 1/2	1.73 [1.28-2.34]
Tertiary Education	2.03 [1.35-3.03]
Non Medical Card	1.53 [1.13-2.08]
Married/Cohabiting	1.86 [1.14-3.03]
FEMALES	
Social Class 1/2	1.29 [0.93-1.79]
Tertiary Education	2.61 [1.64-4.13]
Non Medical Card	1.45 [1.08-1.94]

Table 3: Logistic regression models: Dependent variable Four or more servings fruit and vegetables per day

Source: Survey of Lifestyle, Attitudes and Nutrition, SLAN 1998. Centre for Health Promotion Studies, NUI, Galway



Children

Child poverty is still a significant issue, with 23.4 per cent of all children aged under 18 living below the 60 per cent median income poverty line in 2001, reflecting only a small decline since 1994 (Whelan *et al.* 2003). However, there has been a dramatic decline in the number of children experiencing consistent poverty, that is living below 70 per cent median income poverty line and experiencing basic deprivation. In 2001, 6.5 per cent of children were living in consistent poverty, compared to 15.3 per cent in 1997 (Whelan *et al.* 2003). As discussed earlier, three of the basic deprivation items used to calculate consistent poverty are food related and therefore the decline in consistent poverty suggests that fewer children may be experiencing food poverty than in the past.

As part of the 1999 Living in Ireland Survey, just over 800 mothers were asked whether their children (defined as under 14) had to go without a range of items, including three meals a day, because of a lack of money. Of these 800 mothers, 7.7 per cent stated that their children had to go without three meals a day because of a lack of money (Cantillon *et al.* forthcoming). This has significant implications for food-poverty policies and interventions.

Results from the Health Behaviour in School-Aged Children (HBSC) survey (CHPS 1999) show that Irish boys and girls aged 12-17 years from the two lower social

class groups consume less fruit than those in the higher social categories. There are similar findings for girls with regard to vegetable consumption and this trend has become worse since then (CHPS 2003). Consumption of foods high in fat and sugar is more regular among the more socially disadvantaged children.

Children are one of the most powerless groups in society and are more likely to experience poverty than adults. Living in poverty means the children are likely to suffer from malnutrition because parents do not have enough money to spend on food. The 2002 HBSC survey identified that 19 per cent of boys and 14 per cent of girls always or often went to bed hungry because there was no food in the household (CHPS 2003). Given that almost one in four children live in households experiencing income poverty, services that provide meals directly to children, e.g. school meals, Breakfast Clubs, are applauded both as a means of supplementing diets and of relieving household poverty (ibid.). Gormley *et al.* (1989) stress the importance of school meals being both nutritious and appealing.

Older People

In the Republic of Ireland older people (defined as those aged 65 years and over) from socially disadvantaged circumstances are less likely to comply with the daily dietary recommendations, particularly in the fruit and vegetable food group, and have poorer mean nutrient intake levels (Friel *et al.* unpublished). Layte and colleagues' study *Income Deprivation and Well-Being among Older Irish People* (1999) shows that one in ten older people experience the same levels of combined income poverty and deprivation as the general population. Single-person, older households are also at greater risk of housing deprivation, i.e. living in housing that is damp, has structural problems or lacks the most basic facilities. Living in poor conditions such as these is likely to undermine efforts to eat well. The Food Safety Authority of Ireland draws attention to research findings which indicate that lack of income, education and adequate facilities are all associated with a decreased nutrient intake in older people (FSAI 2000). Other dietary determinants for older people include inability or motivation to shop and prepare food, difficulty digesting certain foods, lack of education about nutrition, social isolation and loneliness. Older people living alone in rural areas have been shown to have a poor dietary quality, attributed mainly to lack of transportation (Quandt *et al.* 2000).

While the majority of older people are healthy and live independently in the community, old age can bring immobility, disability and frailty and these can turn everyday tasks, such as trips to the shops and cooking a meal, into insurmountable challenges. Some older people rely on meals received from meals-on-wheels or eaten at day centres. In such cases the nutrient value of these meals should be of the highest quality and appropriate to the older people as this may be the one balanced meal that a person receives in a day. For the 5 per cent of older people in long-term

care in Ireland the quality of food is of utmost importance as they rely entirely on this for their nutritional requirements. While long-term care would appear an ideal setting to engineer a well-balanced diet, research has found nutritional deficits in long-term care residents more frequently than in community-based populations (FSAI 2000). Clearly, in care settings both catering and care practices have an impact on residents' diets and must be properly managed and delivered to ensure a nutritionally balanced, acceptable diet is provided to older, vulnerable members of society.

Food Consumption Patterns of Low-Income Groups

Research findings available on the patterns of food consumption for specific low-income groups are reported below. Within the population living on a low income the social circumstances of some groups raise particular issues in relation to food consumption and food poverty.

People who are Homeless

People who are homeless include those living in temporary accommodation such as B&Bs, those sleeping in hostels or night shelters and those sleeping rough. Homeless people experience severe material deprivation, psychological distress, insecurity and low self-esteem (DoHC 2001). Being homeless means that the burden of coping and managing on a restricted budget is extremely difficult (Stitt *et al.* 1994). Many people who are homeless eat fewer meals per day, lack food more often and are more likely to have inadequate diets and poorer nutritional status than housed populations (Derrickson *et al.* 1994, Stitt *et al.* 1994, Power and Hunter 2001, Wiecha *et al.* 1991). The people who are homeless generally do not have access to cooking and food storage facilities and therefore rely heavily on shelters, day centres, and soup kitchens as their main food source (Wiecha *et al.* 1991). The food provided by these sources tends to be filling but research has shown that it often lacks variety, is high in saturated fat and cholesterol and low in nutrient density (Luder *et al.* 1990). Crane and Warne's study of living conditions of homeless people in the UK reported that rubbish bins are the chief source of food for some street homeless people (Crane and Warnes 2000).

There has been little assessment of the extent of food poverty among people who are homeless in the Republic of Ireland. Focus Ireland is currently in the process of reporting on a research study 'Hungry for Change: Social exclusion, food poverty and homelessness in Dublin, which investigates issues of diet and nutrition among a discrete sample of adults who are homeless in Dublin city and offers a range of policy-oriented recommendations in response to the research findings (Hickey and Downey 2004). The study identifies for the first time in the Republic of Ireland, both quantitatively and qualitatively, that food poverty is a key issue for homeless households. Walsh (2002) undertook a study to determine the food and nutrient intake of people who are homeless in Galway city, based on the protocol used in the

Focus Ireland study. An interview-administered questionnaire, including a semi-quantitative food frequency section and questions on food provision and cooking/storage facilities, was utilised for data collection purposes. Twenty-five men and five women, with a mean age of 39 years, were recruited for interview primarily through shelters in Galway city. Forty per cent of the participants had access to a kitchen or food preparation area in their accommodation. Of the twelve that did have access to a kitchen ten had access to a communal kitchen and two have a private kitchen. Some participants had varied access to a range of cooking utensils such as kettle, microwave and refrigerator. All other participants either had no access to facilities but had food provided directly to them by the shelter or else obtained their food from means other than the shelters.

Within Walsh's study, a nutritional audit of the types of food provided by the shelters to the homeless people was also undertaken. Three daily meals are provided to residents and one meal daily to non-residents. Both white and brown bread are provided on a daily basis with only a full-fat spread provided for bread and toast and only whole-fat milk provided for breakfast cereals, drinks and daily cooking. Fruit is served 4-5 times a week and is generally served as fresh fruit (when in season) and tinned fruit. Fresh vegetables are served daily. Red meat, poultry and fish are served in the shelter. Certain meals are rotated throughout the week; for example fish is usually provided on a Friday. Potatoes are served but chips, rice and pasta are not provided. Plain and chocolate biscuits, cakes, buns, pastries, chocolate bars and crisps are also provided occasionally.

One-third of the respondents are satisfied with the food provided in the current accommodation, especially those residing in the shelter, but many said they would like more of a variety of food. Ten per cent of the sample said they would like better access to cooking and food storage facilities and 7 per cent said that they do not have enough money to buy the foods they would like.

Walsh (2002) also undertook an analysis of the actual food and nutrient intake of this homeless population. Compared to 1998 SLAN data for social class 5/6 in the general population, fewer people who are homeless comply with the food pyramid recommendations for cereals, bread and potatoes (23 per cent), fruit and vegetables (47 per cent) and foods from the top shelf of the pyramid (3 per cent). Conversely, 80 per cent of the people who are homeless in this study comply with the recommendation of three servings from the dairy shelf compared with only 21 per cent of social class 5/6 respondents to SLAN. Furthermore, 50 per cent of the people who are homeless in this study comply with the recommended two servings of meat, fish and poultry a day compared with 41 per cent of social class 5/6.

A nutrient analysis of the reported food intake among this population identified lower than recommended levels of calcium, folate, fibre, riboflavin and vitamin E (Table 4). The low intakes of fruit and vegetables may help explain the shortages of folate, fibre, riboflavin and vitamin E in the average diets of the people who are homeless. The RDAs against which comparisons are being made are the Irish RDAs for men (FSAI 1999).

Nutrient	Mean (sd)	RDA
Energy (kcal)	1950 (955.7)	
Protein (%)	17.5 (5.4)	10
Fat (%)	33.3 (8.8)	35
Carbohydrate (%)	47.8 (12.3)	55
Fibre (g)	21 (19.2)	~25
Thiamine (mg)	1.67 (1.3)	1.1
Vitamin B6 (mg)	2.3 (1.2)	2.2
Vitamin B12 (µg)	5.7 (7.6)	1.4
Riboflavin (mg)	1.43 (0.8)	1.6
Vitamin A equivalence (µg)	888.2 (1584.5)	700
Vitamin D (µg)	2.3 (1.92)	0-10
Vitamin E (mg)	4.9 (2.7)	10
Vitamin C (mg)	82.2 (64.7)	60
Folate (µg)	249.3 (120.4)	300
Calcium (mg)	696.4 (339.1)	800
Phosphorus (mg)	1271.7 (677.7)	550
Iron (mg)	10.4 (6.1)	10
Zinc (mg)	10 (6.2)	9.5
Selenium (µg)	47.5 (27.7)	55

Table 4: Mean (standard deviation) daily intake of nutrients among males who are homeless compared to Recommended Daily Allowances

Source: Walsh 2002



The findings from this small Irish study are very much in keeping with the international literature on homelessness as mentioned at the start of this section. Overall the dietary intake of this group of people who are homeless in Galway city is substantially lacking in two of the major food groups and with subsequent nutrient inadequacy. It is worth noting that this sample represents adults who avail of some shelter and food provision. Their dietary intake is therefore likely to be better than people who are homeless without such provision. The study highlights a number of structural issues, namely lack of finances and lack of physical access to cooking facilities, which impact upon the dietary intake of such a socially excluded group. The direct food provision through the shelter attempts to address the nutritional needs of people who are homeless. However, normal dietary habits are not possible, reflected in the complaints about lack of variety and choice.

People who are Unemployed

In 1989 Lee and Gibney carried out research on patterns of food and nutrient intake in a suburb of Dublin with chronically high unemployment. Data were collected on 50 households in the area of study looking at diet history of a typical seven days in a recent month, weekly food purchases, income and food expenditure (Lee and Gibney 1989: 5).

Analysis of the dietary behaviour of the sample shows that fat intakes in adult males and females exceeded the recommended value. Fibre intakes for adults of both sexes were below the recommended minimum value per day but were particularly low in women. Iron intakes in adult females and adolescent girls were very low. Many children, especially girls, also had iron intakes below their recommended dietary allowance. Vitamin C intakes were low in women and children and although intakes in adult males were in line with recommended dietary allowance they were low in comparison with other study findings. Those found to be at the highest risk of nutritional inadequacy were women in general and in particular women in single-parent families (Lee and Gibney 1989: 84).

Analysis of the eating habits of the study group showed that the range of foods consumed was very limited, with little variation in the types of food eaten from week to week. Cost, ease of preparation, convenience of transportation and storage were the principal factors affecting food choices. Diets were characterised by high consumption of milk, bread and potatoes and low consumption of fresh fruit and vegetables. Meat consumed was of the cheapest variety and fresh fish was seldom eaten, with fish fingers featuring instead. Tinned peas and beans were the most commonly consumed vegetables, with carrots eaten regularly in stews. Fresh fruit was a luxury item which was related to the relatively lower vitamin C intakes observed. Children consumed a lot of breakfast cereals often in the evening as well as for breakfast (Lee and Gibney 1989: 74).

Secondary analysis of data relating to unemployed respondents in the 1998 SLAN survey shows substantial similarity with the findings from Lee and Gibney's study (1989). The mean intake of macronutrients is generally in line with dietary recommendations for Irish adults. There is little difference between males and females unemployed and those working, in terms of percentage contribution to total energy intake from protein, fat and carbohydrate (Table 5). However, as Lee and Gibney (1989) found, the mean fibre intakes for unemployed adults of both sexes are below the recommended minimum value per day. Unemployed respondents, particularly males, consume diets with high levels of breads, cereals, potatoes and vegetables but low fruit intake. Higher intakes of full-fat dairy produce and snack foods are observed among unemployed people compared to those working. Meat intake is similar among the two groups and both wine and beer consumption is lower in unemployed respondents.

	UNEMPLOYED Mean (SE)	EMPLOYED Mean (SE)
MALES		
Energy	2345 (73.4)	2226 (25.3)
Protein, %E	17.92 (0.39)	18.00 (0.13)
Fat, %E	34.8 (0.59)	34.5 (0.20)
Carbohydrate, %E	48.11 (0.73)	47.95 (0.25)
Fibre, g	23.42 (0.96)	21.50 (0.33)
≥ Rec. %Fat intake	53.5%	50.0%
FEMALES		
Energy	2151 (67.1)	2132 (23.7)
Protein, %E	18.42 (0.36)	17.83 (0.12)
Fat, %E	33.15 (0.54)	33.76 (0.19)
Carbohydrate, %E	50.03 (0.67)	50.05 (0.24)
Fibre, g	23.84 (0.88)	23.16 (0.31)
≥ Rec. %Fat intake	46.3%	45.3%

Table 5: Age-adjusted mean daily intake of energy and macronutrients of unemployed and employed Irish adults

Source: Survey of Lifestyle, Attitudes and Nutrition 1998, Centre for Health Promotion Studies, NUI, Galway



Traveller Community

The Traveller community represents the largest ethnic minority group in the Republic of Ireland. This distinct, nomadic ethnic group comprises approximately 4,500 families accounting for about 24,000 people (DoHC 2002). Although Travellers are not included in large-scale poverty statistics there is evidence that they have a relatively low standard of living and are at a higher risk of poverty than the general population (ibid.). Approximately 1,000 families live on the roadside without the most basic facilities such as sanitation and electricity (Government of Ireland 1997). As a group, Travellers suffer substantially more ill health and have a lower life expectancy and higher infant mortality rate than the settled population (Pavee Point 2001). The nomadic lifestyle and cooking and food storage facilities available will affect Travellers' diets. To date there has been little research carried out on the actual food and nutritional intake of Travellers in this country. However, one study undertaken in 1995 on dietary habits of Traveller women in Dublin did identify higher fat levels in the Traveller diet compared to the settled population and shows that kitchen facilities available to the Travellers are limited especially with regard to fridges and freezers (McNamara 1995). Another study, carried out over five different halting sites and which included 421 Travellers, found that more than three-quarters of respondents did not plan their meals on a weekly basis. More than one third of participants felt that the lack of a refrigerator was a reason that meals were not planned.

Asylum Seekers and Refugees

A recent phenomenon in Irish society is its growing multiculturalism. A significant contributor to this is the recent increase in the number of people seeking asylum in Ireland. Numbers have risen from a relatively small base in 1996 to 7,700 applications for asylum in 1999 (Faughnan and Woods 2000). This population is generally not included in large-scale poverty studies that are based on private households on the electoral register. Although not counted in these official statistics there is emerging evidence that asylum seekers face a range of circumstances which combine to heighten their risk of being poor and socially excluded. These circumstances may include being excluded from work, from social networks, having little income or capital and weakened family networks and being able to exert little influence over one's future. In the Republic of Ireland people seeking asylum are subject to a system of direct provision since April 2000, supplying accommodation and three daily meals and a small allowance of currently €19.05 a week per adult and €9.52 per child. Research carried out by Fanning and colleagues for the Irish Refugee Council showed that in general families that live under direct provision frequently have no access to kitchen facilities and cannot afford to supplement the food provided in the hostels (Fanning *et al.* 2001a). There was evidence of malnutrition among expectant mothers, ill health relating to poor diet in babies, and weight loss in children. Asylum seekers often find they are faced with a monotonous diet of foods they are often unable to digest. They also have little or no say in what

they or their children would like to eat. Under direct provision asylum seekers are deprived of the choice and control that being responsible for their own cooking arrangements would provide (Faughnan and Woods 2000).

There is limited literature on food and poverty among ethnic groups in the Republic of Ireland. Research in the UK identified complications when choosing to eat a diet based on traditional, culturally appropriate foodstuffs. These foods are often relatively expensive and stocked by a limited number of shops/markets, so travelling to these sources adds a further expense and inconvenience (Cole-Hamilton and Lang 1986). It is likely that eating a culturally specific diet in Ireland presents similar difficulties as those encountered in the UK. This hypothesis is being tested through a Combat Poverty Agency funded collaborative research study between the Centre for Health Promotion Studies, NUI, Galway and the Departments of Public Health and Health Promotion, North Western Health Board, entitled 'Food, Nutritional Status and Poverty among Asylum Seekers in the North West of Ireland'.

People with a Disability

People with a disability or illness have been shown to be at greater risk of poverty and this primarily relates to their exclusion from participation in paid employment. Two-thirds of households headed by a person who is ill or disabled were below the 60 per cent poverty line in 2001 (Whelan *et al.* 2003: 23). Those in receipt of illness and disability related social welfare payments were at the highest risk of income poverty at the 60 per cent median income measure in 2001 (Whelan *et al.* 2003: 31). The risk of living in poverty for this group increased sharply between 1994 and 1997 from 30 per cent to 53 per cent and a further sharp rise was observed in 2001 to 66.5 per cent (Whelan *et al.* 2003: 31).

Looking at the measure of consistent poverty, which takes account of both income poverty and being deprived of basic items because of the inability to afford them, the risk of consistent poverty is highest in households where the reference person has an illness or disability, representing 22.5 per cent of such households experiencing consistent poverty where the income element is measured at 70 per cent of median income (Whelan *et al.* 2003: 40). Given that food-related items account for three of the eight basic life-style deprivation indicators we can assume that those with an illness or disability are also at greater risk of food poverty. For people with a disability unequal access to transport is another factor that would exacerbate their risk of experiencing food poverty.

A study conducted by the National Rehabilitation Board in 1995 explored how disability affects the living standards and lifestyles of people with disabilities in Ireland, the costs associated with disability, how people with disabilities manage their incomes and the issues that they face in their daily lives (NRB, 1995).

The research identified additional costs due to disability including costs relating to regular purchases; food, clothing and footwear; heating; equipment, aids and furniture and adaptations to homes. In relation to regular purchases, 22 per cent of participants indicated they had to buy items specifically related to their disability each week – including special food, medication, as well as laundry services. The cost to individual participants associated with this expenditure ranged up to €48 per week in 2003 prices. A further 41 per cent of respondents to the NRB study indicated they had to buy such items, but less often than weekly. In relation to additional food costs, 20 per cent of participants indicated that their appetite increased as a result of their disability, while 16 per cent indicated that they could not eat the same food as others in the household (NRB, 1995).

Rural Influences on Food Intake

One of the main characteristics of poverty in rural Ireland is its seemingly invisible nature. Rural areas, unlike some urban areas, do not present homogeneous areas of advantage and disadvantage; they are diverse and the experience of poverty is often individual and dispersed over a greater geographic area. Rural areas suffer in many cases from remoteness in terms of physical access and in many rural areas, poverty, disadvantage and marginalisation remain significant problems (Nolan *et al.* 1998).

To date little information has been published on the social variation in dietary habits of Irish rural dwellers and this has made it difficult to identify needs and appropriately target groups at risk in such localities. Secondary analysis was performed on data pertaining to rural respondents to the 1998 SLAN. A total of 2,798 respondents were classified as living in rural areas, defined as localities with populations of less than 1,500 as determined by the Central Statistics Office. Respondents were grouped by differing degrees of 'rurality', i.e. those living in areas with populations of <500, 501-1000 and 1001-1500 inhabitants. The data were analysed according to the shelves of the food pyramid in order to determine possible differences in compliance with dietary recommendations across the different degrees of 'rurality'. Additionally, the socio-economic and demographic variation in dietary compliance within a rural area was tested.

Little variation is observed in dietary behaviour across the rural groups as a whole, as shown in Figure 6. There is, however, substantial variation between socio-economic categories within each rural grouping as seen in Table 6, with the more socially disadvantaged respondents reporting the less healthy dietary habits. The most persistent socio-economic variation in dietary habits is predominantly in the areas with fewer inhabitants. Fewer respondents from the lower social groups in these areas comply with the recommendations for fruit and vegetables, meat/fish and poultry and foods from the top shelf of the food pyramid.

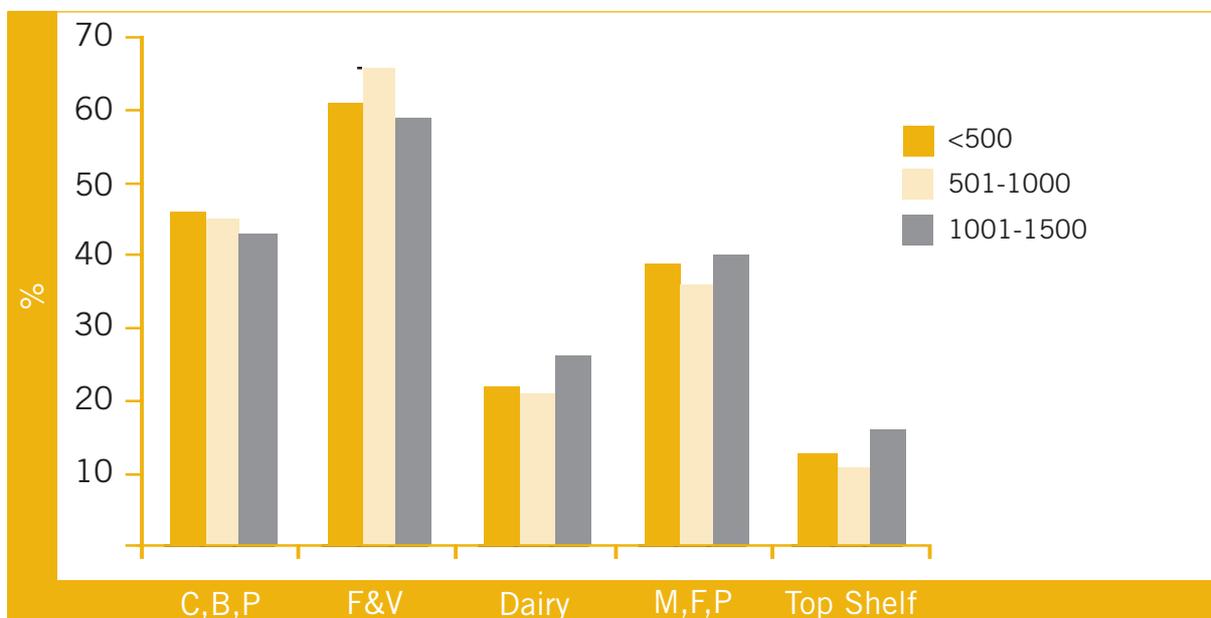


Figure 6: Variation in compliance with dietary recommendations across rural groups

Source: Survey of Lifestyle, Attitudes and Nutrition, SLAN 1998. Centre for Health Promotion Studies, NUI, Galway

Notes:

C,B,P: Cereals, Breads and Potatoes

F&V: Fruit and Vegetables

M,F,P: Meat, Fish and Poultry

Top Shelf: Foods high in fat and high in sugar



	Food Shelf	Pop: <500 N=1468	Pop: <500-1000 N=890	Pop: 1001-1500 N=122
Gender	C, B & P		✓	
	F & V	✓	✓	✓
	Dairy		✓	
	M, F & P	✓	✓	
	Top Shelf	✓		
Age	C, B & P			
	F & V	✓	✓	
	Dairy	✓	✓	
	M, F & P	✓	✓	✓
	Top Shelf	✓	✓	

	Food Shelf	Pop: <500 N=1468	Pop: <500- 1000 N=890	Pop: 1001- 1500 N=122
Social Class	C, B & P F & V Dairy M, F & P Top Shelf	✓	✓ ✓	✓
Education Attained	C, B & P F & V Dairy M, F & P Top Shelf	✓	✓ ✓	
Medical Card Status	C, B & P F & V Dairy M, F & P Top Shelf	✓ ✓	✓ ✓	
Employment	C, B & P F & V Dairy M, F & P Top Shelf			
Home Tenure	C, B & P F & V Dairy M, F & P Top Shelf	✓ ✓	✓	✓

Table 6: Social status variations in food pyramid shelf compliance within rural groups

Source: Survey of Lifestyle, Attitudes and Nutrition, SLAN 1998. Centre for Health Promotion Studies, NUI, Galway

Notes:

C,B,P: Cereals, Breads and Potatoes

F&V: Fruit and Vegetables

M,F,P: Meat, Fish and Poultry

Top Shelf: Foods high in fat and high in sugar

✓ indicates significant variation between the categories of a particular social indicator with respect to compliance of a particular shelf recommendation.



The 1998 SLAN survey also recorded the type of transport used to go to shops. This varies substantially depending on the level of rurality someone dwelled in. Use of car is high in each area but significantly greater in the very rural area (84 per cent), which decreases to 71 per cent in the area with 1000-1500 inhabitants. As may be expected, due to proximity and availability of shops, walking to the shop is higher in the more populated area (14 per cent) compared to 7 per cent in the area with < 500 people. Nine per cent of people in the most populated area use public transport compared to only 2 per cent in the other two areas. Whilst these data are limited in depth of information relating to physical access to food retail outlets, they do give an indication as to the transport issues that may be affecting the more socially disadvantaged groups in rural communities. Generally, within the rural areas poorer dietary habits are exhibited among the more socially disadvantaged individuals, with the same gradient as that observed among urban dwellers. Physical access problems, however, may be more pertinent in rural locations and if compounded by socio-economic deprivation may lead to clustered areas of food poverty.

Household Level Food Patterns

Information is collated at the national household level in relation to absolute and relative food expenditure across different socio-demographic and socio-economic households. This allows inferences to be made concerning the relative capacity to purchase different foodstuffs across the different social categories. In addition, information from small-scale qualitative research has been collated which offers useful insights into how food features in the daily lives of low-income families.

Household Food Expenditure

Household food expenditure and price are good indicators of food patterns and priorities and the Central Statistics Office (CSO) routinely collects and collates data pertaining to this through the Irish Household Budget Survey (HBS). The main purpose of the HBS is economical: to determine patterns of household expenditure on all items for the purpose of updating the weighting basis of the Consumer Price Index (CSO 1989). Extensive household detail is recorded including socio-demographic and economic information as well as expenditure on all commodities, including foodstuffs. These surveys provide a routine, standardised collection of statistically powerful data which may be interrogated for food and health surveillance purposes (Friel *et al.* 2001).

In real terms the actual expenditure on food has remained relatively unchanged in the recent decade (Friel 2003). In 2000 the average weekly Irish household expenditure was €578 with 20.4 per cent of that spent on food, but this varies significantly depending on social group as seen in Table 7. In each indicator of socio-economic status (SES), those households in the lower SES category spend in absolute terms the least amount of money on food. However, this is proportionately more of their overall household expenditure compared to the more socially advantaged households.

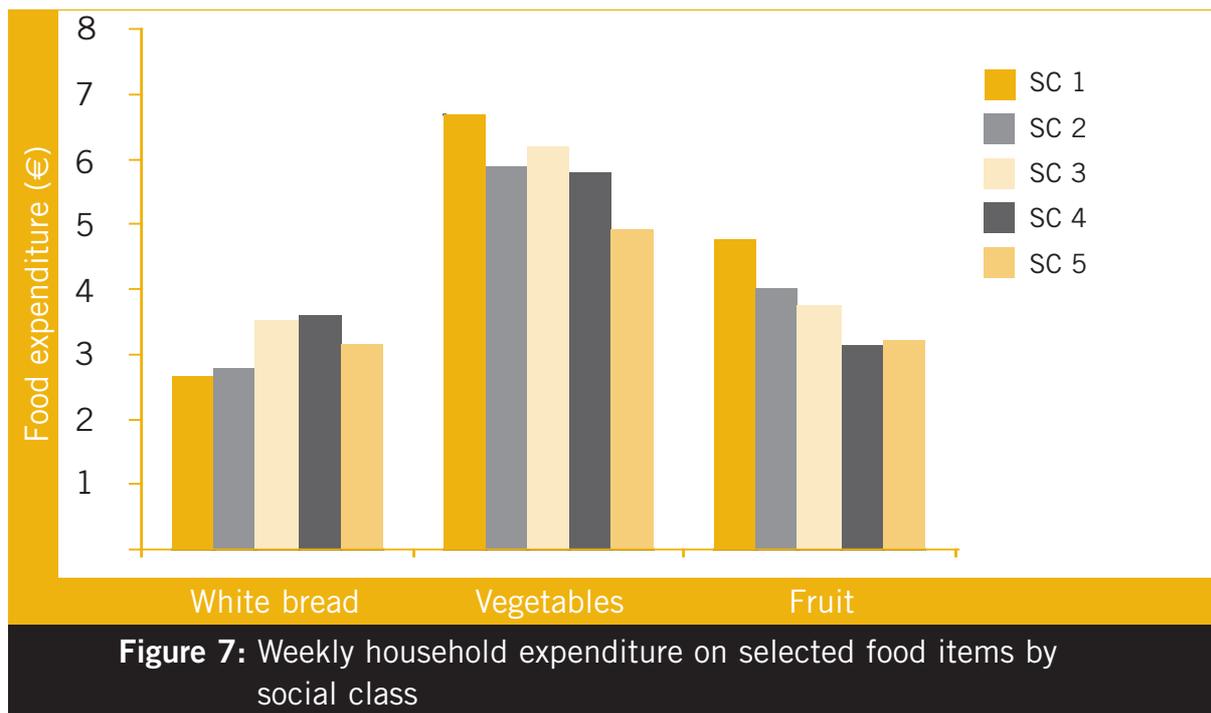
	No.	Food Expenditure (€)	Total Expenditure (€)	% F/T
Social Class				
1	2,567	135.52	752.81	18.00
2	1,022	119.87	636.09	18.84
3	1,212	123.32	563.87	21.87
4	1,135	112.93	481.54	23.45
5	1,708	90.52	354.52	25.53
Income Quintile Levels (€)				
214.46	774	62.52	214.61	29.13
473.59	768	96.08	386.15	24.88
664.19	797	126.84	603.51	21.02
1016.63	759	153.74	789.46	19.47
>1339.22	716	197.03	1,213.26	16.24
Employment Status				
Self Employed	1,189	147.09	682.25	21.56
Employee	3,387	137.15	744.44	18.42
Out of Work	369	105.57	414.66	25.46
Retired	1,402	79.21	336.69	23.53
Other	1,297	85.34	343.84	24.82
Household Tenure				
Owned	6,385	250.6	1,247.8	20.08
Rent Local Authority	572	90.04	306.99	29.33
Rent Private	613	99.81	601.93	16.58
Rent Free	74	73.05	433.06	16.87
Locality				
Urban	4,170	117.63	612.53	19.20
Rural	6948	128.4	520.49	24.7

Table 7: Food and total household expenditure across a range of social indicators

Source: Household Budget Survey 1999-2000, CSO 2002.



Figures 7-11 present the weekly household food expenditure on a number of selected food items, across different indicators of socio-economic circumstance and demographics. As seen in Figure 7 a social gradient exists in the amount spent on the selected food items. Households from the lowest social category spend less money on fruit and vegetables compared to the higher social status households, whereas the gradient is in the opposite direction for white bread.



Source: Household Budget Survey 1999-2000, CSO 2002.

In Figure 8, the weekly expenditure on the same food items is shown within household net income quintiles. A similar social gradient to that of social class emerges for expenditure on fruit and vegetables. A slightly higher expenditure on white bread is, however, recorded by those with the highest income.

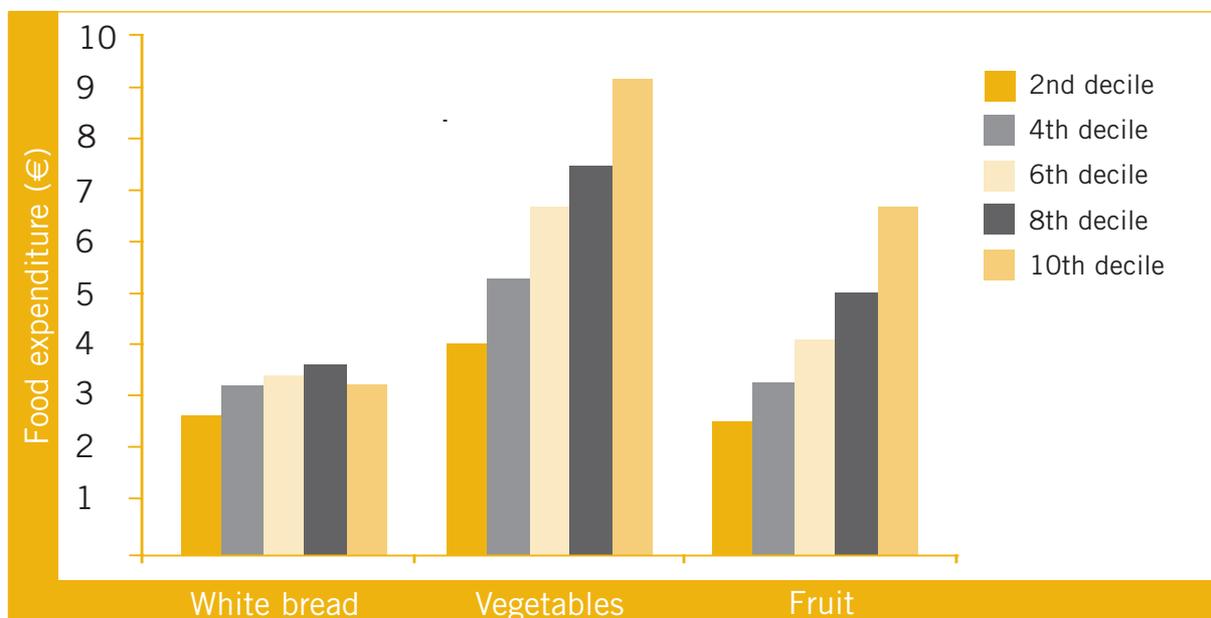


Figure 8: Weekly household expenditure on selected food items by income

Source: Household Budget Survey 1999-2000, CSO 2002.

People in employment spend more money on fruit and vegetables compared to those not in employment (Figure 9). The strong employment gradient observed in fruit and vegetable expenditure is not so obvious in relation to white bread expenditure.

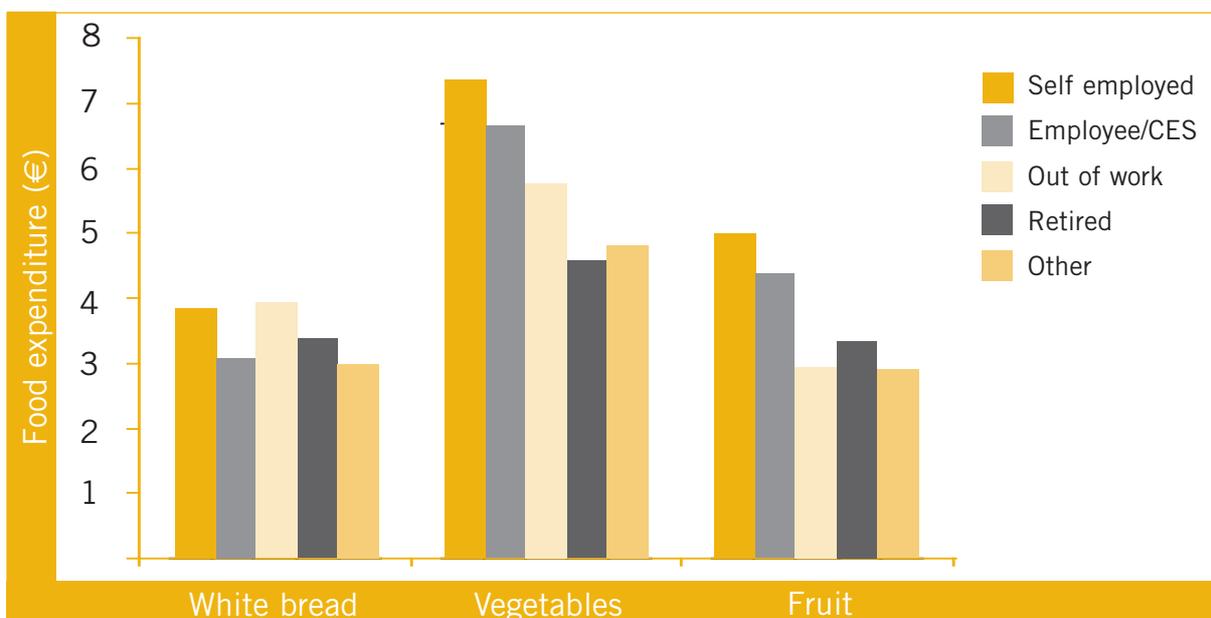


Figure 9: Weekly household expenditure on selected food items by employment status

Source: Household Budget Survey 1999-2000, CSO 2002.

Figure 10 highlights the variation in household expenditure on white bread, fruit and vegetables by home tenure. Those owning their own home spend most money on each food item. The social status gradient is observed in fruit expenditure, with those renting from local authorities spending least.

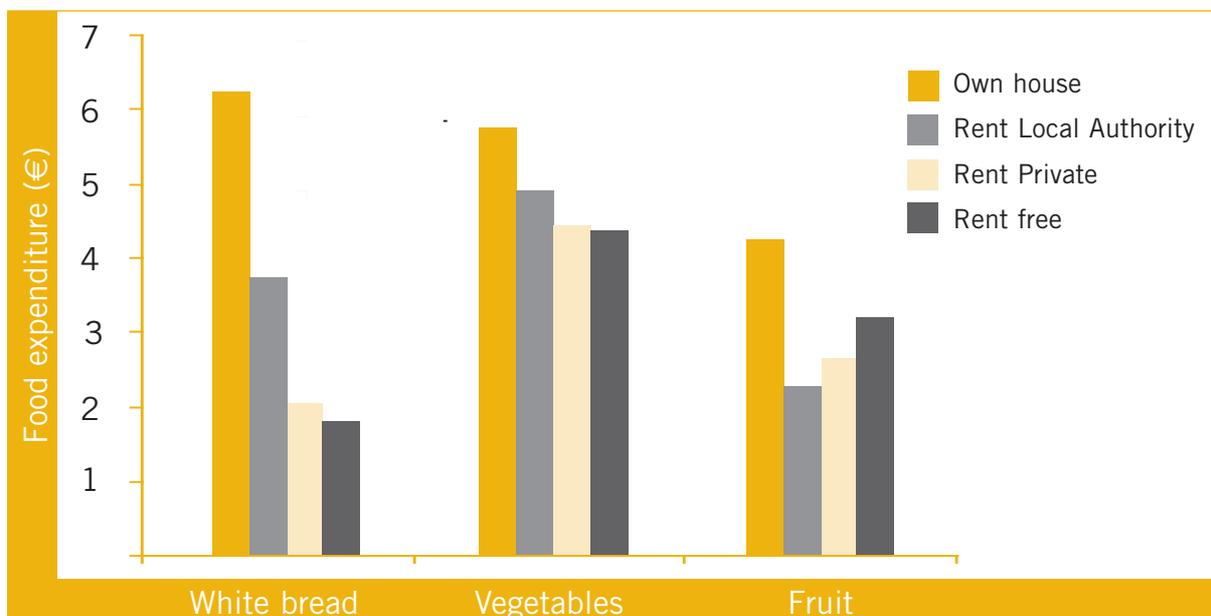


Figure 10: Weekly household expenditure on selected food items by housing tenure

Source: Household Budget Survey 1999-2000, CSO 2002.

Less marked variation in household expenditure on these food items is observed at the neighbourhood level, as seen in Figure 11. Only very small differences in expenditure on white bread, fruit and vegetables are observed between respondents from urban and rural localities.

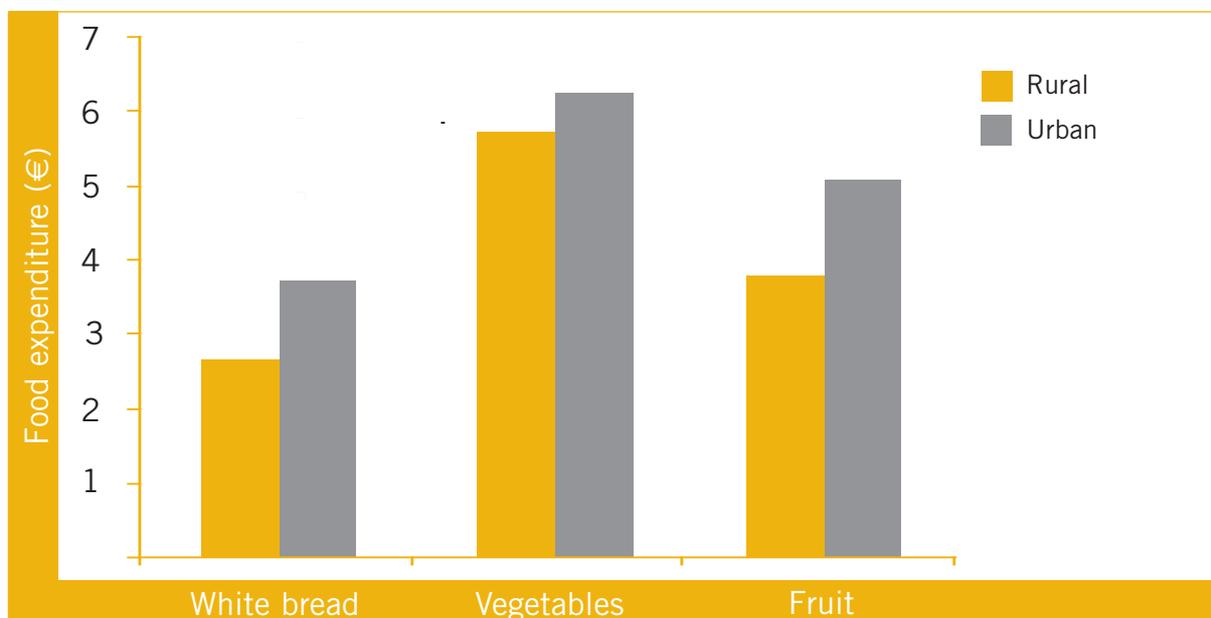


Figure 11: Weekly household expenditure by locality

Source: Household Budget Survey 1999-2000, CSO 2002

Household Budget Survey data from 1987 were also used by Murphy-Lawless (1992) to compare the typical spending patterns of a two-adult, two-children family dependent on social welfare (welfare family) with a family that has an income related to average industrial earnings (average family). In both households food represents the largest expenditure item but the proportion of the household budget spent on food by the welfare family was 34 per cent compared to 25 per cent for the average family (Murphy-Lawless 1992:16). In real terms the welfare family spend 25 per cent less on food than the average family do. These findings from the Murphy-Lawless investigation, and this current interpretation of the 2000 HBS, show consistent inequality in household food purchasing patterns, whereby in socially disadvantaged households food accounts for a higher proportion of expenditure though less is spent on food in real terms.

Murphy-Lawless' (1992) analysis of food expenditure of both families also shows that the average family have better quality food, larger portions and greater variety. Fruit consumption is severely limited for the welfare family who rely heavily on cheap filler foods like potatoes and white bread, again reflected in the 2000 HBS data. The mother of the welfare family makes do with smaller portions and compromises her nutritional status (Murphy-Lawless 1992: 78).

Low-Income Households' Food Behaviours

Low-Income Family Life in Ireland

Daly and Leonard's (2002) qualitative study sought to make visible the lives and concerns of some of Ireland's poorest households. It involved qualitative interviews with 78 participants, 28 children and 50 adults from 30 households in three different areas of the country – a Dublin suburb, a town in the North West and a rural area in the West. Of the thirty households a lone adult headed eleven while a couple headed nineteen. The households participating in the study had above- average levels of income poverty compared to those found among the general population.

Consistent with other study findings, Daly and Leonard's study shows that food is the single largest category of spending, accounting for almost a third of household income (2002: 20). Parents in the study expressed concern about the content and nutritional balance of their children's diets and in some cases children are kept out of school because of lack of food (Daly and Leonard 2002: 94). When faced with an emergency most replies indicate that they would not cut back on food and that the children's needs are paramount (Daly and Leonard 2002: 39). Elsewhere in the study, though, it is reported that some cut back on food in order to make purchases necessary for children for Christmas (Daly and Leonard 2002: 62).

In couple households the principal method of managing the household income is for the man to give the woman the money to which both then have access. The responsibility for the management of the money often rests on the woman. Their findings show that almost all income is regarded as collective and accordingly shared (Daly and Leonard 2002: 49).

Low-Income Families in Dublin

The Vincentian Partnership for Social Justice (VPJ) undertook a study of living standards and budget choices for families on low income in Dublin in 2001 (VPJ 2002); 118 people were surveyed and this was followed by in-depth interviews with 45 people each representing a household. Participants were recruited from twelve community centres in the inner city and disadvantaged areas of Dublin.

The VPJ study found that housekeeping and food are the most costly items of expenditure for the majority of households regardless of income. Those living on social welfare income alone spend a large proportion of their income on food but could not manage an adequate diet (VPJ 2002: 9). When respondents were shown the food pyramid the most frequent response was that fresh fruit, vegetables and meat are unaffordable on a low income (VPJ 2002: 83). When study households' food-consumption patterns were compared with the Department of Health's

Recommended Daily Allowances it was concluded that it was unaffordable to meet these recommendations in the case of all households (VPJ 2001: 93). This research highlights that the principal barrier to providing a reasonably healthy diet is inadequate income.

One of the strategies used to deal with the on-going shortfall resulting from an inadequate income was for adults to limit their intake of food. Many sacrifices are made, especially by mothers, to ensure that their children and partners/husbands do not go hungry (VPJ 2002: 154). Food shopping is dictated by children's tastes and there is no room to vary the diet due to the risk of wastage, as children will not eat unfamiliar foods (VPJ 2002: 84).

The study concludes that the lower the level of income the more difficult it is to achieve a healthy eating pattern (VPJ 2002: 104). Those living on social welfare alone have a large proportion of their income absorbed by food expenditure, yet an adequate diet appears to be impossible. Those who have extra income from employment or participation on a Community Employment scheme are in a position to buy food items such as yoghurts and fruits that are not affordable when relying exclusively on social welfare payments (VPJ 2002: 155).

Mothers in Low-Income Households

Coakley's research was a qualitative study of the patterns of money management in social welfare households with dependent children and was based on interviews with fifty mothers in a Dublin suburb (2001). All of the households were dependent on social welfare, either long-term unemployment assistance or one-parent family payments. In addition, 35 per cent of the participants worked part-time. Thirty-three of the participants were married and seventeen were lone mothers.

Coakley found that mothers as managers in low-income households try to ensure that their families have access to both healthy food as officially defined and food choices enjoyed by the rest of society, but that cost constraints limit their capacity to do so on a daily basis (Coakley 2001: 91). Women bought fresh meat and vegetables more so than frozen food. Shopping for food was described as time-consuming and involved shopping around to get the best value. One large weekly shop on the day when payments are received was the norm and items purchased are generally the same each week. In most couple households women reported shopping alone rather than with husbands who would be less mindful of watching the bill (Coakley 2001: 93-4). Coakley described food as occupying a contradictory position in the budgeting of low-income families in that it was both the main priority and the main item mothers could cut back on to meet other financial commitments such as clothes and bills (2001: 96).

Mothers wanted to provide the range of foods considered the norm for children such as snack bars, minerals, ice cream and crisps and strived to make these available particularly for school lunches. They were cut back on when money was needed for other items (Coakley 2001: 97). None of the households ate out on a regular basis in either restaurants or fast-food outlets and less than one tenth had take-away meals every few weeks, something that was more common where women worked (Coakley 2001: 96).

When asked what they would do if they had an extra £10 (€12.70) per week to spend on food, mothers said they would like to get more fresh food particularly fresh meat, fruit and vegetables, better quality meat and luxuries including biscuits and yoghurts. Those with older teenage children said they needed more food (Coakley 2001: 95). Some of those interviewed had recently entered into paid employment and the increase in family income this represented made a significant difference in the food choices available (Coakley 2001: 100). Coakley concluded that for the mothers in her study the pattern of food purchasing and consumption shows the lack of choice in diet and the barriers to enjoying changed cultural practices in food consumption due to financial constraints (Coakley 2001: 101).

Moloney undertook a qualitative study to assess which environmental, psychosocial and personal factors influence the food choices made by low-income mothers living in Galway city. The information is based on interviews with twenty mothers on the caseload of public health nurses in the Western Health Board (Moloney 2001). Sixty per cent of the sample was lone parents and the remainder were two parent families.

Mothers are aware which foods contribute to a healthy diet and the benefits of healthy eating. Respondents were shown the five food groups of the food pyramid and asked to give a breakdown of their typical weekly shopping list according to these foods. All of the women reported that they regularly shopped for cereals and dairy products, 95 per cent buy meat and fruit and vegetables in a typical week and 80 per cent regularly include foods from the tops shelf of the food pyramid in their weekly shopping. Findings also indicated that 90 per cent of the respondents consume three meals daily, with the remaining 10 per cent consuming an average of three meals a day (Moloney 2001: 46). Whilst the main food groups from the pyramid are frequently consumed, the study found a low consumption of fruit and vegetables compared to the high consumption of starchy and sweet foods (Moloney 2001: 36).

The mothers surveyed reported not having enough money to buy the foods they would like or need on a regular basis. On average two-fifths of the respondents' money is spent on food, with the majority of respondents spending an average of approximately €75 weekly (Moloney 2001: 38). Mothers feel the effect of their

budgetary constraints and in fact 40 per cent of the women said they seek more money in order to improve their standard of living (Moloney 2001: 53). However, when asked what they would do if they ran out of money 55 per cent of respondents reported that they would never ask for food or money from an outside agency. The factors most strongly associated with reluctance to seek outside financial help are (1) stigma of accepting charity, (2) embarrassment and (3) fear of being identified by charity personnel (Moloney 2001: 58).

Price and convenience appear to be the primary reasons why the respondents give their custom to a particular shop (Moloney 2001: 42). A substantial proportion (40 per cent) of respondents use a bus service when going shopping, 35 per cent walk and 25 per cent have access to a car. The largest proportion of the sample shop in Dunnes Stores (40 per cent), 35 per cent in Kumarket and 30 per cent in Supervalu. Other stores mentioned to a much lesser extent were Tesco, Lidl, Aldi and Duggans.

Similarities can be observed in both Moloney's and Coakley's findings. Both samples of mothers on low income know which foods are healthy and try to provide these to their families. This is restricted, however, by financial difficulties and physical access issues to healthy affordable foodstuffs.

Food Supply

Access and affordability are key factors in food poverty and relate to the availability of food, the cost of food and the proportion of the household budget located to food. Over the past few decades the retail trade in Ireland has changed dramatically. From the early 1960s to the present time there has been what is termed a 'retail revolution' where both the variety and method of sales have undergone a marked change. The rise in pre-cooked/ready-made meals has been coupled with changing consumer tastes and lifestyles. In recent years the number of convenience and forecourt shops has increased dramatically around the country. This has not come about entirely by co-incidence, however, but rather is the result of a number of trends in the Irish economy and society over the past decade; Irish people have become more affluent, more are employed, more of those working are women, more Irish people are travelling abroad, education levels have risen, families have become smaller and car ownership is rapidly increasing (Checkout Ireland 2002). Location of retail outlets is a significant factor in relation to equity of access to healthy foodstuffs. On average, shopping centres are getting larger, with the retail park format spreading rapidly throughout the country during the 1990s. According to market research, 79 per cent of those surveyed cited car parking as a factor in choosing a store (Checkout Ireland 2002).

Retail Provision

The market share within the Republic of Ireland is divided between the Multiples (e.g. Dunnes, Tesco), Groups or Symbols (e.g. Centra, Supervalu, Londis) and

Independents. Multiples are the most common type of shop used in all social groups, but there is evidence of a class pattern, with more people from lower social groups shopping in Groups/Symbols (Figure 12). According to a survey conducted by Market Research Bureau Ireland for Checkout Ireland (Checkout Ireland 2002), Tesco Ireland attracts more Irish shoppers than any other Multiple or Symbol in Ireland. However, these shoppers tend to be from affluent or professional backgrounds, while Dunnes and Supervalu are more popular with the lower social groups – the MRBI survey shows that Londis was ‘the farmers’ favourite’. Londis attracts between 2 and 3 per cent of every social group with the exception of 15 per cent farmers. This may be the result of the absence of large multiples in rural areas. Both Lidl and Aldi actively target rural and lower socio-economic profile areas.

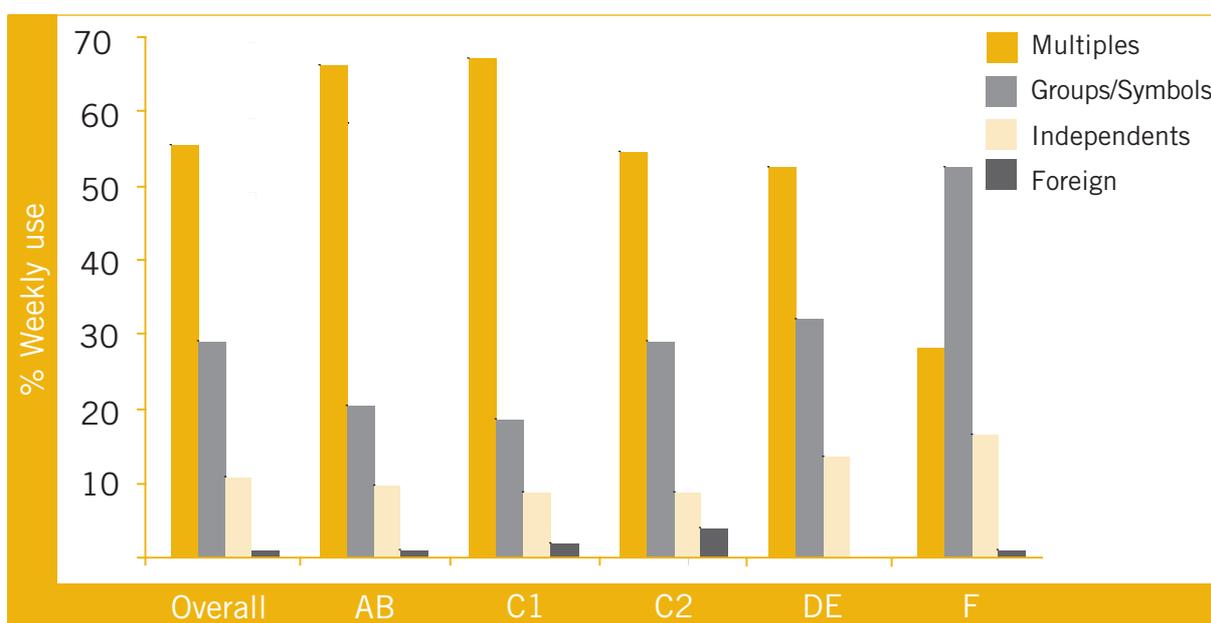


Figure 12: Retail outlet most commonly used for weekly grocery shopping

Source: Checkout Ireland, 2002

Notes:

Multiples: Dunnes, Tesco, Superquinn

Foreign: Aldi, Lidl

Groups/Symbols: Supervalu, Londis, Centra, Mace

AB = Top professionals

C1 = All other white collar workers

C2 = Skilled tradesperson

DE = Semi skilled / unskilled manual

F = Farmers

The study by Daly and Leonard describes shopping patterns among low income groups consistent with other research (Daly and Leonard 2002: 55-7). The most widespread shopping pattern is for a large weekly food shop at the cheapest of supermarkets and for sundry items, like bread and milk, to be bought on a day-to-day basis locally. While people monitor prices in different shops, families in the study shopped in only three supermarket chains. The content of people's shopping is highly routinised. Daly and Leonard report striking practices relating to strict controls around food shopping and diet.

Food Prices

On a monthly basis, the consumer magazine *Checkout Ireland* visits a randomly selected area in the Republic of Ireland and purchases the same basket of shopping in a number of retail outlets in the locality in order to compare prices. The 2002 monthly purchases have been collated for the purpose of this report, in an effort to determine if food prices vary according to type of retail store. Figures 13-17 below show the retail price of a number of selected foodstuffs in each of the various stores visited by Checkout Ireland. For presentation purposes the foodstuffs are grouped together into the five shelves of the food pyramid. While these data are limited, in that details of promotions were not available, marked differences can be seen for some foodstuffs. There appears to be little fluctuation in the prices of foodstuffs from the cereal, breads and potato food group across the various retail outlets visited (Figure 13). The breakfast cereal, however, which is a recommended way to start the day, is slightly more expensive in the Groups/Symbols outlets.

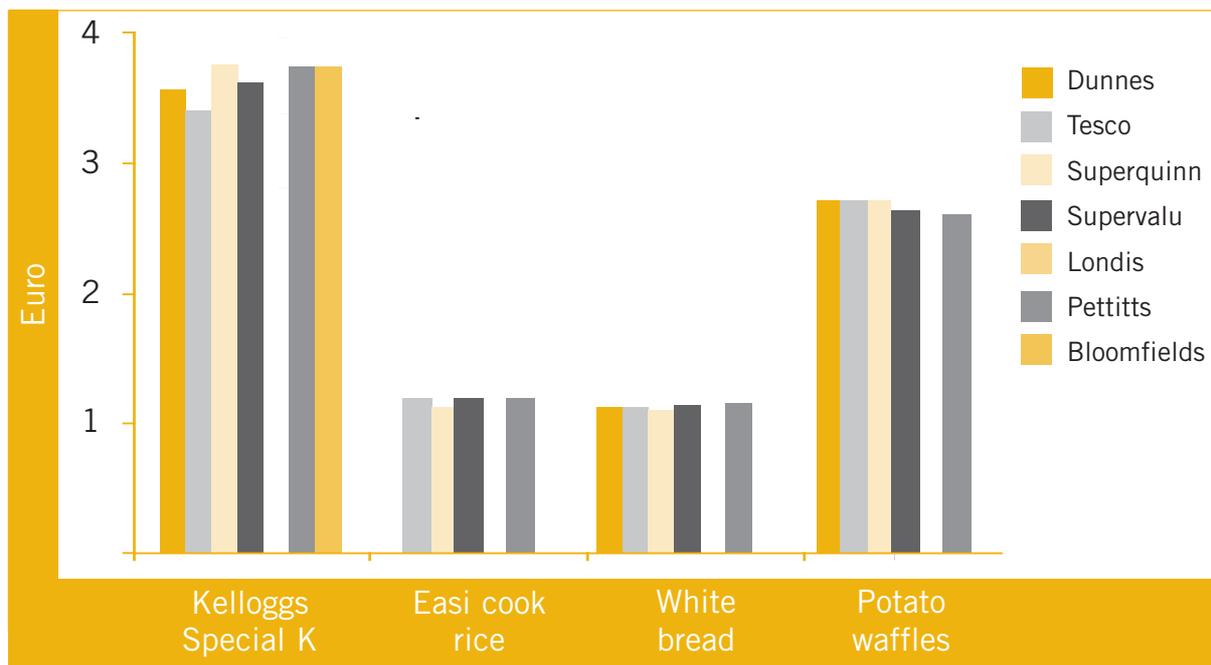


Figure 13: Price variation in Cereal, Bread and Potato food group

Source: Checkout Ireland, 2002



Fruit and vegetable items vary quite substantially in price depending on where purchased. Figure 14 shows the retail cost of a number of fruit and vegetable items in various Multiples, Group/Symbols and Independent outlets. The cost of fruit juices is substantially more in the Symbol Londis compared to the other outlets. Vegetable produce varies substantially in cost, generally being more expensive in the two main Multiples.

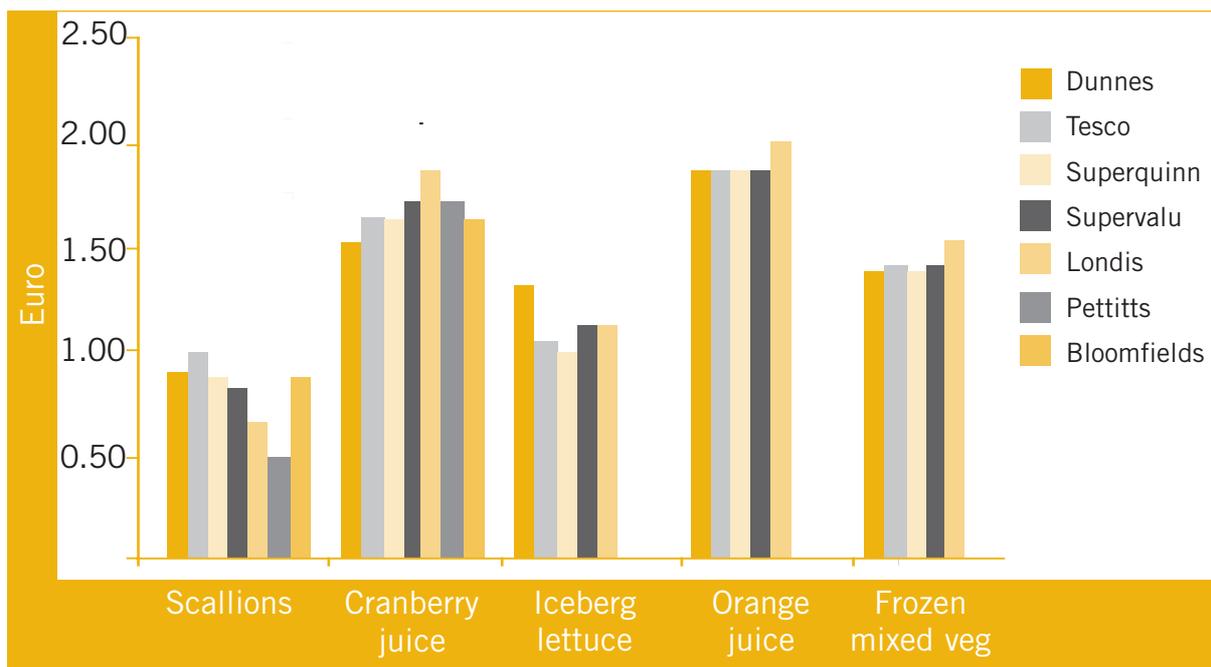


Figure 14: Price variation in Fruit and Vegetable food group

Source: Checkout Ireland, 2002



Cheese shows the most variation in retail cost compared to the other dairy items. As seen in Figure 15, the prices of the two cheese items differ substantially depending on where purchased.

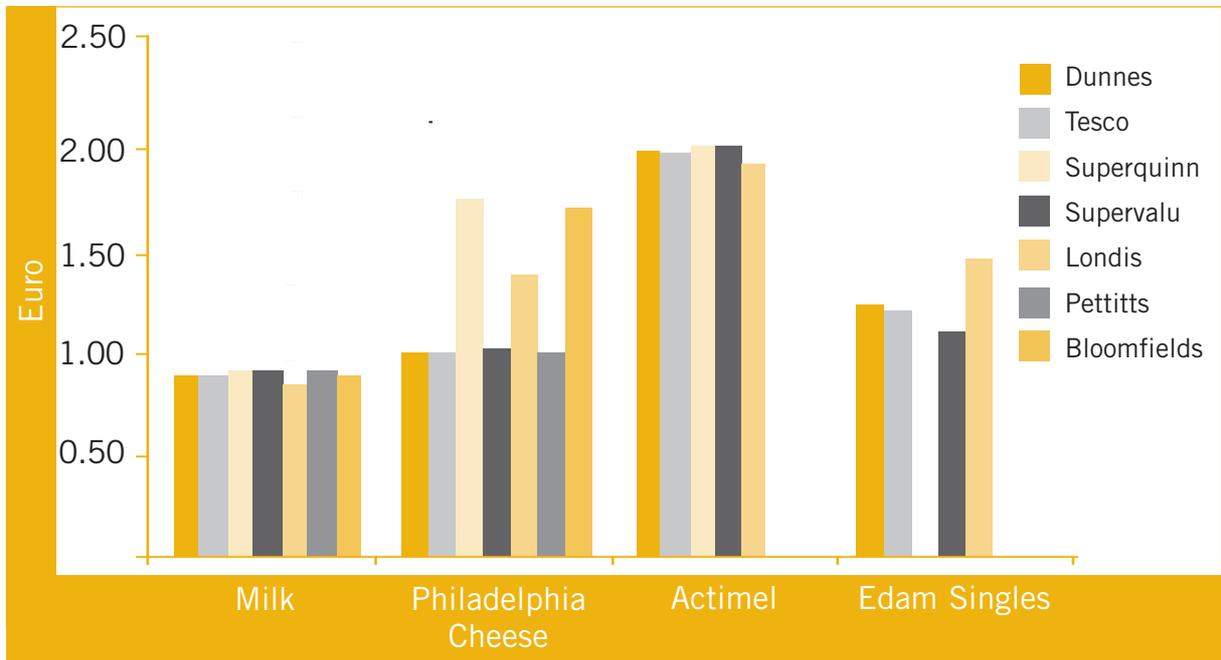


Figure 15: Price variation in Dairy food group

Source: Checkout Ireland, 2002

The retail cost of food items from the meat, fish and poultry shelf of the food pyramid is shown in Figure 16. Poultry is substantially more expensive in the Multiples compared to the Groups/Symbols.

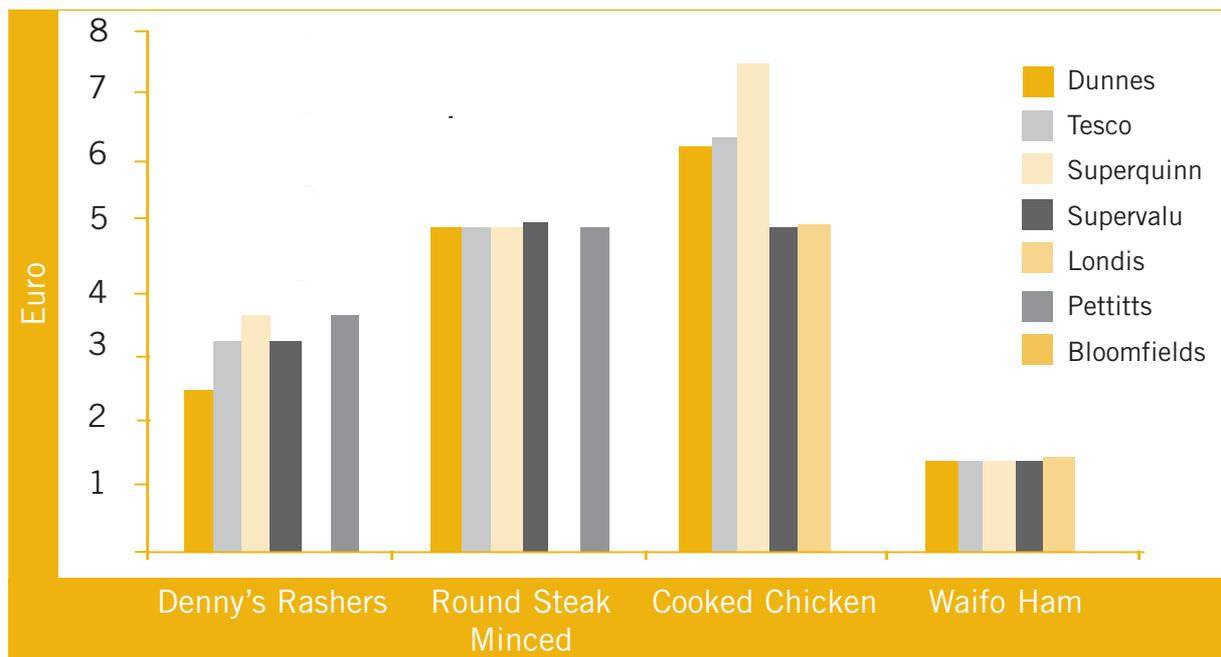
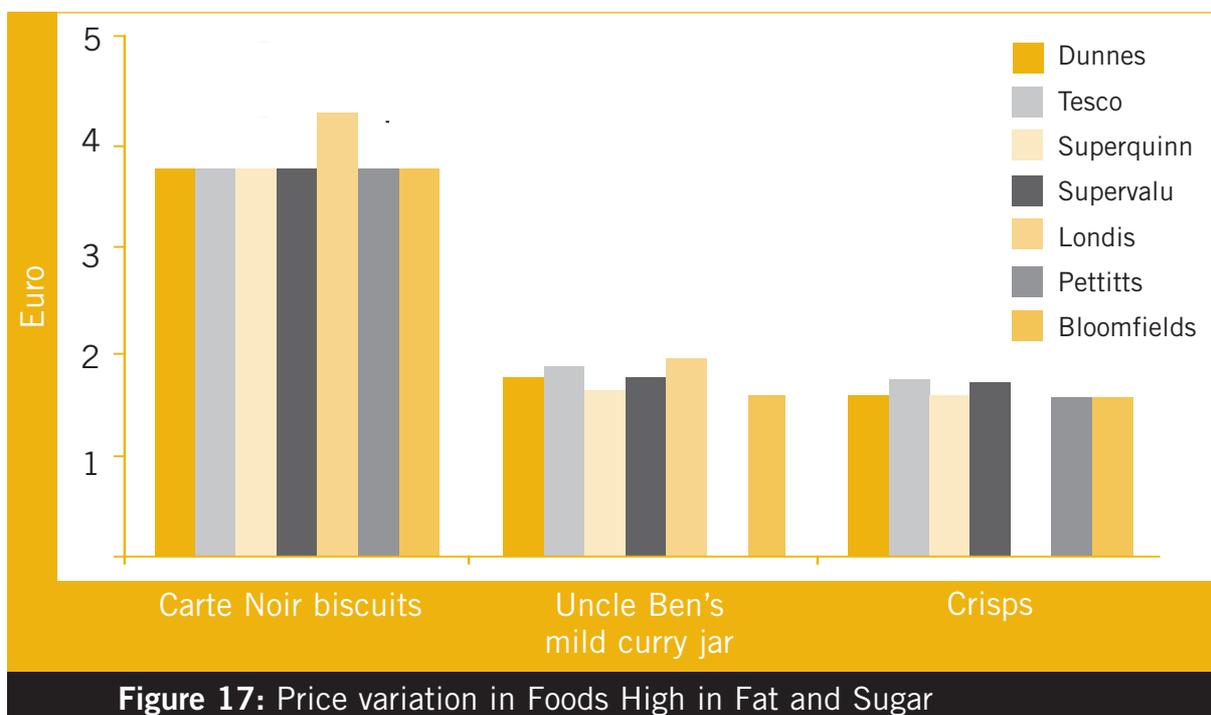


Figure 16: Price variation in Meat, Fish and Poultry food group

Source: Checkout Ireland, 2002

Of the food items from the top shelf of the food pyramid (i.e. food high in fat and high in sugar), the choice of biscuit is around 50 cents more in Londis compared to all other outlets (Figure 17).



Source: Checkout Ireland, 2002

Food price varies by shop type and tends to be more expensive in Groups/Symbols (which are favoured by lower social class groups, as seen in the previous Food Supply section). This is particularly so for fruit and vegetables and for foodstuffs within the meat, fish and poultry group. Interestingly, Londis has a higher proportion of items not stocked. This could possibly have implications for foods available to Londis shoppers particularly where no other retail option is available. As mentioned previously a high percentage of Londis customers are farmers, suggesting that the same range of both food brands and food products may not be available to those living in rural areas.

Current research being carried out by the Centre for Health Promotion Studies, NUI, Galway funded by the Combat Poverty Agency is investigating the retail cost of a healthy diet across a range of retail outlet types. This will help identify equality issues around affordability and availability of healthy foods for low-income families, lone parents and older people (Friel and Walsh 2003, ongoing).

Summary and Conclusions

There is little information directly pertaining to the levels of food poverty in the Republic of Ireland. However, interpretation of the information collated in Chapter 3 allows us to summarise that social inequality in dietary behaviour exists in Ireland and that socially disadvantaged people in the Irish population are certainly at risk of food poverty. These groups:

- *Eat less well compared to those from socially advantaged groups*

A range of socially disadvantaged groups in the Irish population shows higher intake levels of less healthy foodstuffs, lower levels of compliance with dietary recommendations and poorer nutrient intake. Being from social classes five and six, having little or no formal education and being eligible for a medical card each independently puts people at risk of poor dietary intake. Restricted dietary habits, in relation to both consumed nutritional adequacy and access to nutritional foods, are clearly observed among the particularly disadvantaged members of society, including those unemployed, people who are homeless, Travellers, the elderly, asylum seekers and refugees and low-income families. Living in rural Ireland *per se* does not appear to create inequality in dietary behaviour as much as social inequality at the individual level. Within each of the rural settings there are persistent gradients across the social strata in terms of compliance with dietary recommendations.

- *Spend relatively more money on food*

These analyses concur with findings from other research showing that whilst people on a lower income spend less money on food compared to the spending of higher social groups, a greater percentage of their income is spent on food. Differential household purchasing patterns are observed across socio-demographic and economic groups, with disadvantaged groups spending relatively more money on food but not on healthy options. For example, expenditure remains high on white bread but low on fruit and vegetables.

- *Have difficulties accessing a variety of nutritionally balanced, good quality and affordable foodstuffs*

Purchasing of food is done primarily in supermarkets which are less likely to stock a variety of healthy foods and when they do these foods are often more expensive than the less healthy option. There is restricted availability of healthy options for the more socially disadvantaged populations such as people who are homeless and Travellers and similarly restricted access to cooking and storage facilities.

- *Know what is healthy but are restricted physically and mentally by a lack of financial resources*

While socially disadvantaged groups display an awareness of what constitutes healthy eating, deciding on what to eat is a combination of factors and influences including dependants, personal preferences, access to shops and financial constraints.

In conclusion, from this collation and analysis of information relating to dietary habits of different populations groups in the Republic of Ireland it is clear that people from socially disadvantaged positions are less resourced than other social groups to make healthy food choices and that socio-economic inequality strongly drives the inequality in dietary habits. The observed individual dietary choices, household food expenditure patterns and retail outlet usage and pricing are determined by a number of factors including structural policy matters. As noted by Milio (1986) disposable income, education, housing conditions, employment, food supply and prices are policy issues that impact significantly on people's ability to make healthy food choices. Certainly, from the secondary analysis of the 1998 national health and lifestyle survey, SLAN, the powerful effect of education on individuals' dietary choices delivers a strong message about the importance of education in empowering people to make healthy choices throughout life. Education not only confers cognitive ability but is also linked to a person's 'cultural capital' (Manor *et al.* 1997), meaning that the lifecourse people follow, the social environment to which they are exposed and the social norms that they follow are strongly influenced by their educational experience and general social status.

Much of the Irish data highlights issues of affordability and access to healthy food. The findings from the various Irish studies concur with those of Dobson *et al.* (1994) and Coakley (2001) who noted that financial resources and the costs of food are the most important factors when considering food priorities among low-income groups. The amount of money an individual or household allocates to food expenditure is driven by the money available and the relative importance placed on food (Dowler 1998). Irish households' food expenditure patterns follow that observed in the UK by Graham (1992) and Hobbiss (1991) where compared with higher socio-economic households lower class households spend a greater proportion of their money on food, but in real terms the amount spent is less. Financial constraints mean that the range of foods consumed is limited, with little flexibility for variation in case of wastage, and the costs of food often result in the less healthy option in these food groups being purchased. This impact is observed in the different socio-economic household purchasing patterns, Irish retail data and the findings from Coakley's study on low-income mothers (2001).

Many of the Irish population groups experienced difficulty in accessing a variety of nutritionally balanced foods due to physical barriers. As shown in the food supply section, the Irish market appears to be controlled by large multiples and, as research in the UK identified, this may affect what foods get into shops and their pricing structures (DoH 1996). Certainly the Irish food prices and retail outlet usage suggests restricted access to varied, affordable quality foods by low-income groups. The dominance of supermarkets, often located on the outskirts of towns, twinned with inadequate and/or expensive public transport systems are a key factor in food

poverty (Watson 2001). In Ireland, the reliance on the car to go shopping and the minimal use of public transport in very rural areas highlight the issue of transport to food for rural populations. Similarly low-income mothers living in urban areas repeatedly highlighted physical access to shops as a barrier to healthy food consumption. The term 'food desert' has been used to describe areas of relative isolation where individuals experience physical and economic barriers to accessing healthy food (Reisig and Hobbiss, 2000). To date little work has been undertaken in the Republic of Ireland to determine the existence and extent of food deserts but this current compilation of data suggests that many of the contributing factors to food deserts do certainly exist in modern Ireland. As in other countries such as the UK, actual storage and access to cooking facilities are also very real physical barriers to healthy food among marginalised groups in society such as people who are homeless and Travellers.

In addition the individual dietary choices made and the explanations provided for them clearly highlight a number of psychosocial factors which impact on food choice. As noted previously personal taste, attitudes, beliefs, nutritional knowledge, peer influences, social norms and the availability of food and nutrition related information all play a role in determining food choices (Watt *et al.* 2001, Nic Gabhainn *et al.* 2002) – data from low-income Irish mothers show that whilst there is awareness and knowledge of healthy foods, deciding what to eat was influenced by dependants, personal preferences, access to shops and financial constraints. For other population groups in receipt of direct food provision, satisfaction with the variety of food provided was low and the food was generally perceived as monotonous.

The observations made from these data agree with those of Dobson *et al.* (1994) and Coakley (2001): the recurring impact of financial constraints on food choice not only affects the nutritional quality of individuals' diets but also defines the social and cultural food boundaries within which socially disadvantaged groups operate.

Section 2:
Policy Approaches
to Food Poverty

Chapter 4:
Policy Approaches
to Food Poverty
of International
Bodies and
Selected Countries

Having looked at the dimensions of food poverty in developed countries and the nature of food poverty in the Irish context we now turn to consider policy responses to food poverty. In this chapter we look at the international context to consider policies put in place by both international or supra-national bodies and those of specific countries, including Britain and the USA. Practical responses to food poverty in place in these countries are also considered.

Policies of International Bodies

Governments worldwide, including Ireland, have ratified the International Covenant on Economic, Social and Cultural Rights which entails a commitment by them to meet the basic needs of their citizens (United Nations 1966). In Article 11 of the Covenant, the right to adequate food is acknowledged with a statement that appropriate steps will be taken to ensure this right.

11.1. The States Parties to the present Covenant recognise the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realisation of this right, recognising to this effect the essential importance of international co-operation based on free consent.

11.2. The States Parties to the present Covenant, recognising the fundamental right of everyone to be free from hunger, shall take, individually and through international co-operation, the measures, including specific programmes, which are needed:

- (a) To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilisation of natural resources;
- (b) Taking into account the problems of both food-importing and food-exporting countries, to ensure an equitable distribution of world food supplies in relation to need. (UN International Covenant on Economic, Social and Cultural Rights 1966)

Children's rights are explicitly set out in the 1989 United Nations Convention on the Rights of the Child which Ireland ratified in 1992. The Convention includes recognition of the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development under Article 27.1. The role of State signatories in upholding this right is set out in Article 27.3. which states that:

States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing. (UN Convention on Rights of the Child 1989)

The World Declaration on Nutrition, signed by 159 States including Ireland, acknowledges that access to nutritionally adequate and safe food is a right of each individual and that nutritional well-being is impeded by social, economic and gender inequities (Food and Agriculture Organisation 1992). The Declaration notes that more extreme hunger and food poverty is due to inequitable access to food, safe water and sanitation, health services and education and is exacerbated by poverty and lack of education (FAO 1992, paragraph 5). It also acknowledges that inadequate budgetary allocations for health, education and other social services seriously impact on the nutritional well-being of a population (FAO 1992, paragraph 8). Nutritional well-being is stated as a must at the core of food, nutrition, health, social and economic policies and development plans and strategies (FAO 1992, paragraph 11).

International Policies Relating to Nutrition

The World Health Organisation's Regional Office for Europe report sets out the impact of poor nutrition and lack of adequate access to food on the EU region (WHO 2000a). It stresses the need to develop food and nutrition policies that protect health and contribute to socio-economic well-being. In 2000 the WHO Regional Committee for Europe endorsed the proposal of the WHO Regional Office for Europe to develop national food and nutrition policies for 2000-2005. The Regional Office prepared an Action Plan for Food and Nutrition policy to guide member states in developing intersectoral food and nutrition policies (WHO 2000b). The support offered by the office involves the collation of research evidence, the dissemination of information and the development of indicators for reporting on food and nutrition policy. The Office is also setting up a Food and Nutrition Task Force for the European region of the WHO. Nutrition counterparts in the WHO European Region met in March 2003, to discuss progress towards developing national food and nutrition action plans. At this meeting Member States unanimously supported the need for a second food and nutrition action plan 2006-2010 (WHO 2002).

International Policies Relating to Food Production

There are numerous international and national policies that independently influence how food is produced, who consumes it, how much they pay and its impact on health (Lang 1998a). Globalisation and free trade of food products, harnessed under the General Agreement on Tariffs and Trade (GATT), now drives the food chains of developed countries. At the level of the European Union there has been conflict

between the food production policies and those relating to nutrition and health. The Common Agricultural Policy (CAP) was established in the 1950s to increase food production, stabilise the markets, assure availability of supplies and exert some level of control on consumer prices (Lobstein 1998).

A number of commentators have criticised the CAP for its market distortions through its price support mechanisms and subsidised exports resulting in inflated food prices and excessive surpluses (e.g. Lobstein and Longfield 1999). Swinbank (1994) argues that the CAP, in reality, has the primary aim of increasing farm incomes and that although the CAP was intended to stabilise the market it has in effect supported higher prices. This has the most detrimental effect on families on low incomes. Arable crops, beef and milk accounted for the greatest share of the 1997 CAP budget. Unfortunately much of the arable crop subsidies are for animal fodder, not human consumption.

It is here that conflict occurs between food production policies and nutrition and public health policies. In most European countries dietary recommendations are primarily based on increased consumption of fruit and vegetables and grains, decreased consumption of foods high in saturated fats, refined sugars and limited consumption of meat and meat products. The CAP encourages over-production of foodstuffs that the nutrition and health policies recommend less consumption of, and destruction of the produce that consumers should be eating more of (Lobstein 1998). A review, co-ordinated by the National Institute of Public Health, Sweden, of four sectors in the CAP identified that approximately €2.2 billion, out of a total budget of €43 billion, is used for products and measures that harm the public health of the European Union (Shafer Elinder 2003). In 2001 over 1 million tonnes of fruit and vegetables were withdrawn from the market, of which between 70 and 80 per cent was destroyed. Through a combination of subsidies and supports, there is a production surplus of milk currently running at a level in the region of 20 per cent. Consumption aid measures encourage consumption of butter and full-fat milk to get rid of surplus milk fat (Shafer Elinder 2003).

Of the many management, regulatory and scientific committees informing the European Commission concerning agricultural matters, none incorporates the socio-economic dimension (European Commission 1999). There is little harmonisation between the different departments of the European Commission, a matter for concern since it is from there that much Irish policy is directed. It also remains unclear as to where the role of nutrition and health will sit, if at all, in the newly established European Food Safety Authority. It is not only governmental policy that lends itself to inequity of consumption of a healthy diet. The strength of the food and agriculture industry should not be undervalued in its role in determining the food economy and market (Lang 1998b).

Economic and Social Policy

There is almost no national social policy worldwide that acknowledges its role in addressing food poverty and hunger (Riches 1997). The living standards that people may enjoy, including those of food, are heavily determined by their access to resources such as income, wealth, goods and services (O'Flynn and Murphy 2001). In order to deal with the inequity that arises in a society governed by market forces, redistribution policies tend to be the political response to compensate for the market failure to provide for all. This may be done through transfers, regulation and direct provision, in the form of social spending, social wage, and through spending on public services like health, education and housing.

Internationally, reform strategies have been introduced to reduce social spending and welfare dependency. This is done through encouragement to re-enter the labour market and the provision of basic assistance such that it is less than the minimum wage (Riches 1997, O'Flynn and Murphy 2001). However, the labour market in industrialised countries has changed from being manufacturing and agriculture based to services and information technology based. This means that higher education is now more important than before and that relatively fewer unskilled jobs are available resulting in a move of more people into unemployment or very low-paid temporary positions (O'Flynn and Murphy 2001). Substantial changes in women's social and economic roles and in the organisation of the domestic and reproductive domains have also occurred. These combined have seen a shift in poverty further down the lifecycle. Traditionally the welfare state looked after older people and the labour market looked after younger people and children. Now, because of the demographic and labour market changes people are falling out of those safety nets, with clearly more creative mechanisms needed to cater for those social groups (Graham 1993, Cantillon and O'Shea 2001).

Food, Nutrition and Health Policies in Britain and the US

Britain

At a policy level many developed countries do little to specifically acknowledge the existence of hunger and food poverty (Riches 1997). However, in the UK, food poverty has gained wider recognition in recent times. A Food Poverty Eradication Bill had a first reading in the Westminster parliament in December 2001. The purpose of the bill was to require the government to publish and implement a national strategy, with appropriate targets, for eradicating food poverty. The Bill was not moved for a second reading but in February 2003 a Food Justice Strategies Bill was introduced in parliament for its first reading. The purpose of this Bill was to require local authorities to develop strategies to promote food justice and eradicate food poverty. This Bill, however, was also dropped at its second reading.

The UK Food and Health Action Plan, led by the Department of Health, in collaboration with the Department of Environment, Food and Rural Affairs, was launched in December 2002 (Department of Health 2002a). The Plan aims to benefit groups most at risk from poor health through diet by addressing food production, manufacture and preparation and access to healthier food, and providing information for consumers about healthy eating and nutrition. All sections of the food chain will be involved including food growers, food producers, manufacturers, retailers, caterers and consumers. The aims of the plan will be met by reforming the Welfare Food Scheme (DoH 2002c), implementing a *Five a Day* programme (<http://www.doh.gov.uk/fiveaday>) to increase fruit and vegetable consumption and working with industry to reduce salt, fat and sugar in the nation's diet. The first two elements of the plan entail some direct food provision on both a universal and targeted basis.

The Welfare Food Scheme was introduced as a war-time measure to provide for the nutritional needs of mothers and children at a time of shortages. The scheme is ongoing and currently provides tokens for milk (liquid and formula), and vitamins to expectant and nursing mothers and to babies and infants under five. Originally benefits were universal but currently they are restricted to those in receipt of income support. A recent review of the scheme identified flaws in the current format. The strong emphasis on milk and formula provision is the primary concern such that the wider nutritional needs of mothers and children are not being met as they would be if the scheme allowed for a greater choice of food and, additionally, it acts as a disincentive to breast-feeding. Proposed reform of the scheme will provide fixed face value tokens for a broader range of foods including fruit and vegetables, cereal-based foods, other foods suitable for weaning, liquid milk and infant formula. The scheme is to be renamed the *Healthy Start programme* (DoH 2002c). The effects of this approach will be to ring-fence funds for healthy foods, give greater choice to beneficiaries while allowing a greater range of healthy foods to be purchased and equalise the benefits for breast-feeding mothers. Registration for the scheme will be through health professionals, primarily midwives and health visitors who can support the scheme through the provision of health and nutrition advice to beneficiaries. In addition milk and fruit are provided on a universal basis to children in day care. Proposals are at consultation stage with all relevant stakeholders including beneficiaries, health professionals, retailers and manufacturers.

There are five strands in the *Five a Day* programme to increase fruit and vegetable consumption:

- National School Fruit Scheme (DoH 2000): every infant school child aged 4-6 years is entitled to a free piece of fruit each school day.

- Five a Day Community Initiatives (Department of Health 2003): developed by Primary Care Trusts to increase access to and availability of fruit and vegetables within disadvantaged communities.
- Communications Programme: aims to raise awareness of the health benefits of fruit and vegetables, targeting those groups with the lowest consumption.
- Work with food industry including producers, retailers and caterers with the aim of increasing provision and improving access to fruit and vegetables for the general public.
- Evaluation and monitoring: each element of the Five a Day programme is evaluated and monitored, including measurement of access, awareness, knowledge of health benefits and consumption.

A *Food in Schools* programme was announced in 2001 to bring together all food-related initiatives in schools with the aim of developing sustainable programmes to promote healthy eating in children. Breakfast clubs, fruit tuck shops, extending the national school fruit scheme and more initiatives to encourage children to cook and grow food in schools will be provided as part of the package. In addition educational programmes dealing with dietary issues based in the school setting have been developed collaboratively between the Department of Health and the Department of Education and Skills.

School meals have been a feature of the education system in the UK since the 1944 Education Act required Local Education Authorities to provide a meal for every child. The only standard set for the meal at the time was that 'it would be similar in all respects to the main meal of the day'. While the 1980 Education Act removed this requirement it was re-established in the 1998 Education Act which places a statutory duty on Local Education Authorities to provide a free meal to children whose parents are in receipt of state benefits and a paid meal service if requested to do so by or on behalf of any pupil. Minimum nutritional standards for school meals were introduced in 2001 in England and Wales, based on a balance-of-foods model where food is divided in five groups (fruit and vegetables; bread, cereals and potatoes; milk and milk products; meat, fish and alternatives, fatty and sugary foods). At least two items from the first four groups must be served at each school meal – fruit and vegetables; bread, cereals and potatoes; milk and milk products; meat, fish and alternatives. The last food group, fatty and sugary foods, should make up no more than 10 per cent of the menu. All school children aged four to six years will be provided with a free piece of fruit every school day under the National School Fruit Scheme discussed above.

The Food Standards Agency in the UK has taken a lead in the development of a strategic framework for nutrition with the aim of reducing inequalities by enabling and encouraging vulnerable groups to improve their diets. Health Action Zones are

examples of multi-agency initiatives based in areas of deprivation introduced in 1997. Health Action Zones are partnerships between the National Health Service, local authorities, the voluntary and private sectors, and community groups. They are co-ordinated locally by a partnership board. They have been established in areas of deprivation and poor health. Health Action Zones have two strategic objectives:

- Identifying and addressing the public health needs of the local area, in particular trailblazing new ways of tackling health inequalities
- Modernising services by increasing their effectiveness, efficiency and responsiveness.

These programmes represent a new approach to public health – linking health, regeneration, employment, education, housing and anti-poverty initiatives to respond to the needs of vulnerable groups and deprived communities. The underlying principle is making funding available at local level for spending on locally defined action towards meeting national health priorities (Watson 2001). Throughout the UK, much of the community-based activity has specifically included food projects as a means of achieving health objectives.

Finally, some elements of the wider welfare and anti-poverty policies may indirectly address food poverty in the UK. A minimum income guarantee for pension recipients has been in place since 1999 and those on low incomes are entitled to a National Minimum Wage since 1998. One of the benefits of such policies is that low-income households have more financial capacity and are in a better position to make healthier food choices. Child poverty is being tackled in the UK through increased child benefit and tax breaks such as the Working Families Tax Credit (Watson 2001).

United States of America

The US Department of Agriculture (USDA) administers a food assistance programme with a number of elements which in 2002 was serving nearly one in six Americans at some point during the year (USDA 2002). The food assistance programme comprises five components – the food stamp programme; the national school lunch programme; the school breakfast programme; the special supplemental nutrition programme for women, infants and children; and the child and adult care food programme. The programmes are considered to improve access to a more nutritious diet among people who are poor and particularly children in poor households. The programmes also create an outlet for the distribution of food purchased under federal farmer assistance schemes to support the price of agricultural produce. For example, under the dairy price support programme, surplus butter, cheese and non-fat dry milk are purchased from processors at announced prices to support the price of milk. These purchases help maintain market prices at the legislated support level.

Food Stamp Programme

The food stamp programme is the largest food assistance programme in the US. It provides low-income households with coupons or electronic benefits they can use to purchase approved food items at approved retail outlets. The programme is available to all households that meet income and asset criteria. In 2002, benefits per person averaged \$80.00 (€70.00) per month (USDA 2002). However, Riches (1997: 68) notes that funding for food assistance programmes has been cut back and subsequently food stamp benefits are inadequate for providing adequate nourishment.

National School Lunch Programme

This programme was started in 1946 to encourage children's consumption of nutritious foods and provide an outlet for surplus commodities. Virtually all public and non-profit private schools participate in the programme such that over 90 per cent of all elementary and secondary students attend a participating school. Any child at a participating school may enroll in the programme. Children from families with incomes at or below 130 percent of the Federal poverty level are eligible for free meals. Those from families between 130 and 185 per cent of the Federal poverty level are eligible for reduced-price meals. Children from families with over 185 per cent of the Federal poverty level pay for the meal which is subsidised to a small extent. In 2002 about 58 per cent of all children attending a participating school took part in the programme. Almost half of lunches served were on a free basis, 9 per cent were at a reduced price and 44 per cent were on a paid basis (USDA 2002).

Schools participating in the programme receive cash and some commodities from the USDA to offset the cost of food service. The schools must serve lunches that meet the Dietary Guidelines for Americans. Approximately 17 per cent of the total dollar value of food in school lunches comes from 60 different kinds of agricultural surplus (Gundersen *et al.* 2000).

National School Breakfast Programme

The school breakfast programme was introduced in 1975. It provides low-cost breakfasts to students, with those from low-income families receiving free or reduced price meals on the same eligibility basis as for the school lunch programme. This programme is less widespread, with 72 per cent of all elementary and secondary students in the country attending a school that participates in the programme in 2002 (USDA 2002). In the region of 21 per cent of all children attending a participating school availed of the programme in 2002 (USDA 2002). Almost three-quarters of breakfasts provided were free to students, with another 9 per cent provided on a reduced price basis and just over 15 per cent provided on a paid basis. Breakfasts must meet nutrition guidelines. Unlike the school lunches agricultural surpluses are not used in the breakfast programme.

Special Supplemental Nutrition Programme for Women, Infants and Children

This programme provides a package of supplemental foods, nutrition education and health care referrals to low-income pregnant and post-partum women, infants and children up to the age of five years. Through the programme eligible women are given coupons which allow them to purchase a restricted range of foods considered important for pregnant and lactating women, infants and children. These include iron-fortified infant formula and infant cereal, iron-fortified adult cereal, fruits and vegetable juices rich in vitamin C, eggs, milk, cheese, peanut butter and dried beans and peas.

The Child and Adult Care Food Programme

This programme provides healthy meals and snacks to eligible children and adults who are in a care setting. The programme was first established in 1968 and initially child care centres in areas with poor economic conditions and adult day care centres were eligible. In 1976 eligibility was extended to family child care homes, i.e. child care providers who care for children in their own home. Providers of care are reimbursed for each type of qualifying meal (breakfast, lunch/supper or snack) they serve that meets standards set down by the programme. Since 1997 a two-tier system of reimbursement has been introduced with a higher rate (e.g. \$1.78/€1.64 for lunch) payable to homes in low-income areas or in which the care providers are low income or to low-income children. A lower rate (e.g. \$1.07/€0.98 for lunch) of reimbursement is made to homes that do not qualify as low income (USDA 2002).

Notably, the orientation of these US food assistance programmes is on provision of food so that they function to alleviate rather than address the determinants of food poverty.

Examples of Food Poverty Community-Based Initiatives

The following projects have been selected to reflect the various levels of community intervention responding to identified determinants of food poverty. These are: local food economies, local access issues, role of partnerships and networks, skills necessary for healthy dietary behaviour for the individual and food surplus redistribution mechanisms.

Community Mapping (UK Project)

Community mapping is based on the idea that participation of local community members can use mapping techniques to tackle food poverty. Through Sustain, communities in Brighton, Coventry and Leicester were involved in a community mapping project which entailed using maps and other visual techniques to analyse local food economies and develop action plans to tackle the problems they identified. The Community Mapping project showed that working with local people using mapping techniques provides a sharper insight into what food poverty is and how it affects people's lives.

Tackling Food Deserts (UK Project)

Food deserts are described as areas of relative exclusion where people experience physical and economic barriers to accessing healthy food. Common causal factors in the emergence of food deserts are: the development of superstores by multiple retailers, low car ownership and inappropriate housing developments. Reisig and Hobbiss (2000) set out to examine one English city's (Leeds) approach to addressing food deserts. Firstly agencies in the city whose work has the potential to address food poverty were identified and grouped into sectors as follows: multi-sector organisations, health sector, voluntary and community sector, local authority sector and business sector. The first strand involved identifying on-going projects to address food poverty across these sectors. The second strand involved in-depth interviews with 'key players' from each sector to explore their perceived role in tackling food deserts.

The first strand identified the following food-related initiatives recently carried out or still running:

- educational projects (e.g. healthy eating programmes)
- community-based projects (e.g. food co-ops, school breakfast clubs, community café and food growing schemes)
- supermarket initiated projects (home deliveries, supermarket buses)
- council/estate shop management review aimed at retaining as many shops as possible
- town planning process (government-guided orientation towards maintaining city and town centres)
- strategic multi-sectoral initiatives including one focusing on health that included access to affordable healthy food as an action and a second relating to planning including focus on the vitality of town centres and availability of foods.

Reisig and Hobbiss considered that these initiatives in the main focus on the individual or community level. The underlying macro-structure, in particular economic and infrastructural elements contributing to food poverty and food deserts, are not addressed (2000: 141).

The second strand, involving interviews with key players, demonstrated that tackling food deserts is on the periphery of the different agents' agendas. They found a high level of recognition of the problems of unequal access to food shopping but little in the way of strategic responses. Plans to alleviate food poverty were characterised by an over-reliance on community development projects and the exclusion of the private sector. Reisig and Hobbiss argue that concerted multi-sector tactics need to be employed encompassing both issues of poverty and the food supply (2000). They propose a synthesis of solutions addressing income-redistribution and the food system through an approach that improves access to fresh food by stimulating a local food economy, which in turn creates employment and training opportunities for local

people. Activities proposed include supporting local food producers and processors who use locally fresh foods and sell preferentially to local people, community cafés, food co-ops, community-led stores, community franchising of school meals and having local branch stores of good-quality supermarkets emphasising the sale of fresh foods.

Individual Skills

McGlone and colleagues (1999) examined twenty-five community food projects in the UK, interviewing over 130 people including users, providers, volunteers, funders and non-users. All projects worked with people on low incomes, many living in areas considered to suffer multiple disadvantage, e.g. housing, health, infrastructure problems as well as low income. These community food projects all performed a range of food and non-food based activities. Some had been established to meet a need identified by local people, others on the basis of professional input. The projects were categorised as cook-and-eat skills-building programmes, food co-ops – usually selling fruit and vegetables – cafés, food provision such as breakfast clubs, food growing, nutritional advice, projects that combined some of these functions and partnerships, for instance with local retailers.

In terms of cooking and eating at home, cooking skills and adequate facilities for storing and cooking food are often the areas most in need of attention. Community-based interventions, teaching skills in low-income communities, were introduced to address concerns around the adequacy of cooking skills necessary to maintain a healthy diet. The National Food Alliance in the UK also undertook a project to increase fruit and vegetable consumption among low-income consumers. One of the aims of this project was to explore whether cookery demonstrations are effective in encouraging low-income groups to cook and eat more fruit and vegetables. They found that the cookery demonstrations did prove to be an effective method of encouraging the purchase of fruit and vegetables (National Food Alliance, 1997).

Food Banks (US, Canada, Europe)

Surplus food is food that, at different points in the food chain, is not sold onwards. This includes food removed from sale, e.g. food approaching its sell-by date, food with faulty packaging or agricultural produce removed from the market to stabilise prices. Such food may be distributed to people in need through homelessness schemes, local authorities, charitable organisations and schools. Food banks are a common method of such surplus food distribution. The banks act as central collection and storage points for surplus food and then distribute the food on to organisations involved in making food available in the form of cooked meals, food parcels and food stores.

Establishment of the first food bank dates back to 1966 in the USA, where food banks were originally designed to meet emergency needs (Hawkes and Webster 2000). However, food banks are now part of an on-going food provision system in the United States for people who are poor. The US government has supported the development of a food bank system by diverting surpluses to food banks and away from statutory food stamp (food vouchers for welfare recipients) programmes, introducing tax relief for donors and protecting donors from litigation arising from their donations, so-called Good Samaritan laws (Hawkes and Webster, 2000). As a result, the food bank system has grown steadily in the US. For instance Second Harvest, a food bank umbrella group, has 189 outlets distributing food to 50,000 organisations. The food comes from agricultural surplus and large-scale private donors such as Kraft and Nestle and is mostly non-persishable. Other models for surplus food distribution include that of Food Chain, an organisation that collects perishable goods from restaurants and grocery shops and redistributes it mostly to local social service agencies.

In Canada the first food bank opened in 1981. There are now 615 food banks. A highly developed distribution and sharing system is in place facilitated by the Canadian Association of Food Banks. Again much of the food comes from large-scale corporate donations (Hawkes and Webster 2000). Typically food banks serve the working poor, people dependent on welfare and single-parent families. In Canada, unlike in the USA, there is little legal or tax infrastructure to support food banks.

In Europe the European Federation of Food Banks was established in 1986 (www.eurofoodbank.org). The federation now comprises 158 operational food banks including one in Ireland. The network of food banks is most developed in France where 79 of the 158 members of the federation are located. The federation also has members in Spain (24), Italy (17), Poland (13), Belgium (9), Portugal (8), Ukraine (2), Latvia (1), Ireland (1), Greece (1), Luxemburg (1), UK (1) and Switzerland (1). One of the functions of the federation has been to secure an allocation of the surplus food generated through the EU agricultural system for its member food banks. In 2001 food banks in the federation received 35 per cent of foodstuffs from the EU, 32 per cent from the food processing sector and 13 per cent from the retail sector.

Advocates of the food bank system view surplus food distribution as a rational response to saving waste and providing food to those most in need, thereby producing a 'win-win' situation (Hawkes and Webster 2000). However, while surplus food distribution is valuable for the part it plays in alleviating food poverty, among vulnerable groups it has the potential to institutionalise food poverty (Riches 1997).

Summary and Conclusions

International conventions recognise the right to be free from hunger and the right to adequate food. These rights are accompanied by commitments to take positive measures to ensure they are protected. However, food production and trade policies have tended to distort market prices and impede access to foods recommended for good health especially for those on a low income. Over-production of less healthy foodstuffs is another outcome of market support measures and these foods can often make their way into programmes directed at alleviating food poverty such as the US Food Assistance programmes. In this way food production policies conflict with nutrition policies and contribute to sustaining and perpetrating unequal access to a nutritionally balanced diet, food poverty and hunger. Meanwhile there is almost no national social policy worldwide that acknowledges its role in addressing food poverty and hunger specifically. There is therefore no leadership or responsibility in addressing the macro-economic determinants of food poverty and hunger.

Initiatives taken in Britain and the United States are reviewed here. The attempt in Britain to introduce legislation to address food poverty specifically is an interesting approach. The proposed instrument sought to draw together all of the strands of state policies and services, through local authorities, into a co-ordinated approach to promoting food justice and eradicating food poverty. Failure to adopt the Bill indicates a lack of political will to codify policy and provision in this area and a preference to have food justice and food poverty addressed through Department-led programmes and schemes. The UK policies discussed do have some valuable characteristics including strong inter-departmental and inter-agency collaboration, both universal and targeted provision and a food poverty prevention as well as alleviation focus. However, the primary focus of these initiatives is the consumer and they address food choices at the point of consumption without a broader focus on issues further back along the food production and distribution process. The approach taken in the US concentrates on alleviation through food assistance rather than prevention of food poverty. The food assistance programmes are used as outlets for surplus commodities generated as a result of policies that distort the price and supply of foodstuffs. This makes them a very unsatisfactory tool in addressing food poverty in any sustainable way.

Of the projects addressing food poverty identified, those involving communities in generating understandings and solutions to food poverty are effective tools in empowering people to understand and be active in finding solutions to food poverty. However, local food production and distribution initiatives have a limited capacity to meet all of the food needs of a community. The macro-level systems of food production and distribution that create the conditions under which the majority of food is available to consumers need to be addressed.

Chapter 5:
Policy and Practice
Relevant to Food
Poverty in Ireland

This research represents a first attempt to draw together the policy and practice responses to food poverty currently in place in the Republic of Ireland. Policies relating to food and food poverty cross a range of sectors as demonstrated by the framework set out in Chapter One. Drawing on this framework, three main dimensions of food-related policy and initiatives are examined here:

- Welfare aspects of food and nutrition
- Nutrition and health aspects of food
- Food production and distribution including food safety

An integral part of this study was a series of structured one-to-one interviews with key individuals undertaken to identify and assess current policy relating to food by governmental and non-governmental bodies, agencies and organisations. In this way the views of a range of stakeholders were elicited to provide informed comment on the extent to which these policies act to prevent and alleviate food poverty in Ireland. Information was collected from nineteen organisations, with ten representatives speaking from a policy or statutory perspective and nine from a practice or community perspective (see Appendix Two for list of organisations represented). All relevant government departments were invited to participate and all but the Department of Agriculture and Rural Development are represented. Whilst representing the agency or organisation in which they worked, those who took part in the research were also providing an informed opinion on policy and practice in relation to food and poverty in Ireland.

The interviews explored understandings of food poverty, awareness of food poverty and the identification of policy and practical responses to food poverty within each sector. National, regional and organisational action plans and policy statements were requested from the interviewees and reviewed to consider the current policy structures addressing food poverty issues. A descriptive summary of policies and initiatives to address food poverty identified through the interviews is presented.

Following analysis of the interviews, a seminar was hosted by the Combat Poverty Agency where the emerging research findings were presented to the participants and other relevant agencies. The purpose of the forum was to check interpretation of the data and identify pertinent issues that may not have been captured in the interviews.

In this chapter the three domains of welfare, health and food production are considered in turn. In relation to welfare, the extent to which food poverty features in policies relating to each area is assessed; examples of practical initiatives addressing food poverty delivered either by statutory or non-governmental or community led agencies are described; finally, informed comment from interview participants as to the nature and adequacy of the policy and practice response to food poverty in each area is presented.

Welfare Aspects of Food and Nutrition

Food Poverty Issues in Welfare and Anti-Poverty Policies

The key concern of this research is the food consumption and poverty interface. The development of a National Anti-Poverty Strategy (NAPS) in 1997 'Sharing in Progress' was a critical landmark in the development of Irish social and economic policy (Government of Ireland, 1997). The strategy represents a model for addressing the underlying causes of poverty and social exclusion in an integrated and co-ordinated manner. This cross-departmental government initiative aims to set poverty reduction at the top of the national agenda and integrate it into future policy development across all government departments. The 1997 NAPS acknowledged the cross-cutting nature of poverty through social groups and geographic locations and identified five key areas as needing particular attention in tackling poverty: income adequacy, unemployment, educational disadvantage, urban concentrations of poverty and rural poverty.

Recommendations relating to income adequacy include reducing tax on the lower paid, rewards for working, simpler tax and social welfare systems, increasing social welfare rates of payment to 'adequate' levels and reducing the rate of long-term unemployment from 7 per cent to 3.5 per cent. A fundamental mechanism for poverty reduction and a key goal of economic policy in general has been an increase in employment. The strategy identifies employment as a protective factor against poverty and sets an objective that work should provide a sufficient income to keep people out of poverty. This is to be accomplished through wage and tax policies. Incomes other than wages were targeted by promised increases in social welfare rates and support of pensions.

The partnership agreement 2000-2002, the Programme for Prosperity and Fairness (PPF), included a commitment to carry out a review of the NAPS in the context of continued economic growth (Government of Ireland, 2000). The review noted that over the period 1994-2000, the proportion of the population in consistent poverty fell from 15.1 per cent to 6.2 per cent. The measured reduction in poverty was attributed to the benefits of economic growth, growth in employment, in wages, in social welfare payments and tax reform (DSFA 2002). The key target set out in the revised NAPS 'Building an Inclusive Society' is to reduce the numbers of those who are 'consistently poor' to below 2 per cent and if possible eliminate consistent poverty (DSFA 2002). The approach set out to meet this target is to:

- sustain economic growth and employment
- provide levels of income support to those relying on social welfare sufficient to sustain dignity and avoid poverty, while facilitating participation in employment, and to achieve economic independence, if possible
- address the needs of groups at high risk of poverty with specific needs
- tackle the causes of inter-generational poverty
- support disadvantaged communities
- provide high-quality public services to all.

The revised targets incorporate the areas of health and housing and look at the particular situations of vulnerable groups. Specific targets are set out for vulnerable groups with a high or increased risk of poverty including children and young people, women, people with disabilities, older people, Travellers and members of minority ethnic groups. The focus on health sets the objective of reducing the gap in premature mortality between the lowest and the highest socio-economic groups by at least 10 per cent by 2007 in relation to circulatory diseases, cancer and injuries. Throughout the strategy targets relating to specific areas or specific groups make no specific reference to issues of food and nutrition.

A National Action Plan against Poverty and Social Exclusion (NAPs/incl) 2001-2003, was developed as a result of action at European level. It aims to:

- facilitate participation in employment and access by all to resources, rights, goals and services
- prevent the risks of exclusion
- help the most vulnerable
- mobilise all relevant bodies (DSCFA 2001).

The NAPs/incl 2003-2005 (DSFA 2003a) includes a stated policy task of increasing social welfare payments in real terms and ensuring they are properly structured to reflect household needs. Policy measures set out under the heading of health include reference to health promotion and community participation and states that health promotion and education activities will be further developed in partnership with the community, targeting specific areas including healthy eating.

Income Adequacy

The adequacy of welfare rates is a key issue in tackling food poverty. CORI Justice Commission argue that to eradicate income poverty and ensure everyone has the resources necessary to live life with dignity the lowest social welfare rates have to be set at a level that would provide sufficient income to make that possible, and these rates have to be linked to an index that reflects the changing standard of living in the society. They advocate index linking welfare rates with the gross average industrial wage and specifically setting the lowest social welfare rates at 30 per cent of gross average industrial wages.

Under the revised NAPS a benchmark is set for the lowest social welfare payments of €150 by 2007 (in 2002 terms) with equivalence levels of child income support to be set at 33-35 per cent of the minimum adult social welfare rates. Since the formulation of NAPS, Social Partnership agreements² have included commitments on

² Since 1987 Social Partnership Agreements have been negotiated between the Government and the social partners focusing on incomes, fiscal, social, economic and competitiveness policies. The social partners are organised into four pillars: Trade Union Pillar, Employer and Business Pillar, Farming Pillar and the Community and Voluntary Pillar. The Community and Voluntary Pillar were included for the first time in negotiations on Partnership 2000.

the implementation of the strategy. Under the current partnership agreement, Sustaining Progress 2003-2005, the commitment to meet the target for the lowest social welfare rates and appropriate child equivalence levels by 2007 as set out in the revised NAPS is reiterated (Government of Ireland, 2003). This is to be achieved by implementing increases in the lowest social welfare rates, child benefit rates and pensions.

The NAPS target for lowest social welfare payments set out above is in the region of 30 per cent of the average industrial wage in 2002 terms. Trends in wage growth will determine whether this will continue to be the case over the time-frame of the strategy. To safeguard this level would require the development of a minimum income standards benchmark. This has been advocated by the Combat Poverty Agency and was endorsed by the VPJ (2002) on the basis of their research findings. Findings from the VPJ study (2002), which included a detailed focus on income adequacy for an adequate diet, indicate that this standard should be in the region of 40 per cent of the average industrial wage.

It would be preferable if benchmarks for social welfare payments were linked to average industrial earnings rather than being a value specific benchmark. The current partnership agreement, Sustaining Progress, has taken this approach in its commitment to increasing the level of social welfare pensions by setting an overall objective of bringing the level up to 34 per cent of average industrial earnings over a 5-10 year period. The application of such an approach across all social welfare payments would make for greater consistency of standards over time. The adequacy of the benchmark must then be taken into account. While more detailed research in this area is necessary, the VPJ (2002) proposed a standard of 40 per cent of average industrial wage in order to avoid a very inadequate diet. By this standard current policy on welfare target levels is inadequate.

Statutory-Led Practical Responses to Food Poverty

School Meals

Direct provision of food is a supplementary strategy to safeguard the welfare of people on low income or those with specific nutritional needs. The provision of school meals through the School Meals Scheme is a central pillar of statutory initiatives to address food poverty among children.

The current School Meals Scheme provides meals to some 60,000 children in almost 400 schools and is available to primary school children only. The scheme has two elements, an urban scheme dating back to 1914 and a scheme specifically for Gaeltacht areas introduced in 1930. The urban scheme is still operating while the Gaeltacht scheme last operated in 1991. Funding of food for the scheme is evenly split between the Department of Social and Family Affairs and Local Authorities, while Local Authorities also undertake day-to-day administration of the scheme.

The objective of the scheme is to assist children who are *unable by reason of lack of food to take full advantage of the education provided*³. The scheme was the subject of a review undertaken by a Department of Social and Family Affairs working group, which was published in 2003 (DSFA, 2003b). The review identified a number of shortcomings of the current scheme. It was considered to be inefficient in relation to the number of agencies involved in its operation and the high cost of administration relative to the low value of the food provided. There are no consistent eligibility criteria for participation in the scheme and the review found that due to its current legislative and operational basis it is ineffective in meeting the target group of children. Lack of a specific nutritional goal was identified as a further weakness. Under the School Meals Scheme pupils in participating schools receive buns, muffins or sandwiches and a carton of milk at lunchtime. Some pupils in severely disadvantaged areas or who attend special schools receive hot soups or hot meals. The review found that meals provided under the scheme did not meet the international standard for contribution to Recommended Daily Allowance of nutrients. The review concluded that while there is a compelling case for the provision of school meals the current scheme does not provide an efficient or effective policy response to the need identified.

Alongside the School Meals Scheme a number of other projects have been providing food to children in schools. The School Meals Community Programme operated by the Department of Social and Family Affairs aims to provide additional funding on a more *ad hoc* basis for school meal initiatives delivered by parents, voluntary groups and schools outside of the statutory scheme. In the school year 2000/2001 funding was provided to 67 projects benefiting 5,100 children in providing breakfast clubs, light meals clubs, dinners clubs and snack clubs. Provision ranged from every day of the school year to less than five days a week and/or part of the school year. Funding is for food items only and operation of the scheme is undertaken by school personnel, FÁS workers, voluntary workers and the children themselves. In some cases local Partnerships have become involved in the development and delivery of school meals projects.

Under their Early School Leavers Initiative the Department of Education and Science has been funding the Dublin 17 Breakfast Club covering six schools and benefiting 900 children. The Club started with a grant of money from the Society of St Vincent de Paul. Parents and teachers administer and run the club on a voluntary basis while local retail businesses supply the food at reduced prices. In a third *ad hoc* initiative Dublin City Council has been operating a Hot Soup Scheme in eight national schools of inner city Dublin. The scheme came about as a result of a request from the Dublin Corporation School Meals Committee in the early 1980s to introduce hot meals to one inner city national school in view of the level of deprivation and exceptionally high levels of unemployment in the area.

³ Section 276 of the Social Welfare Consolidation Act, 1981

All of these projects also came under the review of the School Meals scheme (DSFA, 2003b). The meals provided through the clubs and schemes were found to have a number of benefits. They contribute to the children's daily nutritional requirements and impact positively on their attentiveness, concentration and behaviour in the classroom. The Clubs have a strong voluntary underpinning, emerging as local responses to locally identified needs and resulting in a strong sense of ownership among the community partners involved in their delivery. However, all of these schemes have been initiated and operate on an *ad hoc* basis which has implications for funding and means that they operate outside of any broader strategic context. In most cases there is no assessment of the nutritional value of the meals provided.

The review group proposed the implementation of a reformed scheme to be called the School Food Programme to replace all of the school meals provision outlined above. The programme has both a short-term and a long-term objective. The short-term objective is to ensure the provision of appropriate school meals to school-going children whose educational opportunities or nutritional or health status are impaired by reason of lack of food. The long-term objective is to ensure that school-going children have access to appropriate meals in a manner that positively impacts on their educational opportunities and their overall health. This approach prioritises and targets resources at children considered to be in need of free meals in the first instance. Once this has been achieved the possibility of meals being made available, if required, on a paid basis to children not in need of free meals both in schools providing free meals and in other schools should be considered. The objectives for the reformed programme are welcome in the way they associate the scheme with addressing nutritional and health status in their own right as well as their impact on participation in educational opportunities. This is also evident in the set of indicators established for evaluating outcomes from the proposed programme which were grouped under welfare, education and health and include food deprivation and nutritional status.

The criteria proposed for determining need are in keeping with the NAPS target to address early school leaving. The programme is therefore targeted at post-primary schools with students most at risk of early school leaving and their feeder primary schools. This extends provision into the post-primary sector and locates the programme within broader anti-poverty measures. The review group also sought to include criteria that would give disadvantaged children in other schools entitlement to meals. Entitlement to the Back to School Clothing and Footwear Allowance was identified as a suitable educational support with which to link eligibility to the School Food Programme. Finally, it was proposed that individual children should be admitted on a case-by-case basis where a need is identified by school or health board personnel. Under these criteria the target group of children numbers 130,000 to 220,000. While these criteria are welcome for having a broad base and being

flexible in their application, associating eligibility for school meals with need puts programme recipients at a high risk of being stigmatised. Universal provision of food in schools ensures that all children benefit from enhanced nutrition without those who benefit most being stigmatised.

Nutritional guidelines for school food were developed as part of the review and the proposed programme sets specific nutritional value targets for meals provided in schools. It is proposed that a range of meal options should be offered including breakfasts, hot and cold lunches/dinners and snacks which should aim to provide a child with 25 per cent, 33 per cent and 10-15 per cent respectively of key recommended daily nutrient requirements. The lack of facilities to prepare and serve meals in schools was identified as one of the biggest practical difficulties to be overcome.

A more streamlined system of administration is proposed under the revised scheme with the Department of Social and Family Affairs as the lead agency and a dedicated Unit established to implement, monitor and evaluate the School Food Programme. The Department of Health and Children would have responsibility for nutrition criteria for meals, food safety and environmental health standards involving community dieticians and health promotion personnel at local level.

The review recommended that the proposed programme should strive to retain the involvement of school personnel, parents, businesses, children and the local community, the latter being considered a key success factor in the current scheme. In particular it was considered that the concept of corporate social responsibility should be encouraged further under the programme.

Overall then the School Food Programme proposed by the review is welcome for having a broader strategic focus and target group, more streamlined operational structures, a formal approach to nutritional assessment and an in-built system of monitoring and evaluation. The long-term objective that all school-going children should be able to access meals in their school setting is particularly welcome. However, the failure to make this a universal entitlement could impede uptake of the programme among those most in need due to stigma.

Direct Provision for Asylum Seekers

During the 1990s there was a marked increase in in-migration into Ireland including an increase in the numbers of people seeking asylum in the country. The government implemented a system of direct provision for asylum seekers in April 2000, supplying accommodation and meals and a small weekly allowance. This had the effect of removing asylum seekers from mainstream welfare provision. Under the 'direct provision' scheme accommodation is generally provided in shared hostel-type centres on a full-board arrangement with a payment of €19.10 per adult and €9.60 per child being made to recipients weekly.

Research undertaken for the Irish Refugee Council in 2001 was highly critical of the system of direct provision in relation to meeting the food needs of people seeking asylum (Fanning *et al.* 2001). They found that in general the food provided in hostels was inadequate and unsuitable for the needs of parents and those of their children. People seeking asylum who are in receipt of direct provision may experience extreme deprivation as a result of inadequate diet and inability to afford the purchase of sufficient and appropriate food from their incomes. Some respondents reported experiences of extreme deprivation. These included malnutrition amongst expectant mothers, ill-health related to diet amongst babies, weight loss amongst children, worries about health of children and hunger amongst adults as a result of 'within household rationing' of available resources in an effort to provide for the needs of children and babies. An overwhelming majority of study respondents on direct provision (92 per cent) stated that they considered it necessary to buy extra food to supplement the food provided in the hostels for themselves and their children, resulting in financial hardship. Most respondents on 'direct provision' (69 per cent) stated that they were unable to afford to purchase extra food. In some cases the absence of an adequate diet for pregnant women and mothers with young babies caused difficulties in breastfeeding or led women to switch to using baby formula (Fanning *et al.* 2001b: 5-6).

Fanning *et al.* (2001b) recommended the abolition of direct provision as a system that puts people seeking asylum at a high risk of poverty, with food-poverty issues being highly pronounced. The Refugee Council has also called for the abolition of direct provision, citing failure of the system to meet the food requirements of asylum-seeking children as a principal reason. More recently they put the case for reforming direct provision and limiting its duration for any individual to a maximum of six months while granting the right to work after the same length of time. In 2003 the organisation of Free Legal Advice Centres (FLAC) published a report analysing the scheme of direct provision. They considered the scheme to be a departure from existing Irish social welfare legislation and described it as discriminatory and without legal basis. FLAC also recommended an end to the scheme of direct provision for asylum seekers (FLAC, 2003).

Diet Supplement Scheme

The only scheme operated by the Department of Social and Family Affairs to assist in costs associated with food is the Diet Supplement Scheme. This is the State's response to people in receipt of social welfare payments who may not have enough income to buy special foods prescribed by their doctor or dietician. A diet supplement payment is available for persons with special dietary needs who are not working full-time and satisfy a means test. The purpose of a diet supplement is to assist with the additional cost of food where a person has been prescribed a special diet due to a specified medical condition. To qualify for a diet supplement,

a hospital consultant or a hospital registrar must certify that a diet has been prescribed by virtue of a specified medical condition and the nature and duration of the diet must be verified. A list of diets to which the supplement applies has been specified in legislation and includes diabetic diet; gluten free diet; high fibre diet; high protein, high calorie diet; low fat, low cholesterol diet; low lactose, milk free diet; and reducing (calorie restricted) diet.

However, it was announced that this scheme is to be phased out as part of the budget estimates put forward by the Minister for Finance in 2003. The rationale presented for doing so is the increases in social welfare payments in the past number of years. Under the proposed reforms diet supplements will only be paid to qualifying applicants who would otherwise have to spend more than one third of their social welfare income on food. As the scheme was only available to social welfare recipients, phasing out the diet supplement can be expected to increase financial pressures on those in receipt of social welfare with special dietary requirements and may make it difficult for them to have an adequate diet.

Community-Led Projects Involving Direct Provision of Food

Various organisations that participated in interviews for this study were involved in the provision of food to specific vulnerable groups of the population. The examples described below are not intended to be exhaustive but rather are illustrative of the types of voluntary-led projects in place that provide food directly to people using different settings and formats. A number were involved in work specifically related to people who are homeless because this group emerged as being at high risk of food poverty. In all organisations the emphasis was not only on meeting people's nutritional needs but also on helping to foster the social dimension associated with eating and to normalise the consumption of food.

Initiatives addressing Food Poverty among People who are Homeless

Focus Ireland is an organisation working to respond to the needs of people out-of-home and those at risk of becoming homeless, through a range of appropriate services including the provision of emergency transitional and long-term accommodation for people out-of-home. Focus Ireland operates a coffee shop in Dublin's city centre for people who are homeless where the aim is to provide good-quality, low-cost meals for people who would otherwise find it difficult to access regular, healthy meals. Meals are subsidised and the intention of providing them in a coffee shop setting is to seek to normalise people's access to food. As people pay for the meals they can then have expectations about the service and the quality and variety of foods. People have a choice of meals, they can request to have items placed on the menu and they can complain if food is not up to standard.

Another dimension of Focus Ireland's work in relation to food consumption among people who are homeless is the provision of a transition programme called *In Focus*

for people who are moving into their own accommodation. The programme includes areas such as cooking skills, budget management and home management to assist people in developing their skills and capacities to provide a nutritious and adequate diet for themselves on a limited income when living independently.

St Vincent de Paul's Back Lane Hostel is another example of voluntary provision of food for people who are homeless. The hostel provides accommodation on a long-term basis for people who are out of home. As well as accommodation the Hostel provides food in a setting that not only strives to meet the nutritional requirements of people but also creates a supportive social environment in which residents look forward to meal times and have a more positive attitude to food.

Crosscare are involved in the direct provision of food to homeless people through four food centres in Dublin city centre. The ethos of the food provision initiatives of Crosscare is to provide a properly staffed, warm place for those who cannot access food easily. The objective of the food centres is to provide users with the experience of the social dimension of food rather than just providing something to eat. On a daily basis five hundred meals are cooked and provided both to hostel dwellers and to homeless people who do not have even temporary accommodation. This is not means tested. A mid-day four-course nutritionally balanced meal including two vegetables, potatoes and meat/fish and tea/coffee is provided. The food centres represent places where an otherwise neglected group of people gather and thus are believed to represent an important opportunity to access the group for health treatment and information. In the past a public health nurse provided a clinic in the food centres called 'clinic for the homeless'.

Crosscare also provide a 'Meals on Wheels' service to homes adjacent to the food centres. These comprise prepared hot meals delivered to the homes of recipients. In Dublin city centre meals are provided to 200 older people who are housebound or people with a psychiatric illness living in the community. The recipients of this service are identified through contact with community welfare officers of the local health board. Measures to ensure the nutritional balance of meals include providing those recruited as cooks with opportunities to complete training. Every three months menus are assessed with the staff chef or cooks.

In all cases there is no formal input or assistance from a dietician to assess the nutritional contribution of the meals provided to the Recommended Daily Allowance. This represents an opportunity for community dieticians to become involved in contributing to improved nutritional provision for vulnerable groups.

Stakeholders' Informed Comment

When respondents were asked to give their own views on the factors contributing to food poverty or an increased risk of food poverty in Ireland, income adequacy was the most frequently highlighted factor. Participants were of the view that access to a nutritionally balanced diet is a basic human right and should be affordable to everyone. A consistently recurring factor mentioned by interviewees was the issue of income adequacy and the need to know the cost of a healthy diet. Income adequacy is a major issue as the principles of a market economy apply to food so that it is commodified in the same way as any other goods. Despite limited hard data, it was believed that the cost of a healthy diet was out of the reach of many marginalised groups. It was noted, however, that research was needed to establish exactly how much it costs to have a nutritious, adequate, healthy diet. Based on such information it would then be possible to work out if incomes are adequate to ensure a balanced healthy diet. Income adequacy to achieve a nutritionally balanced diet needs to be addressed, with the cost of food placed as a central dimension of improved and targeted social welfare entitlements.

There was strong consensus that entitlements such as social welfare, basic income and pension entitlements are often insufficient. The impact of scarce resources on the ability to provide a nutritionally balanced meal was seen to often mediate through the competing financial demands a low-income person/family might have, such as rent or mortgages, school books, bus fares. Financial restrictions were considered to make people fearful of experimenting with new foods particularly when feeding young children who may refuse to eat foods such as vegetables. This led to people relying on processed foods of a lower nutritional value. People with special dietary requirements were considered to be disadvantaged since such foods were often more expensive.

On specific measures, the provision of school meals was cited as an important strategy to address food poverty among children and increase educational participation. There were mixed views on whether or not meals should be provided on a targeted or a universal basis. Those advocating universal provision highlighted the risk of stigma attaching to a sub-group of students in receipt of free meals which experience from the UK has shown to have a detrimental effect on up-take of the meals. The argument in favour of universal school meals reflects the problems of identifying children of families whose income level would justify their entitlement to such a service on an equitable basis throughout the State. Instead universal provision would ensure all eligible children were reached while even those who would not be deemed eligible under a means test or similar criteria would benefit from the nutritional, social and educational advantages of meals at school. These benefits would go a long way to off-setting the economic cost of the scheme. Those advocating the provision of meals on a targeted basis argued that the costs

associated with providing meals to children on a universal basis diverted resources away from those most in need.

Some respondents highlighted the role of food in the process of social exclusion. Social norms, consumerism and food culture were believed to create a level of expectation that is difficult to achieve by some groups. This includes expectations of eating out regularly, of inviting friends to dinner and of eating particular types of foods. In families with children pressures exerted through commercial advertising to eat branded food products were considered to be a particular pressure on low-income parents. Families and individuals who cannot meet these expectations experience social exclusion related to food. Meanwhile some people such as those who are homeless or older people who are more likely to live alone often miss out on the social interaction associated with food.

When considering responses to food poverty all interviewees saw working in partnership as essential. Provision of food through the school system, such as the Breakfast Clubs funded by the Department of Social and Family Affairs, requires partnership with the Department of Education. Partnership models currently in place between staff, parents, private partners and volunteers in the community were considered to enhance the effectiveness of the service. The development of a link with the Department of Health and Children to undertake nutritional assessments was considered by many to be important.

Nutrition and Health Aspects of Food Poverty

Food Poverty Issues in Health and Nutrition Policies

Within the public health and health promotion arenas, recognition of the role of adequate nutrition in benefiting health has long been acknowledged internationally (e.g. Riboli and Kaaks 1997, Hu *et al.* 2000). To date a policy on food or nutrition has not yet been developed in Ireland despite preparatory work during the 1990s. In 1991 the Minister for Health established a Nutrition Advisory Group to assist in the formulation of a national food and nutrition policy. Among its terms of reference was the identification of specific sub-groups in the population with specific nutritional needs.

In 1995 the advisory group published Recommendations for a Food and Nutrition Policy for the Republic of Ireland (NAG 1995). The emphasis of the report was on the importance of diet for disease prevention. There was also a focus on adequacy of food and nutrition in-take. Two recommendations were made specifically addressing low-income groups. The first related to Government policies and recommended more detailed investigations to develop and implement policies and strategic plans for vulnerable groups, including those on low incomes. The second related to health and social services and recommended that welfare agencies should carry out pilot

projects with families on low incomes to enable them to provide sufficient and varied food to meet all their nutritional requirements (NAG, 1995). No food or nutrition policy has been developed since the Advisory Group published their recommendations. However, these individual recommendations relevant to food poverty have been taken up in subsequent policy initiatives.

In the absence of the development of such a policy on nutrition, the 1999 Cardiovascular Health Strategy, *Building Healthy Hearts* (DoHC 1999), took up some of the issues highlighted by the Nutrition Action Group. Two specific recommendations of the Cardiovascular strategy relate to low-income groups.

Recommendation R5.31 states that:

Targeted, focused, sustained programmes should be implemented to promote healthy eating, especially for those on low incomes and in other risk groups (DoHC, 1999: 57).

Recommendation 5.35 reiterates some recommendations of the Nutrition Advisory Group including:

Welfare agencies should carry out pilot projects with families on low income to enable them to provide sufficient and varied food to meet all their requirements (DoHC, 1999: 57).

The inclusion of these recommendations in the strategy prompted the formation of a working party comprising the Department of Health and Children, the Department of Social and Family Affairs and the Combat Poverty Agency to consider how to act on them under the lead of the Department of Social and Family Affairs.

The Department of Health and Children initiated a Nutrition and Dietetic Service in 1995 as a key component of the implementation of the Health Promotion Framework for Action Nutrition Plan in operation in Ireland from 1992-1996. In 1995 the Nutrition Advisory Group recommended that community nutrition and dietetic services be provided throughout the country (NAG 1995). The Cardiovascular strategy (1999) also recommended further expansion of the Community Nutrition Service – the employment of a further ten community dieticians and the appointment of a fulltime senior dietician to develop policy and co-ordinate health promotion by community dieticians.

Community nutritionists work within the remit of the Health Promotion Framework for Action Nutrition Plan (1991) and the Cardiovascular strategy (1999). The policy remit of the service is to implement and co-ordinate food and nutrition policy measures at local level. A Consultant Community Nutritionist based in the Department of Health and Children convenes meetings of community nutrition teams

from each health board to facilitate dialogue on the implementation of national policy at health board level. At health board level, community dietician managers have the responsibility of co-ordinating the regional response to food and nutrition policy. A key component of the service has been to develop specific food initiatives focused around building cooking skills and increasing the knowledge of the components of a balanced diet targeting marginalised groups. This reflects an undertaking in the 1994 health strategy 'Shaping a Healthier Future' to extend to other areas community-based initiatives on nutrition for lower socio-economic groups piloted in the Eastern Health Board (now the Eastern Regional Health Authority) (DoH, 1994).

The impact of this development was evident in the 1997 review of the Health Promotion Framework for Action Nutrition Plan in operation in Ireland from 1992-1996 (NNSC 1997). The review reported an increasing profile for nutrition and a progression towards multi-sectoral action in addressing nutrition-related health issues primarily through the implementation of nutrition interventions across a range of settings and population groups. These are usually community-based practical information and skills programmes, incorporating a community development approach. The service is also linking in with the component of dietary education delivered at primary school level through the Social, Personal and Health Education curriculum and specific food and nutrition guidelines for pre-schools and primary schools are being developed. However, it was noted that many actions have tended to focus at the individual level, relating to awareness raising and information dissemination including the national healthy eating week.

Since the Review (NNSC 1997), action on nutrition health promotion has been focused more on the needs of socially disadvantaged groups (DoHC, 2000). In recent years nutritional issues for low-income groups have featured as part of National Healthy Eating Week delivered by the Department of Health and Children since 1992. At Department level the decision was taken to make funding available specifically for the appointment of community nutritionists with a low-income brief as part of the expansion of the service recommended in the Cardiovascular strategy. This means that within each health board there is at least one member of the community nutritionist team with a dedicated food and low-income brief.

The 2000-2005 National Health Promotion Strategy embraces the need to modify high-risk lifestyle behaviours, including adverse dietary habits which impact on the well-being in all social groupings (DoHC, 2000). The Strategy seeks to take account of the needs of vulnerable groups in a manner that complements the National Anti-Poverty Strategy. The sole focus in relation to low-income groups is to work in partnership to develop and adapt eating well programmes. This continues the trend of focusing action at the individual level in the form of awareness raising and information dissemination.

Looking at health policy generally, Health Strategy 2001 sets ‘better health for everyone’ (DoHC, 2001a) as the first of its four national goals. Reducing health inequalities is among the four objectives under this goal. This goal recognises that ‘collaborative action from a number of agencies both within and outside of the health system is imperative to achieve and sustain a healthy population’ (DoHC, 2001a). The role of diet in shaping health is also acknowledged in the goal.

As mentioned earlier the Department of Health and Children have forged a partnership with the Department of Social and Family Affairs and the Combat Poverty Agency to address issues of low income and nutrition. The Department has also forged a partnership with the Department of Education and Science. Schools are seen as an ideal setting for nutrition education as increasing evidence shows that eating habits for life are established during childhood (Law 2000). The importance of training young people to cater for themselves is highlighted in recommendations to include cooking skills in the national curriculum. Many of the regional health boards have implemented the Department of Health and Children schools programme, NEAPS (Nutrition Education at Primary Schools), which provides teaching, materials and support to primary school teachers in 3rd and 4th class. In some locations, NEAPS is being incorporated into a whole school programme. Development of the food component of the Social, Personal and Health Education (SPHE) programme is a collaborative project between the Department of Health and Children and the Department of Education.

Statutory-Led Practical Responses

Peer-Led Training in Nutrition Information and Cooking Skills

At the health board level community dietitians with a specific low-income brief are involved in the development of services and initiatives addressing food poverty at local level. Initial tasks have involved identifying groups at risk of food poverty in the board’s administrative area. Throughout the boards a range of food and health related programmes have been developed that target socially disadvantaged groups. The dietitians work in partnership with local community development organisations, who help identify the need for a programme for a particular group in the community and facilitate its delivery. Three principal programmes focusing on food issues for low-income groups are being delivered – ‘Healthy Food Made Easy’, ‘Eat Well, Be Well’ and ‘Cook It’. These are all peer-led training programmes in nutrition information and cooking skills. These actions were mainstreamed under the 2000 Health Promotion Strategy. To date their effectiveness has not been evaluated in the Irish context.

The ‘Healthy Food Made Easy’ programme was delivered for the first time in the Eastern Health Board on a pilot basis and the 1994 health strategy provided for its expansion into other areas (DoH, 1994). It is a six-week, peer-led initiative, targeting

low-income young mothers. The community dieticians train people from the community organisations to deliver the project and there is also a local co-ordinator who liaises with local groups. The programme focuses on cooking skills, basic food preparation, information on nutrition and other issues relevant to the needs of the group.

The 'Eat Well, Be Well' food and health programme focuses on building cooking skills and increasing knowledge of the components of a balanced diet. The programme works in partnership with community development organisations, is delivered by trained health tutors and is about six weeks in duration. Over time issues of healthy eating and information such as the food pyramid are built into the programme with a hands-on approach to food and cooking. Across the health boards a wide variety of groups are targeted for this programme such as: Travellers, older men living alone in rural areas and active retirement groups. The programme is adapted specifically to meet the particular needs of the group; for example the content would vary depending on whether it was a rural men's group or a young urban women's group.

The 'Cook It' programme is a six-week nutrition education programme that aims to teach basic cooking skills and increase knowledge around food. People in the community are trained to run the programme themselves. Each week there is a different theme and participants are actively involved in the cooking process. The 'Cook It' programme seeks to create an educational learning environment that is non-threatening and remove the fear of experimentation with new recipes. Target groups for the programme include low-income groups, young mothers, older people, Travellers and people with disabilities.

Killorglin Day-Care Centre

Another element of the food-related activity of health boards is the provision of food in communal settings to vulnerable groups. Older people living in the community are a key target group for such provision through day-care centres throughout the country. For this research a case study was carried out of one day-care centre – Killorglin Day-Care Centre in Co. Kerry – to gain an understanding of the nature of this type of provision. A central feature of the Killorglin Day-Care Centre is the provision of food to older people along with the creation of a supportive social environment from Monday to Friday 9am-5pm. On average thirty older people are catered for each day. A nurse manager runs the centre, with a part-time nurse also employed in the centre. The centre employs two cooks, a caretaker, a laundry worker, and a chiropodist visits as well. Meals are planned with regard to variety, nourishment and special needs that older people may have. The staff and cooks assess the menus which seek to include fresh vegetables every day and fish once a week, with the menu changing every six weeks to ensure variety and more enticing meals. There are no formal criteria applied to the assessment of the menu. A part-

time nurse in the day centre gives talks to the older people on healthy eating and cooking methods. The health-board-employed community nutritionist has provided information and advice to the centre. However, no formal input has been made in the form of a nutritional audit or regular visits to the centre.

Community-Led Practical Responses

Primary Health Care for Travellers Project

The Primary Health Care for Travellers project is a joint project between Pavee Point, the national Travellers' organisation, and the Northern Area Health Board. The Traveller Health Unit of the Department of Health and Children also provides core funding. Its aim is to improve the health status and quality of life of Travellers. The first project was established in 1994 as a pilot initiative in the Finglas/Dunsink areas with funding from the Eastern Health Board. The success of the project has seen it replicated by numerous Traveller organisations and health boards around the country. To facilitate this replication Pavee Point have developed a 'Training for Trainers' course, accredited by University College Dublin.

The work of the project includes community-based health liaison work, on-site health education sessions and production of Traveller specific health promotion material as well as in-service training for health professionals. A key component of the project is the training of members of the Traveller community to work as Community Health Workers. At present sixteen Traveller women work as Community Health Workers and deliver the project in partnership with health professionals in the area. A balance in approach between health and community development is reflected in the staff backgrounds. According to project personnel, remarkable improvements in levels of access to child health services, women's health services, family planning and oral/dental services have been observed through the work of the project. While food poverty is not a central element of the project it is addressed through healthy eating information. A series of posters concerned with issues of healthy eating, breast-feeding, healthy teeth, methods of healthy cooking and the food pyramid have been produced as part of the project. These posters were designed in consultation with the women involved in the project, with the aim of being culturally sensitive. For example the food pyramid was adapted into a more culturally appropriate format and a dietician assisted by giving practical information on how to measure portions and the correct portions of fruit and vegetables needed to maintain a healthy diet. These materials are being used continuously by the project.

Stakeholders' Informed Comment

Interview participants from the health sector identified their role as addressing inadequacies in relation to cooking skills and skills necessary to differentiate between the real costs of healthy and unhealthy foods and to identify nutritional

content from food labels. Low literacy levels, lack of knowledge and awareness and low standard housing conditions with inadequate cooking and storage facilities were all considered to undermine the capacity of people to consume adequate, nutritious food.

Various models of implementing strategies to increase health education and information and awareness on how to maintain a healthy lifestyle were suggested. One proposal was to bring food poverty within the policy remit of schools and the curriculum delivered from an early age. A compulsory element of the curriculum focusing on food preparation and nutrition was suggested as an important tool in educating young people generally about food and well-being. Incorporating the issue into the school curriculum allows for universal delivery of both information and skills. Health-related education issues around food and health could also be incorporated into adult education centres and vocational educational courses.

When food and health programmes are being delivered to communities it was considered important to use a community development approach. Training members of the community to become health workers means that programmes to groups such as low-income groups, young mothers, older people and Travellers can be peer-led. This form of capacity building at local level is valuable. It was generally understood that local and bottom-up approaches to addressing food poverty were most effective, drawing on the principles of community development. Initiatives that begin at a community level and are delivered by community members are believed to be most successful. The interviewees noted that this approach requires innovation, adequate support from community dietitians in the form of training to facilitators, recognition of the role of the Community Health Workers and adequate funds to develop and deliver initiatives.

This in turn raises issues in relation to gaps in the professional training received by community dietitians/nutritionists. Those interviewed described how dietitians are trained very much in the clinical diagnostic model without any focus on methods of working in a community setting. This indicates a need to include a module on community development into the professional training programme for dietitians/ nutritionists.

A vision of an expanded role for community dietitians/nutritionists is discernable from the interviews with community-based organisations. They consistently noted a desire for formal contact with health board community dietitians/nutritionists in the form of regular liaison and provision of training to community services, advice on meeting special dietary requirements of population groups, nutritional audits of catering facilities in residential services and working with cooking staff to plan balanced nutritious meals. It was proposed that regulatory nutritional standards are needed for food provided in communal and residential settings.

There was some criticism of the way in which healthy eating messages were delivered. Community-based respondents were critical of the food pyramid as a middle-class notion of food that fails to take account of different cultures and habits around food that exist in different groups. The adaptation by the Primary Health Care Project for Travellers of the food pyramid into a more culturally sensitive format is an example of how this can be overcome.

Food Production and Distribution

Food Poverty Issues in Food Production and Distribution Policies

The Department of Agriculture, Food and Rural Development (DAFRD) has principal responsibility for food production policies. According to DAFRD its aim in relation to agriculture and food development is to promote the development of an efficient agricultural sector while ensuring the retention insofar as practicable of the highest number of farm households. For the food industry its aim is to promote the growth of a competitive, consumer-oriented and added-value food processing sector. The emphasis of the Department appears to be on sectoral viability as opposed to having regard for the impact of such production policies on consumption patterns and food security in Irish society. Such emphasis is evident in current policies relating to agriculture and food.

In June 1999 the Minister appointed a committee of experts in all areas of the agri-food sector to the Agri Food 2010 Committee whose terms of reference were to propose a strategy for the development of Irish agriculture and food over the next decade in light of the changes and challenges likely to evolve nationally and internationally over that period (DAFRD 2000a). In setting the context for the development of such a strategy the issues highlighted include trade liberalisation at global level, new trends in the EU food market driven by consumer lifestyles and concerns, and concentration at retail level. Food security issues are not addressed. As a result the vision set out in the strategy is for a dynamic agricultural sector and a competitive food industry underpinned by the principles of innovation, marketing and food safety. A singular consumerist approach is taken to the production and distribution of food, focusing on food safety and quality standards but without specific reference to nutrition or food security.

Food safety policies are designed to ensure quality safety standards along the food production chain to consumers, whereas nutritional policies are primarily aimed at promoting individual choice as the key element in determining a healthy diet. Whilst food safety is a function shared by a large number of government bodies and departments, the Food Safety Authority of Ireland (FSAI) was set up in 1997 as an executive agency under the auspices of the Department of Health and Children with the responsibility of co-ordinating inspection and enforcement of food safety laws.

The FSAI has no executive function in relation to nutrition. It has been highly effective in developing food safety policies and infrastructure.

Since 1998 it has been a legal requirement for all food businesses to have a food safety management system based on the principles of HACCP. Hazard Analysis and Critical Control Points (HACCP) is a systematic approach to identifying and controlling hazards (i.e. microbiological, chemical or physical) that could pose a danger to the preparation of safe food. In 2003 the FSAI launched a joint HACCP campaign with the ten health boards to encourage the food industry to enhance their food safety management standards, which in turn will further protect consumers from illness related to food. The campaign aims to facilitate an increase in the adoption of food safety management systems based on the principles of HACCP within the Irish food industry and focuses on temperature control as one of the key control measures to ensure the production of safe food. The emphasis on food safety in food production policy as discussed above is a key factor in the development of such infrastructure in relation to food safety. This demonstrates the importance of having food security incorporated onto the policy agenda so that such an infrastructure can emerge to ensure access to good quality, nutritious food for all. The effectiveness of the implementation of food safety represents a model of effective partnership with health boards that could be followed when considering how nutrition standards in food could be implemented.

An all-island body, the Food Safety Promotion Board (FSPB), was established under the auspices of the Good Friday agreement and has responsibility for the promotion of food safety and nutrition on the island as a whole. The principal function of the FSPB is to promote awareness and knowledge of food safety and nutrition issues among producers, processors, distributors, caterers and consumers. It is interesting to note that in its mission statement relating to public health the Board refers only to over-nutrition and does not make any reference to the potential for members of our society to be at risk of food poverty. However, as described below, the FSPB is involved in funding a project designed to address the issue of food poverty.

The National Development Plan 2000-2006 includes initiatives for the food sector. These are underpinned by the principles of increased efficiency and competitiveness and food safety and quality across the four measures of capital investment: research, technology and innovation, marketing and promotion and human resource development. As with all NDP measures, projects seeking financial assistance for capital investment should be able to demonstrate their contribution to environmental, equality, poverty and rural development issues. The concern with poverty follows on from commitments to poverty-proof public expenditure set out in the National Anti-Poverty Strategy. Meanwhile there is no discernable focus on the phenomenon of food poverty among the range of sectoral priorities set out for the

food sector in the National Development Plan. The only supported initiative specified in the plan that could contribute to preventing and addressing food poverty is the development of 'near farm' enterprises within the horticultural sector which could assist in the distribution of fresh produce on a local basis. This sole measure suggests that this set of initiatives is not informed by an understanding of food poverty.

Distribution processes determine access to food through the placement of retail outlets and the diversity of retail outlets within an economy. The control of the market by Multiples and the placing of retail outlets in out-of-town locations adversely affect access to food by lower-income groups in particular. We saw in Chapter 3 how lower-income groups tend to shop in Groups or Symbols (e.g. Centra, Supervalu, Londis) outlets. The Department of the Environment and Local Government have developed guidelines for planning authorities in relation to retail outlets. A policy objective in the Retail Planning Guidelines for Planning Authorities (2000) is to focus on the local availability of some form of efficient, equitable and sustainable retail provision which is readily accessible to people, particularly marginal groups such as the elderly, lone parents, low-income families and Travellers (DoELG 2000). These guidelines are compatible with a strategy to address food poverty by ensuring that food deserts, particularly in urban centres, do not emerge. However, in the current format of guidelines they do not represent a strong regulatory mechanism.

Access to food is also largely affected by transport provision and this is particularly important for communities living in rural areas. The absence of an adequate transport system in many areas in Ireland makes it difficult to avail of training and education or to enter or retain employment as a means of avoiding poverty. At a more immediate level it makes access to retail outlets selling a range of foods at an affordable price difficult. Rural transport is given particular attention in the NAPS and a number of government actions are already underway which deal with rural transport issues. The National Development Plan has allocated €4.4 million to fund transport services in rural areas, in order to tackle rural social exclusion. Though food poverty is not an explicit concern of any element of transport policy in Ireland, we can expect that improved transport provision for isolated rural areas would have a beneficial impact on alleviating food poverty.

EU level – Impact of CAP Reform

Food production and distribution policies in Ireland are developed within the framework of the Common Agricultural Policy (CAP). As set out in Chapter 4 the CAP has been criticised for generating market distortions and contradicting nutrition and public health policies. In 2003 a major programme of reform of the CAP was agreed. While it is not possible to analyse the full implications of the reform here, its fundamental aim is to break the link between the payment of subsidies and production so as to address surplus production through a process called 'decoupling'.

While industry analysts highlight the negative impact this will have on the price received by the farmer/producer for produce, there is no indication that the reform will bring about price reductions in retail prices of foodstuffs. Reducing the amount of milk and beef in intervention should lead to a reduction in consumption aid for these goods, which in the past has been considered to contradict public health and nutrition policy. Further reforms are anticipated for the fruit, vegetable and grain sectors.

Statutory-Led Practical Responses

Distribution of EU Surplus Food

The Department of Agriculture, Food and Rural Development undertakes distribution of EU surplus Irish dairy and beef produce to certain recipients. Intervention Irish butter is distributed without charge to suitable charitable organisations for provision to the most needing people in the community. Normally the scheme is limited to voluntary organisations providing emergency and short-term accommodation for people who are homeless or to day-care centres that provide meals for people who are homeless. The Department will meet the transport costs of the product from the intervention storage facility. The unit size of the product has been very large in the past. In the scheme ending September 2002 the butter was provided in single 25kg boxes so that recipients had to be in a position to store and use such a large single quantity before they could benefit from the scheme.

Canned Irish Beef from the EU Special Purchase Scheme has been distributed by the DAFRD in the past. The beef is comprised of prime cuts of beef from excess cattle stocks which has been prepared for example as stewed beef in gravy or corned beef and then canned. Distribution has been to registered charitable organisations engaged in the relief of poverty through the provision of food.

Finally the DAFRD also operate the EU School Milk Scheme which grants aid to nursery schools, pre-schools and National schools administered or recognised by the State to purchase milk products such as whole or semi-skimmed milk, flavoured milk, yoghurt and cheeses. Aid of a maximum daily quantity of 0.25 litres per pupil is granted to the schools who enter into an arrangement with a supplier to supply the produce subject to conditions laid down by the scheme.

Community-Led Practical Responses

Southhill Food Co-Op

The Southhill Food Co-Op in Limerick city was established to provide daily access to fresh fruit and vegetables at an affordable price to members of the local community. It is a community-led project staffed by FÁS community employment workers and operated in collaboration with the community dietician service of the Mid-Western

Health Board. Currently in the region of 400 people access the Co-Op. The Co-Op is involved in the direct production of food that is sold when harvested at an affordable price and in the sale of food bought from a local supplier on a not-for-profit basis. The direct production of food by the Co-Op is a particularly interesting feature as the workers involved acquire skills that they may then impart into the broader community. The Co-Op has been found to be particularly relevant to groups in the community such as older people, young mothers, Travellers and people with a disability. There are plans to develop the food co-op into a lunch-providing service both for community participants and for children attending the local school.

Dublin Food Bank

The Dublin Food Bank was established in 1989 by the Dublin Diocesan Agency Crosscare to provide food and grocery products to caring organisations. These organisations include hostels, day centres, school meals, night shelters, food centres and residential units for older people.

It represents the only organised Irish system of withdrawing food from the market place, supermarkets, wholesalers, growers and EU intervention stocks. The overall goal is to redistribute surplus food, which would otherwise go to waste, to those in need. The bank collects food and grocery products with its own refrigerated transport. The products are brought to the bank warehouse and stored according to product type. The voluntary organisations then come to the bank on an appointment basis each day and the goods are made available to them.

The food taken into the bank is largely food surplus, end of promotional line, close to sell-by-date, mislabelled foods or products with damaged external packaging. Freshly grown vegetables that do not meet the supermarket quality standard in terms of size and shape are now readily supplied to the food bank on a weekly basis from the growers. A small number of large producers make social contributions to the food bank, i.e. provision of requested products. Odlums flourmills provide flour four times a year and Greencore plc provide sugar four times a year. These are considered to be social responsibility contributions, i.e. they are not waste or surplus.

Decent Food for All

The Food Safety Promotion Board has provided funding for a demonstrator pilot programme entitled 'Decent Food for All' within the Armagh and Dungannon Health Action Zone (HAZ) in Northern Ireland. The mission statement of the programme is to improve the provision and consumption of affordable, safe and healthy food, to protect and improve public health particularly among the disadvantaged and vulnerable. The aim of the programme is to provide practical, community-based and focused help and advice on food issues and nutrition. The four elements of the programme are community education, individual empowerment to permit healthy

food choices, regeneration of local communities and markets and sustainability. The approach taken will be to reduce one or a combination of the three barriers to accessing decent food, barriers relating to financial access, physical access and access to information. The programme will build on existing initiatives in the HAZ area comprising a Fresh Fruit in Schools pilot, a Community and School Food Garden project and an impending Breakfast Club scheme. The project began in 2003 and is of three years duration with an in-built programme of evaluation being undertaken on an on-going basis (Donaldson *et al.* 2003).

Stakeholders' Informed Comment

The interviewees identified impediments to choice of and access to a wide variety of food, good quality foods and fresh foods as contributing to food poverty. In addition to the provision of such foodstuffs, environmental factors were also a concern. Lack of suitable transport, location of retail outlets and planning of the built environment were seen as prohibitive factors, especially for people living on a low income, older people, rural dwellers, Travellers and lone parents. It was felt that such a situation could result in these groups being forced to outlets that may be more expensive and lack variety and choice.

Respondents referred to the political economy of food in our society by which tastes and trends in food purchasing, preparation and consumption are market driven. Interviewees for this study who had experience of the nature of food poverty at community level expressed concern about the marketing of food, particularly that targeted at children. It was proposed that standards should be set in relation to the advertising of foodstuffs such as that which applies to the advertising of financial products. These standards should have regard in particular to nutrition and value for money.

Ireland is a food-rich country and is in fact producing foods that are directed into storage because they are considered as surplus. It was argued that agricultural policy and food policy need to interact in the formulation of policies relating to food production and distribution with a view to reducing surplus while ensuring food security. In the meantime, while surplus is still a feature of food production, an efficient system is needed to manage those surpluses so that they are diverted to organisations involved in the direct provision of food to those at risk of food poverty. From the food provider's perspective, food donations from private industry must be improved. Food donations from partners in industry must be of nutritional value and not just a cheap mechanism of waste disposal for that organisation. This practice would be enhanced if there was a specific commitment to the regular delivery of an agreed amount of nutritious, quality and appropriate foodstuffs. Some respondents were of the view that the government should intervene to control the management of excess in a way that is equitable and fair. Financial redistribution through equitable taxation by the government was believed to be a better approach than surplus goods distribution or social contributions by private partners.

Concern was expressed about the potential for the availability of such excess production to create dependency among organisations working to address food poverty on the ground. In the retail sector there is huge pressure to reduce the amount of food produce that actually goes out of date and to extend shelf life by investing in new, innovative packaging technologies. This will decrease the supply of surplus food products which will impact negatively on organisations like Crosscare who rely on excess for their food provision. A direction for the future is to examine European models where companies commit at the start of the year to a certain percentage of turnover, i.e. the social contribution model. Under the social contribution approach a producer commits to supply goods to a specified value and allows the food bank to select from among their products those most appropriate to meet the needs of its constituency. This allows for choice and supply of high demand foods from a guaranteed source as well as flexibility as to when the goods are taken, having regard to the needs of the organisations the bank serves. The respondent from Irish Business and Employers Confederation acknowledged that within the food industry there are on-going improvements in reducing surplus production. As a result IBEC is generating awareness among its members of the importance of incorporating social contribution practices into the food and drinks industry. However, the overall position of the food bank at present is managing surplus. The food bank operators, Crosscare, proposed that the ideal position would be managing social contributions plus surplus from industry.

Finally the issue of food production needs to be addressed. In contrast to our recent past when many of those living on small holdings were engaged in direct food production for consumption by the household, this practice is increasingly rare. Few families now grow or harvest foodstuffs for consumption by the household. Meanwhile, a small area of land used effectively can produce a worthy amount of nutritious foodstuffs for a household or even a community.

Summary and Conclusions

The overall consensus from both the policy and practice perspective was that food poverty exists. Numerous definitions from a practical and policy point of view were identified but there was divergence of opinion as to what exactly food poverty constitutes, especially at policy level. A working definition is explicitly recognised in only a few organisations. In addition some respondents expressed a certain amount of resistance towards the term 'food poverty' as it was believed to convey a sense of absolute poverty with an element of stigma attached to it. Drawing on the range of positions, the following definition of food poverty would have broad agreement: 'not having enough money to be able to afford a diet that is nutritious as an outcome of factors such as income inadequacy, difficulty accessing foodstuffs, inadequate transport and inadequate knowledge and skills'.

There tended to be a greater awareness of the problems associated with poverty generally rather than food poverty specifically. There were differing levels of awareness among those working in policy making and practice settings. At a policy level food poverty *per se* has not received much attention and explicit efforts to alleviate the adverse implications of food poverty are sparse. The primary concerns of government and statutory bodies are not directed towards addressing food poverty explicitly, but it is recognised that the focus on for example income adequacy, provision of school meals, raising awareness and knowledge around healthy eating and addressing transport needs each indirectly contributes to preventing and alleviating food-poverty issues. However, there was an acceptance that food poverty is a growing problem and needs specific direction at a policy level.

A more comprehensive understanding of food poverty appears to exist from the practice perspective especially among those working directly with socially disadvantaged groups or, as in a few instances, involved in the direct provision of food, e.g. Crosscare, St Vincent de Paul and Focus Ireland. These organisations would have demonstrated a more nuanced understanding of food poverty and its effect on people. As well as the dimensions of food poverty referred to above as having broad agreement, those working to address food poverty directly were more likely to highlight the social participation or cultural dimension of food and the concept of food-related social exclusion. Meanwhile, those organisations who work with specific population groups such as people who are homeless, Travellers and older people would acknowledge their role in addressing food poverty but do not view it necessarily as a priority in the context of other poverty issues that affect their constituencies.

Through the research we identified various policies and initiatives of government departments and statutory bodies which, whilst not specifically termed 'responses to food poverty', address some of the factors affecting existing social inequalities in dietary behaviour. Table 8 below presents a summary of these policies and policy level initiatives. The research also identified examples of initiatives involved in the direct provision of food. The need to facilitate the provision of healthy, nutritious food to vulnerable people and increase the capacity of people to choose healthier options are central components of initiatives targeting food poverty. Table 9 below summarises the practical initiatives developed by statutory agencies and non-governmental organisations aimed at addressing poverty, with a central focus on food identified during the project.

Organisation	Policy/Action	Main Focus of Policy/Action
Dept of Social and Family Affairs	National Anti-Poverty Strategy School Meals Programme Breakfast Clubs Diet Supplements Scheme	Policy framework for addressing poverty Provision of food directly to disadvantaged children Provision of breakfast to all children in target high-risk schools Part of the supplementary allowances scheme
Dept of Health and Children	Healthy Eating Week Nutrition and Dietetic Service in Health Boards Food and Nutrition Guidelines Social, Personal and Health Education	Awareness and knowledge raising of food and nutrition issues among low-income groups Established posts in each health board of community dieticians with specific brief of food and low income Food and nutrition guidelines for pre and primary school Food and nutrition education at primary school level as part of SPHE
Dept of Environment and Local Government	Retail Planning Guidelines for Planning Authorities	Establish local, efficient, equitable and sustainable retail provision which is readily accessible to people, particularly marginal groups
Dept of Education and Science	SPHE	Food and nutrition education at primary school level

Table 8: Summary of current policy level actions addressing food poverty

Organisation	Policy/Action	Main Focus of Policy/Action
Combat Poverty Agency	Funding for research relating to diet and food poverty Policy submissions Working Group on Food and Low-Income Groups Building Healthy Communities demonstration programme	e.g. Policy Response to Food Poverty, Social Variation in Food and Nutrient Intake, Cost of Healthy Eating e.g. Review of School Meals scheme Funding demonstration programme on links between community development and health
Food Safety Promotion Board	Funding research projects	‘Decent Food for All’ – Armagh and Dungannon Health Action Zone Developing communication tools for food safety and nutrition messages to low-income groups

Table 8: Summary of current policy level actions addressing food poverty

Organisation	Initiative/Programme	Main Focus of Initiative/Programme
<p>St Vincent de Paul</p> <p>St Vincent de Paul/Dept, SFA</p> <p>St Vincent de Paul / Southern Health Board</p> <p>(Managed by SVP – part funded by SHB)</p>	<p>Back Lane Hostel for Homeless</p> <p>Breakfast Clubs</p> <p>Killorglin Community Daycare Centre</p> <p>Killorglin Community Daycare Centre – Meals-on-Wheels</p>	<p>Direct provision of food to homeless people, provision of social contact</p> <p>Breakfast provided to children in target schools</p> <p>The centre provides transport to and from the centre, meals throughout the day, and social activities for 30-35 older people who attend daily</p> <p>Meals are delivered to twenty older people living in the community who are unable to attend the Centre</p>
<p>Crosscare</p>	<p>Meals on Wheels</p> <p>Food Bank</p> <p>Food Centres in Dublin City</p>	<p>Meals provided to 200 housebound elderly or psychiatrically ill people</p> <p>Distribute surplus food to established caring organisations that cater for at-risk groups such as homeless people, older people, disadvantaged youth and ex-prisoners</p> <p>Provision of nutritionally balanced main meal to homeless people</p>
<p>Focus Ireland</p>	<p>Coffee Shop</p> <p>In Focus</p>	<p>Coffee shop for homeless people in Dublin</p> <p>Programme for people who are moving into their own accommodation, deals with issues such as cooking skills, budget management and home management skills</p>
<p>Pavee Point</p>	<p>Primary Health Care Project for Travellers</p>	<p>Joint health board and Travellers' organisations initiative. Food component comprises a series of posters concerned with issues of healthy eating, breast feeding, healthy teeth, methods of healthy cooking and the food pyramid have been produced</p>

Table 9: Summary of practical initiatives/programmes addressing food poverty

Organisation	Initiative/Programme	Main Focus of Initiative/Programme
Health Boards	<p>Healthy Food Made Easy</p> <p>Eat Well, Be Well</p> <p>Cook it</p>	<p>Six-week peer-led programme, targeting low-income young mothers. The programme focuses on cooking skills, basic food preparation and information on nutrition</p> <p>Six-week programme delivered by health board trained community health tutors. Focus is on building cooking skills and increasing the knowledge of the components of a balanced diet</p> <p>Six-week peer-led nutrition education programme that aims to teach basic cooking skills and increase knowledge around food</p>
Southill Food Co-op	Food Co-op	Community-run food co-op focused on daily provision of fresh fruit and vegetables at prices affordable to low-income groups

Table 9: Summary of practical initiatives/programmes addressing food poverty

While food poverty is recognised there is no agreed definition of food poverty evident in policy or practice. In general, definitions and understandings of food poverty have been better developed in relation to specific groups with a higher risk of poverty in general as compared with how food poverty manifests itself at the level of the general population. Similarly, practical initiatives to address food poverty to date can be characterised as locally based responses developed in isolation from policy. This means that such initiatives are at risk of duplication of resources and are incapable of sharing valuable learning. In order to harness the potential of these initiatives co-ordination and support is necessary to come from policy and this is where the real challenge lies.

To date no policy area has focused specifically on issues of adequacy in food and nutrition. Ireland has no overall food policy and a review of the relevant policy domains demonstrates that food poverty is not currently a central policy concern. This does not correspond with the State's obligations under international agreements to which it is a signatory such as the International Covenant on Economic, Social and Cultural Rights, the United Nations Convention on the Rights of the Child and the World Declaration on Nutrition.

Chapter 6: Discussions and Recommendations

In nutritional terms poverty in relation to food may be defined as the consumption of too little food to meet basic nutritional requirements with adverse health consequences. It is not just health, however, that is compromised in food-poor households, so too is social behaviour when people cannot eat, shop for, provide or exchange food in the manner that has become the acceptable norm in society due to issues of affordability and access.

To help develop appropriately targeted action it is necessary, as echoed by those participating in the one-to-one interviews, that a definition of food poverty be developed and utilised. At a Forum of interested stakeholders convened as part of this research (see Appendix two for list of participants) the general consensus was that the definition should include 'access to an nutritionally balanced diet'. The following working definition of food poverty is proposed but this should be further debated.

... food poverty refers to the inability to access a nutritionally adequate diet and the related impacts on health, culture and social participation...

The many issues related to food poverty and social inequalities in food practices are complex and hence there is a need for innovative and effective strategies and policies that address these issues in a comprehensive way. Based on an examination of the data gathered in this study, this final chapter highlights a number of priority areas and proposes some key recommendations.

Overview of Findings

There is documented Irish evidence that certain groups in society experience food poverty and that socially disadvantaged individuals and households have poorer dietary behaviour than richer members of Irish society. As in health (Macintyre 1994), socio-economic differentials in dietary behaviour exist in all societies and are apparent throughout the social scale, suggesting that there is not simply a threshold of absolute food deprivation below which people are hungry, but a linear relationship between socio-economic circumstances and diet. The currently available data in the Republic of Ireland do not easily facilitate the quantification of the level of food poverty that may exist but clearly demonstrate a social gradient in dietary habits. The data show that people from socially disadvantaged positions are less resourced than other social groups to make healthy food choices and that socio-economic inequality strongly drives the inequality in dietary habits. In assessing the data we can summarise that socially disadvantaged people in the Irish population are certainly at risk of food poverty. Compared to more affluent groups, socially disadvantaged people eat less well, spend a greater proportion of income on food, have difficulties accessing a variety of nutritionally balanced good quality and affordable foodstuffs and know what is healthy but are restricted physically and mentally by a lack of financial resources.

As is the case in many rich countries, the literature and empirical data suggest that the social position of individuals affords them opportunities or otherwise to make healthy choices and this is strongly affected by structural, material and psychosocial factors which each influences the choices made (Dowler and Dobson 1997). What is apparent from the Irish data is the over-riding effect that financial resource, costs of food and physical barriers have when considering food priorities among low-income groups. The social consequence of these factors on food choices can strongly affect the physical and mental well-being of individuals and indirectly determine the quality of food choices made.

The findings from this study suggest that to address food poverty and dietary inequality requires understanding and support from central government through to local action. However, the information obtained from the interviews highlighted that whilst food poverty and social inequality in dietary behaviour was recognised, it remained peripheral to the daily activities of many policy and practice organisations, other than those whose remit was specifically concerned with food and disadvantaged groups. Despite the growing recognition of the importance of this area, there is currently a lack of coordinated policy in the Republic of Ireland guiding the development of initiatives to redress both food poverty and social inequality in dietary behaviour. Ireland subscribes to rights to be free from hunger in international agreements. However, this does not translate into the government giving a positive guarantee to the right to food amongst the Irish population.

Access to food and nutrition is a basic human right and therefore places these issues immediately on the political agenda. Good quality, affordable food should be available and accessible to all and necessitates political and community intervention beyond welfare provision. This study presents an understanding of food poverty and deprivation related to nutritional and social outcomes, highlighting the social, cultural, environmental and material influences on food choice. It has shown that dietary choice must be viewed within a socio-political framework that involves policy issues relating to food access, price and personal and household income. At the same time, the types of foods people choose to eat are influenced not only by market provision but also by personal factors such as culture, personal taste, attitudes and nutritional knowledge.

Building on Experience

In order to effectively address priority issues, it is critical to build on the experience of the substantial work already taking place in Ireland and internationally. International policy is impacted upon mainly through national government involvement. It is therefore useful to understand and highlight that international food production and trade policies have tended to distort market prices and impede access to foods recommended for good health especially for those on a low income. Over-production of

less healthy foodstuffs is an outcome of the market support measures in place and which have made their way into programmes directed at alleviating food poverty, e.g. the US Food Assistance programmes. In this way food production policies conflict with nutrition policies and contribute to sustaining and perpetrating unequal access to a nutritionally balanced diet, food poverty and hunger.

A commendable feature of UK policies is their strong inter-departmental and inter-agency collaboration, both universal and targeted provision and a food-poverty prevention as well as alleviation focus. This has led to cross-cutting, joined-up ministerial action to address issues relating to food poverty. Much of the focus of these initiatives is the consumer and they address food choices at the point of consumption, without a broader focus on issues further back along the food production and distribution process. There are, however, community-based initiatives such as the Health Action Zones and School Meals scheme that seek to work at the structural as well as individual level.

As noted by Riches (1997) there is almost no national social policy worldwide which acknowledges its role in addressing food poverty and hunger specifically. There is therefore no example of leadership or responsibility in addressing the macro-economic determinants of food poverty and hunger. Attempts to address underlying poverty and social exclusion issues in Ireland are located within the NAPS and acknowledged within national health strategies. This present study has identified a number of policy and practice initiatives currently ongoing in the Republic of Ireland that attempt to address issues relating to social exclusion and food poverty. At the governmental level, access to food among school-going children, the development of a health service which recognises the need for community nutrition involvement among low-income groups and the provision of dietary information to children and adults are among the actions currently in place. As in the UK, much of this action is focused on the consumer as opposed to redressing the social determinants of inequality in dietary behaviour.

At a more local level within Ireland, voluntary organisations have attempted to meet the needs of specific socially disadvantaged groups. This has been done through the development of community-based programmes, the existence of a food bank and the direct provision of food to schools, each often developed and delivered in partnership with statutory agencies. Of the projects addressing food poverty identified in other rich countries, those involving communities in generating understandings and solutions to food poverty are regarded as effective tools to empower people to understand and be active in finding solutions to food poverty. However, local food production and distribution initiatives have a limited capacity to meet all of the food needs of a community. The macro-level systems of food production and distribution that create the conditions under which the majority of food is available to consumers are not addressed.

Best practice and policy can be constantly developed and implemented only through the identification of ongoing action, its strengths and weaknesses and the barriers to progress. The findings and experiences of community-based intervention and ongoing policy initiatives need to be shared in order to provide the opportunity to inform future policy and practice. Currently there is no formal mechanism through which collation, dissemination and sharing of information can take place. It is now timely that one is established which would facilitate a multi-sector, multi-disciplinary exchange of information that is critical to addressing food poverty and social inequality in dietary practices.

It must be recognised that food poverty and social inequality in dietary behaviour are related to the society in which we live and the standards of living that are enjoyed by the majority of the population. Addressing the issues of food poverty and social inequality in dietary behaviours must be initially instigated and driven through national policy. The prevention and amelioration of food poverty requires attention to be directed to alleviating both socio-economic inequality and the reasons for socio-economic variations in dietary behaviour. Different approaches are necessary for different situations. Hungry people require immediate material and practical assistance in order to avoid harm to their health and survival (Riches 1997). Social inequality on the other hand relates to the gradients observed in dietary behaviour which, whilst not requiring immediate action for survival purposes, if left long term will lead to continuing social inequality in related health and social outcomes. Such a comprehensive coordinated strategic approach does not currently exist in Ireland. Addressing this deficit will require creative mechanisms and structures at developmental and implementation level. These levels in turn, require the assembly of appropriate partnerships involving anti-poverty advocates, health, food, welfare experts and community members, at the national and local level, with a strong lead, preferably at governmental level.

Priority Areas and Recommendations

No single approach to tackling food poverty and social inequality in dietary behaviour is believed to address all the relevant issues. The general consensus from the literature (e.g. Watson 2001, Department of Health 1996) and interviews with the key Irish players is that there must be recognition of structural barriers such as trade, taxation, welfare benefits, planning and retailing, combined with the provision of information and the development of skills but without a major focus on the lifestyle issues that place the responsibility on individual and community response.

Based on the findings from this study and in line with relevant international developments, the following priority areas and recommendations are highlighted. If addressed, these issues will help ensure that all groups in society have access to a nutritionally adequate variety of foodstuffs that is financially affordable and

physically accessible and that people have sufficient knowledge, skills and facilities to make healthy food choices.

Priority Area A: Strategic Direction – Framework to Address Food Poverty

The international consensus is that a coordinated approach is critical to effect change around issues pertaining to food poverty and social inequalities in dietary behaviour. This was repeatedly mentioned in the interviews with key players and was understood to require both top-down and bottom-up approaches, with a framework developed that would support and guide it. Clearly the many issues that need to be addressed in order to prevent and reduce food poverty and social inequality in food behaviour does not fall within the remit of any one government department, sector or organisation, but rather cuts across a range. In the interviews, those agencies working with specific population groups acknowledged their role in addressing food poverty but saw their main role as advocating on behalf of their population group to address the fundamental factors affecting poverty among them. It would appear that whilst many organisations wish to contribute to a movement addressing food poverty they are not in a position to do this alone but would like to participate in a coordinated multifaceted approach. In all interviews, working in partnership was seen as essential in order to effectively tackle food poverty and in addition more formal collaboration was requested between government departments, statutory bodies and the voluntary and community sector. In this context the commitment under *Sustaining Progress – Social Partnership Agreement 2003-2005* (Govt of Ireland, 2003) to address what are identified as ‘Special Initiatives’ that include for example ending child poverty in a way that acknowledges the cross-cutting nature of these issues and the requirement to mobilise a range of resources across sectors, organisations and individuals and at different levels of Government signals a positive direction. Such an approach to tackling food poverty would greatly facilitate the development of an effective response.

The most appropriate framework within which to locate a strategy to address food poverty is the National Anti-Poverty Strategy (NAPS) and the related National Action Plan against Poverty and Social Inclusion (NAPSincl). Targets in relation to food poverty should be guided by those set out in NAPS as is the case for example in the proposed reformed School Food Programme. The implementation measures of NAPS, in particular those relating to poverty-proofing mechanisms and data and research need to be informed by an understanding of the nature and effect of food poverty. The proposed Health Impact Assessment system is another important mechanism through which food poverty can be addressed in a pro-active way. The impact of the inability to access a nutritionally adequate diet on health, culture and social participation should be understood and addressed by both of these measures.

Recommendations

- A specific food and nutrition policy is needed which has as its main objective equal access to food for all members in society. This policy should be located within the framework to address poverty set out in the NAPS. This will raise the profile and understanding of food poverty and social inequality in dietary habits and give a guiding framework for the coordinated development and implementation of national and local action. The experiences from the work currently reported on by the Diet and Low Income Team and Sustain in the UK will greatly aid in the development of this.
- A steering committee should be established to ensure the development and implementation of a strategic coordinated plan supporting the national policy and must be supported by high political commitment, support and leadership. This committee should develop from the existing interdepartmental group (comprising the Department of Health and Children, Department of Social and Family Affairs and Combat Poverty Agency) convened by the Department of Social and Family Affairs in response to recommendations within the Cardiovascular strategy.
- Appropriate partnerships should be identified at national and local level for the delivery of the strategic plan.
 - At central government level, improvement of physical access to food falls under the remit of the Departments of Agriculture and Food; Health and Children; Enterprise, Trade & Employment; Environment and Local Government. The strong influence of national and international food supply is directed through the Department of Agriculture and Food and needs to be further integrated with health and social matters. Issues relating to financial access require the involvement of the Department of Social and Family Affairs and government support for the improvement of knowledge and skills is the responsibility of the Departments of Health and Children and Education and Science. The Minister for Children clearly has a role in addressing early interventions for long-term gains. From within the statutory health services, representation from the Community Dietician service is necessary, given its practitioner perspective.
 - More generally the role of community partners, specifically local Partnerships, Community Development Programmes and City and County Development Boards, together with voluntary organisations, are important potential partners in strategies to eliminate food poverty. These actors bring with them community involvement, local knowledge and organisational capacity which are crucial to the implementation of any strategy.
 - NAPS outlines how Corporate Social Responsibility is being developed and given increased recognition in Ireland. Inclusion of corporate business in a strategic framework is necessary to address food poverty.
- A junior Ministry of Food Safety and Nutrition under the Department of Health and Children should facilitate a strong intergovernment-led commitment to addressing the inequalities in the range of issues pertaining to food poverty.

- Collaborative structures and supportive mechanisms are needed to facilitate the work of the various organisations who need to be involved in a coordinated approach to tackle food poverty and inequality in food.
- Poverty and health proofing of all policy documents, national and regional, should take place in a coordinated manner. An integrated approach is necessary to ensure that the impact on food poverty of policies from a range of sectors such as health, welfare, transport, retail and agriculture is understood and embedded. Such impact needs to be monitored and assessed using a Health Impact Assessment approach.
- Sustainable dedicated funding is needed that will adequately resource the implementation of national priority action and the necessary collaboration between sectors. No policy will succeed unless it is supported with adequate resources and so the importance of the allocation of dedicated funding for all of the recommendations set out in this report is vital.

Priority Area B: Structural issues should be assessed and developed in a manner that ensures adequate financial and resource provision appropriate for high-risk vulnerable groups.

The observed individual dietary choices, household food expenditure patterns and retail outlet usage and pricing are determined by a number of factors including structural policy matters particularly relating to issues of affordability and access to healthy food. As noted by for example Milio (1986) disposable income, education, housing conditions, employment, food supply and prices are policy issues which impact significantly on people's ability to make healthy food choices.

Food poverty and social inequality in dietary behaviour can be addressed to a certain extent using nutrition interventions and certain increases in purchasing power. However, these are limited in scope. The underlying inequality in resources must be tackled to ensure sustained nutritional and social well-being. A strategy to tackle inequalities in dietary behaviour should powerfully advocate for redistribution of wealth preferably through benefits in kind such as reduction in unemployment, adequate housing for all, equitable education and income adequacy. This requires sustainable social policy based on real costs of living. In general we would consider that guaranteeing access to an adequate income for all is preferable to a universal scheme of direct provision of food-related benefits such as food stamps. The different needs of vulnerable groups in the population such as low-income families, people who are homeless, Travellers, asylum seekers and older people have been highlighted and must be appropriately targeted as part of a multidimensional strategy. The provision of school meals is a proven beneficial support measure for children in low-income families as part of a strategy to break the cycle of poverty by supporting participation in education to enhance employment chances. The ongoing dietary programmes in schools are to be commended but need to be developed and supported nationwide as part of a long-term strategic approach. The recent review of the School Meals Scheme undertaken by the Department of Social and Family

Affairs (2003) proposed a more comprehensive School Food Programme and is very welcome. The proposals therein to put in place the resources, structures and facilities to provide meals to children in schools in adherence with criteria set out in NAPS in the short-term are strategically expedient.

Recommendations

- Welfare payments must adequately incorporate the cost of a healthy diet. The targets set out in the revised NAPS are inadequate to achieve this according to the findings of a 2002 study by the Vincentian Partnership for Social Justice (2002).
- Research needs to be carried out to determine the costs of an adequate diet for an adult and a child.
- Minimum income standards should be set having regard to a sound evidence base. The standard set should be linked to average industrial earnings rather than a value specific benchmark as trends in wage growths may render such a benchmark inadequate over the designated period of implementation.
- Minimum income standards do not take account of special needs such as where someone on a low income has special dietary requirements. These needs are currently met under the Diet Supplement scheme. Recent proposals to phase out the scheme will result in significant hardship for this group and therefore the scheme should be retained.
- The system of direct provision for asylum seekers should be abolished in line with the stance taken by the Irish Refugee Council that people seeking asylum be treated within the general social welfare schemes and be granted the right to work after six months of residency in the State.
- The School Food Programme set out in the Review of the School Meals Scheme (DSFA 2003b) should be implemented as a matter of urgency.
- In the long-term, consideration should be given to the provision of school meals on a universal basis as opposed to on a targeted basis.

Priority Area C: Making good quality, affordable food available and accessible to all groups in society

The impact of food globalisation, the Common Agricultural Policy and Irish agricultural policy needs to be understood and acknowledged within a strategic framework, with encouragement and support provided from central government for practices that strive for sustainable agriculture and rural development. Similarly, the role of food advertising and food marketing and its potential impact on different groups in society should be viewed within a strategy addressing inequalities in food behaviour and food poverty in particular.

The current approach to food supply and retail coordination in Ireland appears piecemeal and geographically disparate. The role of food supply and retail needs to be considered an integral component of a strategy addressing social inequality in food habits. Issues pertaining to food supply, food quality and physical access to

food were highlighted in the interview data. As noted by Sustain UK, locally accessible shopping can be encouraged by involving local retailers when making planning decisions and improving policing of anti-competitive practice by large stores (Watson 2001). An alternative model of shopping such as food co-ops is sporadic in Ireland and could be developed in a more coordinated and supported manner. The review of the School Meals Scheme highlighted how partnerships at the local level between schools, community organisations and businesses were an important factor in the success to date of some of the food in schools initiatives.

Recommendations

- Central government should investigate lack of coherence between CAP impact and dietary recommendations, particularly in relation to food prices and food supply.
- The Irish Retail Planning Guidelines should be adopted within a strategic framework which includes transport audits, improved infrastructure and provision of commodities in volumes accessible to the vulnerable groups, who are often single units.
- Dedicated regional funds should be made available to support innovative food production and distribution initiatives such as Food Co-operatives and local markets in areas considered to be 'food deserts'. CDPs and local partnerships are in a key position to identify the need for such provision and to have the capacity to implement such projects.

Priority Area D: Address gaps in dietary knowledge and cooking skills

The provision of accessible and culturally appropriate dietary information is critical to help maximise people's capacity to choose healthy foodstuffs. Similarly adequate access to cooking facilities and the knowledge and cooking skills required for healthy eating are crucial for implementing those choices. Addressing accommodation issues for a number of population groups will provide cooking and storage facilities and will help reduce the risk of food poverty among homeless people, asylum seekers and Travellers. Peer-led education programmes have proven to be successful methods of imparting nutritional information and cooking skills to socially disadvantaged groups. Formal approaches to the development of this knowledge base and skills should also be utilised, through integration into the school and continuing education setting.

Recommendations

- Strategic objectives to identify and address gaps in dietary knowledge and required skills, plus a comprehensive action plan, should be an integral component of a food and nutrition policy.
- Ensure materials are developed which are culturally appropriate. The materials developed under the Primary Health Care Project for Travellers represent an example of good practice in this area.
- Integrate cooking skills and dietary information into educational curriculum.

- Build upon current initiatives delivered through the regional health authority community dietician service, to provide community-based nutrition training programmes into out-of-school settings.

Priority Area E: Support and adequately resource community development and locally based initiatives

The importance of community-based action for increasing access to food at a number of different levels is acknowledged and further support of these is strongly advocated. It should not, however, be considered the solution to food poverty (Watson 2001). Community action cannot be expected to overcome structural problems in accessing good quality, affordable food but should be part of an inclusive approach addressing both poverty and the wider food system (Reisig and Hobbiss 2000). The reduction in food poverty and social inequalities in dietary habits depends to a great extent on the development of skills to support the implementation of policy initiatives and to ensure best practice. This research has shown the little experience that exists in Ireland in multisectoral and multidisciplinary working between the food, health and community sectors. However, there is the emergence of health onto the community development agenda, evident in the recent Healthy Communities programme launched by the Combat Poverty Agency. The training of health and community workers with skills necessary for community development and health promotion is central to effective intervention. At the local level the role of local food companies is key in addressing food poverty and food needs.

Recommendations

- Priority should be given within the Healthy Communities programme to community action which addresses food-poverty issues.
- Provision of adequately resourced, quality training in skills required to disseminate effective community intervention and to provide professional training and expert knowledge is necessary.
- Sustainable local food partnerships should be supported and could identify local needs and possibility for action.

Priority Area F: Improve the quality and extent of direct food provision

As highlighted in the literature review, addressing food poverty through food surplus intervention should not become an institutional remedy. Rather, the development and monitoring of direct provision of food needs to be located within a strategic framework addressing food poverty and social inequality in diet. Often the type of food donated to the Irish food bank includes convenience and prepackaged foods such as dried soup, tinned food and sandwiches. These foods are often high in saturated fat and low in nutrient density and do not meet all nutrient needs if they are the sole source of nourishment. The motivation to private industry to make social contributions is the notion of social responsibility in the community and there is a need to develop such a culture in the market place. The food bank gives the food

industry the opportunity to do this via a mechanism that directs food to groups in need. NAPS outlines how Corporate Social Responsibility is being developed and given increased recognition in Ireland.

The provision of meals-on-wheels and similar services should be extended and should conform to agreed nutritional standards. Nutrition guidelines for schools have been developed in Ireland but are not mandatory and in nursing homes and other institutions there is need of reform in terms of availability and standard of nutritional meals to all and incorporating nutritional guidelines in menu planning. The implementation of the HACCP system for safe food by the Food Safety Authority in collaboration with the health boards' Environmental Health service represents a model for the implementation of minimum nutritional standards. In addition the development of Nutritional Standards for School Meals as part of the review of the School Meals Scheme (DSFA 2003b) represents a model for the development of nutritional standards for meals provided in other settings.

Recommendations

- In the development of a strategy to address food poverty, direct food provision should be part of but not the central focus.
- Good practice in corporate business efforts to address food poverty should be explored and promoted under the NAPS framework. In particular where businesses wish to make food donations to either food banks or organisations providing meals to those at risk of food poverty, a policy of committing defined units of the highest value food products should be pursued. Contributions should be negotiated between the corporate giver and the voluntary recipient to ensure maximum value from the endeavour.
- Minimum nutritional standards should be set for each meal delivered by statutory or voluntary services targeted at those at risk of food poverty.
- The implementation of these minimum nutritional standards should follow the model of the HACCP system for safe food, and should be coordinated by the Department of Health and Children with the health boards' Community Nutrition and Dietetic service as key partners in the implementation of this recommendation.

Priority Area G: Research, Information and Evaluation

There is a dearth of evidence-based information specifically relating to food poverty in Ireland. More research is required to investigate each of the priority areas and their relationship with food poverty and social inequality in food. A greater understanding and recognition of food poverty and social inequality in food is needed among policy makers, service providers, voluntary organisations, and consumers. Whilst not a specific remit of this study, there appears to be little evaluation of the work currently ongoing to address food poverty and as a result there is little evidence as to whether the approaches being used are evidence-based and the most effective in the Irish context. Guidelines for food poverty intervention work would greatly assist

in the development and implementation of new initiatives. Criteria for monitoring and evaluating such work are needed in order to determine progress and should be developed in consultation with researchers, community programmes and policy makers.

Recommendations

- A food poverty network should be established which maintains a database of related activities and resource materials. Such a network will provide a forum for exchange and dissemination of information and hence support collaborative working and good practice.
- Ongoing evaluation needs to be an integral part of each component of a strategy to address food poverty.
- Building on the ongoing research to determine the cost of healthy eating in Ireland, data collection systems should be developed which allow for the ongoing assessment and monitoring of the cost of an adequate diet.
- Research evidence on the cost of a healthy diet must inform the setting of minimum income standards.
- On-going data collection and analysis on dietary behaviour and social inequalities in dietary behaviour is necessary. In 2001 the Minister for Health and Children set up a steering group to produce the National Health Information Strategy to act as a blueprint for gathering and using information for health. It is regrettable that as yet this strategy is not developed. It is recommended that food and nutrition consumption patterns be incorporated as a theme in the forthcoming strategy.

Conclusion

This research is a critical first step in attempting to assess the Irish situation with regards to policy response to food poverty and social inequality in dietary behaviour. Whilst it is by no means an exhaustive search, encouragingly there has been commendable action by various sectors in attempting to reduce the risk and inequity. However, there has been a clear lack of coordination and strategic direction; it remains that certain groups in the Irish population are at risk of food poverty and that wide social gradients exist in individual and household level food and nutrient patterns, health consequences and social participation. Building on this information base and having identified the gaps, it is now timely that a coordinated comprehensive policy approach to food poverty is developed involving key players from a policy, practice, research and consumer perspective. A strategic framework is needed which is underpinned by minimum income standards, which is not direct-provision focused, which sets out minimum nutritional standards, which endorses community development and partnership approaches and which makes explicit each stakeholder's role and responsibility in implementing such action.

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Appendices

Appendix One: Collation and Analysis of Existing Food Data

The data collation component of the research study is concerned with documenting the nature and extent of social inequalities in dietary habits and of food poverty in the Republic of Ireland, using existing national, regional and local data sources.

There are four main research questions driving this analysis:

- What are the dietary patterns in relation to socio-economic circumstance?
- Is this pattern the same at the household expenditure and individual consumption levels?
- What are the social and psychosocial influences and outcomes in dietary behaviour among low-income groups?
- What is the extent of issues relating to access, availability and affordability of food?

The measurement of social group differences in dietary behaviour is necessary in order to obtain a deeper understanding of the underlying contributing factors to the resulting inequality in outcomes and hence facilitate an appropriate response (Murray *et al.* 1999). A range of social status indicators is necessary for population health and nutrition monitoring purposes; using a range of indicators, each relating to different aspects of social status, has identified consistent social gradients in dietary behaviour, both in this research and that published internationally (Dubious and Girard 2001). Individual and household measures capture different facets of social inequity in health and dietary habits (Manor *et al.* 1997, Galobardes *et al.* 2001). Each of the different measures of socioeconomic status – occupation, education and income – explains 25 different components and contributes differently to health and related risk inequalities (Galobardes *et al.* 2001, Macintyre 1994).

Various sources of information are drawn upon to investigate the above questions. Secondary analysis is performed on data sets generated by the Centre for Health Promotion Studies, NUI, Galway which contain key information and allow us to build up a picture of the nature and extent of social inequality in food habits in Ireland, incorporating the range of factors affecting food poverty. Information is also obtained from published national and regional reports and peer-reviewed literature on data relating to the Republic of Ireland. Details of the data sources are referred to under each research question heading below.

- *What are the dietary patterns in relation to socio-economic circumstance?*
Variation in individual level food and nutrient intake is investigated by social class, level of education, medical card ownership, employment status and home ownership using the national health and lifestyle survey (SLAN) data set which relates to the general adult population throughout the Republic of Ireland (CHPs

1999). A similar secondary analysis of the SLAN data is also presented for rural respondents only. Published information from the Health Behaviour in School Children Survey (CHPs 1999) is also used to identify variation in dietary behaviour among children in different social class groups. Reference is made to SLAN, the Food Safety Authority of Ireland (2000) and Layte *et al.*'s work (1999) for information on the food and nutritional intake among older people. Details on the dietary behaviour of specific low-income groups is obtained from SLAN and also collated from published literature and presented for people who are unemployed (Lee and Gibney 1989), people who are homeless in Galway (Walsh 2002) and Dublin (Hickey and Downey 2003), the Traveller community (McNamara 1995, McDonnell and Mac Diarmada 1995) and asylum seekers (Faughnan and Woods 2000, Fanning *et al.* 2001a, 2001b).

■ *Is this pattern the same at household and individual level?*

Food expenditure and purchasing behaviour of different social categories of household (social class, income level, employment status, household tenure and locality of residence) is examined using published information from the national Household Budget Survey 1999-2000 undertaken by the Central Statistics Office (CSO 2002).

■ *What are the social and psychosocial influences and outcomes in dietary behaviour among low-income groups?*

Information from published qualitative research studies into the social and psychosocial issues affecting food behaviour of low-income mothers and households is presented. Findings from Coakley (2001), Moloney (2001), the Vincentian Partnership for Social Justice (2002) and Daly and Leonard (2002) provide information on the economic, social and psychosocial factors related to dietary choices among these groups in Irish society.

■ *What is the extent of issues relating to access, availability and affordability of food?*

An investigation into the types of retail outlet present in the national Irish market, identification of the prices of foods found in those outlets and the type of outlet most commonly used by different socio-economic groups is undertaken using information from the National Nutrition Surveillance Centre, NUI, Galway database (primarily Checkout Ireland 2002 publications). Research findings published by Daly and Leonard (2002) also provide further information on the types of outlets used by low-income households.

Appendix Two: Representatives of 19 Organisations Interviewed for Study

- Combat Poverty Agency
- Community Dieticians of Mid-Western, North Eastern, North Western and South West Area Health Boards
- Crosscare
- Department of Education and Science (Social Inclusion Unit)
- Department of Health and Children (Consultant Community Nutritionist)
- Department of Social and Family Affairs (Supplementary Welfare Allowance Section)
- Department of the Environment (Planning Unit)
- Focus Ireland
- Food and Drink Federation, IBEC
- Food Safety Promotion Board
- Health Promotion Manager, Mid-Western Health Board
- Irish Refugee Council
- Killorglin Day-Care Center, Market St., Killorglin, Co. Kerry
- National Council on Ageing and Older People
- Primary Health Care Programme, Pavee Point
- Society of St Vincent de Paul
- Southhill Food Co-Op, Southhill CDP
- St Vincent de Paul Hostel, Back Lane, Dublin 8
- St Vincent de Paul Hostel, Limerick

Appendix Three: Review Forum on Policies Impacting on Food Poverty in Ireland

Thursday, 27th March, 2003: List of Attendees

Name	Organisation
Orla Walsh	Centre for Health Promotion Studies, NUI Galway
Sharon Friel	Centre for Health Promotion Studies, NUI Galway
Dr Tony Parker	Centre for Retail Studies, University College Dublin
Fiona Kelly	Centre for Retail Studies, University College Dublin
Jim Walsh	Combat Poverty Agency
Fidelma Joyce	Combat Poverty Agency
Anne Miller	Combat Poverty Agency
Jack Dunphy	Crosscare
Helen Daly	Crosscare
Denis O'Callaghan	Dublin Food Bank
Clare Hickey	Focus Ireland
Dáithí Downey	Focus Ireland
Mamar Merzouk	Focus Ireland
Marian Byrne	Food Division, Department of Agriculture, Food and Rural Development
Christine Gurnett	Health Promotion Department, Mid-Western Health Board
Aoibheann O'Connor	Health Promotion Department, South Western Area Health Board
Gillian Farren	Health Promotion Department, South Western Area Health Board
Margaret O'Neill	Health Promotion Department, South Western Area Health Board
Dr Kevin P. Balanda	Institute of Public Health
Janis Morrissey	Irish Heart Foundation
Helen McEvoy	National Council on Ageing and Older People
Caroline Mullen	Primary Health Care Programme for Travellers, Pavee Point
Biddy Collins	Primary Health Care Programme for Travellers, Pavee Point
Dr Geraldine Quinn	Scientific and Technical Food Safety Promotion Board
Patricia O'Connor	Social Inclusion Unit, Department of Education and Science
John Mark McCafferty	Society of St Vincent de Paul
Bernadette MacMahon	Vincentian Partnership for Social Justice
Catherine Conlon	Women's Education Research & Resource Centre, University College Dublin
Tony Weekes	

Appendix Four: Policy Responses to Food Poverty in Ireland Interview Schedule

Thank you for agreeing to participate in this study of policy responses to food poverty in Ireland. The study is being undertaken by the Centre for Health Promotion Studies, NUI, Galway, and the Women's Education, Research and Resource Centre, UCD on behalf of the Combat Poverty Agency in partnership with Crosscare and the Society of St Vincent de Paul.

Briefly, the aim of the study is to examine and make recommendations on policy responses to food poverty in Ireland. An integral part of this study is a series of interviews with key individuals in order to identify and assess current policy and practical responses to food poverty by governmental and non-governmental bodies, agencies and organisations.

Research findings will be used by the Combat Poverty Agency and research partners to help inform their thinking, practice and policy recommendations in relation to addressing food poverty issues in the Irish context.

When responding to questions please be aware that there are no right or wrong answers. Also, please include in your responses any and all information that you believe is relevant, even if not specifically asked for.

Catherine Conlon, WERRC, UCD will conduct the interview which will take about forty-five minutes. The interview will be structured along the format of the questions set out below.

The information collected from these interviews will be collated to provide an overview of the current position in relation to food poverty in Ireland under the following headings:

- Recognition and definitions of food poverty
- Factors contributing to food poverty and associated risk groups
- Initiatives and actions addressing food poverty currently in place
- Framework for policy development in terms of strategies, goals, actions and stakeholders.

If you would like any further information or clarification in relation to the research or the interview prior to our meeting please contact me at 01-716 8550 or catherine.conlon@ucd.ie.

Thank you again for your kind assistance with this research.

Schedule of questions

Section 1: Recognition and Definitions of Food Poverty

In your opinion, to what extent is food poverty recognised by your organisation?

What does your organisation understand by food poverty – do you have a working definition of food poverty and if so, what is it?

What, in your view, are the factors contributing to food poverty or an increased risk of food poverty in Ireland?

Do you identify any particular individuals and/or groups as at risk of food poverty?

Section 2: Current Policy Frameworks

Does your organisation currently have in place, or work within any strategies or policies to address food poverty?

Are these strategies or policies central or peripheral to the work of your organisation?

What are the strengths and weaknesses of these strategies or policies?

Section 3: Current Initiatives

Is your organisation involved in providing or funding any services or initiatives to address food poverty?

Are services or initiatives to address food poverty a central or peripheral function of your organisation?

What, if any, other partner organisations are involved in these initiatives and what is their role?

Section 4: Developing a Framework for Policy on Food Poverty

In your field, what strategic direction should future policy take to alleviate food poverty?

What recommendations would you make for future policy goals and actions at local and national level to address food poverty?

What methods should be employed to implement these actions, e.g. top-down, bottom-up?

Do you see a need for linkages between different agencies and sectors to address food poverty and if so what form could these take?

Would you consider public-private partnership a valuable strategy?

Finally

Are there any other initiatives you are aware of in this area?

THANK YOU

Food insecurity and inadequate diet are central to the experience of poverty. Yet, this aspect of poverty has frequently been neglected in Ireland, in comparison with the absolute hunger prevalent in third world countries. This study, an initiative of Combat Poverty, Crosscare and the Society of St Vincent de Paul, heralds a new understanding of food and nutrition issues in low-income households, based on the concept of food poverty. The study reviews evidence about the food and nutrition intake of low-income households, highlighting various structural barriers which restrict access to an adequate and nutritious diet. The study also considers the limited policy responses to food poverty and, drawing on international experience, identifies a coordinated strategy for ensuring an adequate and nutritious diet in low-income households.