Reducing harm through food and work: incorporating food security and peer employment in harm reduction programming

by

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Abstract

Food is usually provided in harm reduction settings, like needle exchanges, low-barrier shelters, and drug consumption rooms. These spaces are often staffed by people who use drugs (PWUD) and/or living with HIV/AIDS (PLWHA) who serve their peers. Yet, there is little comprehensive discussion of how food and peer work fit into organizations with a harm reduction orientation (OHRO) for low-income PWUD/PLWHA. Drawing on 27 semi-structured interviews with OHRO in Greater Vancouver, Canada, this thesis explores the variegated regional landscape of food, peer work, and harm reduction using literatures on harm reduction, poverty management, the shadow state, and foodscapes. Results demonstrate that OHRO are important nodes in low-income PWUD/PLWHA foodscapes, but that they do not systematically integrate food programming with their harm reduction philosophies. Similarly, peer employment is widespread, but organized in ways that can compromise harm reduction goals. I conclude with recommendations to improve food access, and employment for PWUD/PLWHA.

Keywords: foodscapes; harm reduction; social services; poverty; urban geography; Greater Vancouver

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Chapter 1.

Introduction

Everyone has a basic need for nutrition, however, some people are more readily able to meet this need than others. Low-income people who use drugs (PWUD) living with HIV/AIDS often face limited opportunities and resources to purchase and prepare their own food, experiencing high rates of food insecurity and related physical and emotional effects. This leads some social services providers step in to fill this nutritional gap. In particular, service providers who orient themselves around harm reduction principles and programs can act as important nodes in "geographies of survival" (Mitchell & Heynen, 2009, p 612) for PWUD who use their services in order to get harm reduction supplies (e.g. safer crack smoking kits, and clean syringes) and low-barrier services like needle exchanges, supervised injection sites, health clinics, emergency shelters, supportive housing, drop-in programming, and mental health support (Griffiths, 2002; Walthers, Weingardt, Witkiewitz, & Marlatt, 2011; McNeil, Shannon, Shaver, Kerr, & Small, 2014a). Food is prevalent in these spaces, serving to mitigate some of the most acute effects of food insecurity for PWUD, however, the relationship between food and harm reduction services has not been systematically examined.

Many low-income PWUD, some of whom are living with HIV/AIDS in Greater Vancouver, Canada not only rely on harm reduction-oriented services to meet their survival needs, but also as a source of income to supplement welfare benefits through compensated volunteer and staff positions. PWUD in these situations are simultaneously participants and workers. Their roles as 'peer' workers are indicative not only of the need for appropriate employment for this group of vulnerable people, but also broader patterns in the harm reduction service provision sector.

Vancouver's social services landscape has been the subject of numerous academic studies (e.g. Kerr, Craib, Gataric, & Hogg, 2002; Wood, Zettel, & Stewart, 2003; Harvard, Hill, & Buxton, 2008; Shannon, Rusch, Shoveller, Alexon, Gibson, & Tyndall, 2008; Boyd, MacPherson, & Osborn, 2009; Roe, 2009; Miewald, Ibañez-Carrasco, & Turner, 2010; Rhodes, Wagner, Strathdee, Shannon, Davidson, & Bourgois, 2012; Miewald & Ostry, 2014; Drabble, 2015; McNeil, Cooper, Small, & Kerr, 2015). And, while there are studies of how PWUD in Vancouver's Downtown Eastside experience food in their neighbourhood (Miewald et al., 2010; Miewald & McCann, 2014), the ways in which organizations with a harm reduction orientation (OHRO) understand their roles within these geographies of survival is understudied, particularly when it comes to food. With these factors in mind, this thesis teases out the relationships between OHRO and their participants as they relate to harm reduction, food security, the shadow state, and poverty management. OHRO are situated at the centre of these interrelated phenomena, government policies, relationships with other service providers, and the needs of their participants. At the same time, they also shape the experiences, and livelihoods of their participants, both as they access services and sometimes as peer workers who facilitate the provision of harm reduction and food services in these spaces.

Throughout this thesis, I endeavour to use the most specific term between PWUD and PLWHA (or both) for the focus of the literature, or organization being discussed. Depending on the organization interviewed, they may be organizations specifically for PWUD of whom a subset are HIV+; they may be an organization for PLWHA of whom a subset are PWUD; or they may be organizations for low-income, street-involved, or otherwise marginalized populations of whom some are PWUD and/or PLWHA. Further, these organizations may share participants who access multiple organizations with a range of mandates that fit various aspects of their identities, including their income, housing status, substance use, ethnicity, and HIV status. Some issues, such as food insecurity affect all of these groups, while other issues, like injection-related harms are more strongly a concern for PWUD than for other low-income, marginalized populations. As a result, I mention both groups when discussing issues that can be shared by people in those populations, and either PWUD or PLWHA when it is a more specific concern for one or the other population. The overlap between

PWUD who are also PLWHA that results in intersections of the health-, and food-related concerns that stem from drug use, and being HIV+ mean that it is particularly urgent, and difficult to support food security for these groups.

I now turn to my research objectives, followed by a brief overview of my overarching conceptual framework that guides my analysis of food provisioning and peer work in OHRO in Greater Vancouver.

Objectives

I focus on the relationships, networks, landscapes, and foodscapes that are experienced, and created by OHRO who serve low income PWUD and/or PLWHA. In order to investigate these relationships, I investigated how OHRO in Vancouver and Greater Vancouver conceptualize food as it relates to their programming, and what barriers and opportunities exist to providing regular, healthy, and appropriate food. Further, I sought to understand how these services are provided through the people working in harm reduction environments, as well as the opportunities, and barriers they experience.

With these aims in mind, my research objectives are to:

- **Determine** where harm reduction organizations are located in Greater Vancouver, and if they provide food as part of their programming.
- **Inquire** why, how, and where food is provided in OHRO in Greater Vancouver.
- **Investigate** what opportunities, and challenges exist for providing food and peer employment in harm reduction environments.
- **Explore** who provides food, and other services in OHRO in Greater Vancouver.
- **Conceptualize** the implications of incorporating food and peer work into a harm reduction paradigm.

From these objectives stems my conceptual framework, guiding my areas of focus, and analysis for my empirical research in Greater Vancouver's harm reduction foodscape.

Conceptual framework

Harm reduction

Harm reduction addresses high risk relationships with drugs by targeting immediate risks first, such as providing clean injection equipment to reduce rates of abscesses and blood-borne disease transmission, or treating urgent health conditions (Bourgois & Schonberg, 2009). Theoretically, once an individual's immediate situation is stable, they can move on to address other parts of their life that cause more long-term harm, such as attaining stable employment, and adhering to medication. Harm reduction philosophies assume that these behaviours are part of the human condition and, therefore, it is most important to focus on ensuring the highest possible quality of life as defined by individuals themselves (Collins, Clifasefi, Logan, Samples, Somers, & Marlatt, 2011). All of the organizations that I interviewed for this project were harm-reduction oriented, meaning that they did not require abstinence from drugs and alcohol in order for participants to receive, or maintain access to services. Harm reduction is an official part of British Columbia's health policy and health authorities are required to provide harm reduction supplies and support harm reduction services, although the extent to which they do both varies greatly across the province (Harvard et al., 2008; Longhurst & McCann, 2016). As a result of this policy, almost all of the OHRO in Greater Vancouver provide harm reduction supplies like sterile syringes of varying sizes, alcohol swabs, and purified water packets. These practices are seen by OHRO as standard, and largely uncontroversial.

In academic literature, engagement with harm reduction tends to come from public health approaches focusing on HIV transmission rates, and therapeutic strategies for health practitioners (e.g. Kerr et al., 2002; Wood et al., 2003). However, the work most heavily informing my understanding of harm reduction in this thesis comes from work examining harm reduction as a response to illicit drug use by, and within institutions and service providers. For example, 'housing first' is a harm-reduction oriented approach to housing that addresses basic needs for shelter before addictions (e.g. Padgett, Gulcur, & Tsemberis, 2006). Additionally, policies and practices within

institutions like health authorities can impact health equity for marginalized people (Pauly, MacDonald, Hancock, Martin, & Perkin, 2013).

Even within harm reduction frameworks for reducing blood-borne disease transmission, however, different groups have different harm reduction needs. For instance, gay men and PWUD face different risks and therefore have different harm reduction needs (Kerr, Ibañez-Carrasco, & Walsh, 2001). Similarly, indigenous women living with HIV in British Columbia face worse HIV-related health outcomes because they fear rejection and stigma from healthcare workers, and are therefore less likely to seek, and maintain HIV treatment (McCall & Pauly, 2012). Place is also tied to both HIV risk and harm reduction service needs in areas such as improving access to harm reduction organizations that are located in areas perceived by PWUD as dangerous (Shannon et al., 2008).

However, literature about harm reduction and harm reduction-oriented programming does not often mention food as a harm reduction intervention, despite its clear role as an immediate condition that could be improved with direct food provision (see Kerr et al., 2002 for an exception to this trend). With this context in mind, I also use literature about food security and the geographical concept of 'foodscapes' to better understand how food might fit into sites of harm reduction service provision.

Food security and foodscapes

Earlier geographical work on food security forwards the concept of 'food deserts,' or "places where the transportation constraints of carless residents combine with a dearth of supermarkets to force residents to pay inflated prices for inferior and unhealthy foods at small markets and convenience stores" (Short, Guthman, & Raskin, 2007). Although useful for examining disparities in food access for different neighbourhoods with different socioeconomic demographics in a spatialized way, food deserts literature neglects to look at individual and experiential factors impacting food access, such as feelings of safety, the impacts of health on food choices, and the ability to store and prepare food. Furthermore, examining only the locations of food retail outlets does not take into effect different ways of obtaining food, and the ways in which obtaining food fits

into daily geographies of survival amongst other activities (Bedore, 2010; Cannuscio, Weiss, & Asch, 2010; Alkon, Block, Moore, Gillis, DiNuccio, & Chavez, 2013).

Instead, the geographical engagement with food on which I draw most strongly for this thesis is a foodscapes approach, encompassing "the situated and relational geographical context of food distribution within a particular landscape" (Miewald & Ostry, 2014, p 722). A foodscapes understanding highlights the ways in which individuals navigate and negotiate the urban food environment. As such, individuals co-create the urban foodscape with the institutions in which they procure their food, in this case, harm reduction organizations. Yet, my research suggests that, despite acting as important nodes in these foodscapes, OHRO do not think of themselves as key food providers for their participants. This leads, to some conditions on which I elaborate in Chapter 3.

The shadow state

As well as acting as nodes within low-income foodscapes for PWUD and/or PLWHA, OHRO also play a mediating role between the state, and their participants. The shadow state is a way of understanding the relationship between the State, and institutions that provide social services, (in this case, OHRO in Greater Vancouver) and their participants. Shadow state literature understands the way these relationships are expressed stems from government retrenchment from service provision and subsequent rolling out of programs and policies that fund non-governmental organizations to take on providing social services (Wolch, 1990; Trudeau, 2008; Bowlby & Lloyd Evans, 2011). Wolch explains the shadow state as "…a para-state apparatus comprised of voluntary organizations… administered outside of traditional democratic politics. It is charged with major collective service responsibilities previously shouldered by the public sector. Yet it remains within the purview of state control" (Wolch, 1990, p 4). This perspective is useful for my thesis because while harm reduction for illicit drug use and HIV has its origins in grassroots movements, it is a formalized state strategy in British Columbia. The Provincial government funds distribution of harm reduction supplies, and health authorities are required to support harm reduction services (Harvard et al., 2008). However, provision of harm reduction supplies and other low-barrier services is carried out in non-governmental settings, a clear shadow state relationship.

Since the 2000s, the shadow state has become the established stop-gap for state retrenchment from service provision for those who cannot afford private services (Bowlby & Lloyd Evans, 2011). The time that has elapsed between the birth of the shadow state in the mid 1980s, and its current form allows for researchers to study the effects of these changes in service provider structure longitudinally. For instance, Trudeau (2008, 2012) examined how shadow state organizations are simultaneously sites of state-imposed regulation and control that limit potential for activism, but are also actors that can shape, influence, or resist those same regulations. Similarly, Hogg & Baines describe how acts of resistance to state pressure in the voluntary sector produce spaces of hope (2011). Fraser & Kick demonstrate the maturation of the shadow state by examining a neighbourhood renewal non-profit created through a public-private partnership to further the entrepreneurial goals of the municipality and developers (2014). Voluntary sector service providers are aware of the pressure to become more entrepreneurial and express concern that it will spur the loss of their institutional characters and relationships with their clients (Hogg & Baines, 2011).

There are several side effects of shadow state relationships that are important for understanding how these relationships impact OHRO, their peer workers, and their participants. For instance, although the number of voluntary sector services increased due to restructuring that formed the shadow state in the 1970s and 1980s, restrictions, and higher eligibility requirements reduced the overall number of people accessing services (Wolch, 1990). Even as costs for social services programming increase (e.g. food costs), funding for the shadow state does not have to increase. Organizations are under pressure to provide the same, or better services for the same, or lower price because their funders can choose to fund another organization if they do not. If service quality decreases, it is harder to hold funders accountable, and they can penalize service providers for not providing the quality of services demanded. However, for some organizations, resources have increased as part of the shadow state (Trudeau, 2012) through strong ties between service providers, and government funders (Bowlby & Lloyd Evans, 2011).

Furthermore, staffing in the shadow state tends towards more flexible labour (Wolch, 1990). For example, working conditions are often worse in the shadow state

than in the public sector because, although the State funds the shadow state, it does not have to provide the same wages or benefits and can choose not to increase funding, essentially freezing wages (Wolch, 1990; Baines, Hardill, & Wilson, 2011). Stagnant wages for both peer and non-peer workers were reported by multiple service providers in my study. Interviews suggested that these conditions added stress to the organizations and the individuals that comprise them. Additionally, the shadow state engages more volunteers, another form of flexible labour. In Greater Vancouver, although most organizations engage peer volunteer labour, it is not solely to reduce costs. Indeed, other scholars have noted that increasing volunteer labour in the shadow state may not result in cost savings, due to increased paid staff time to recruit, and manage a more professionalized, formalized volunteer workforce (Bowlby & Lloyd Evans, 2011).

The ambiguous, and hybrid natures of many shadow state organizations, where lines between employer, staff, volunteers, and participants lead to a sector that can be flexible and responsive to needs. Bowlby & Lloyd Evans (2011) note that there is relatively little academic scholarship on the effects of shadow state relations on the paid and unpaid non-profit workforce, a gap that they address, and to which I also contribute. They also employ a relational understanding of labour in the shadow state following Trudeau's (2008) framework highlighting the multiple, and contradictory interactions between actors based on the tenets that influence is multidirectional, multiscalar, and embedded in (social) place.

Spatializing poverty management

Poverty management is a complementary framework to the shadow state because it is also useful for understanding how social services interact with their participants, and the state. Poverty management as a concept comprises "the creation of spatial and temporal structures designed to regulate and manage the spillover costs associated with so-called disruptive populations" (DeVerteuil et al., 2009, as cited in DeVerteuil, 2015, p 47; see also DeVerteuil & Wilton, 2009; Fairbanks, 2009; Roe, 2009). The participants who rely on OHRO in Greater Vancouver often have very limited resources, even to meet their basic needs. As such, they regularly rely on low-barrier service providers for things like food, shelter, and healthcare. Consequently, service

providers have a strong role in shaping how low-income PWUD meet their needs. How this role is manifest cannot be taken for granted, however. As DeVerteuil (2015) notes, service providers' relationship to participants tends to be a supportive one, but it is possible that it may also be punitive in certain circumstances. The question of how service providers provide for their participants is, therefore, an open empirical one that demands research. After all, service providers themselves are shaped, and managed by the shadow state relationships detailed above. As a result, workers, managers, and directors of these sites also experience difficult, fluctuating, and sometimes adverse conditions in the form of low levels of funding, restrictive policies, tight funding cycles, and monitoring from regulatory branches of government, such as WorkSafe BC.

Related to the idea of poverty management are risk environments, and therapeutic landscapes. Risk environments are spaces "... in which a variety of factors interact to increase the chances of harm occurring" (Rhodes, 2009, p 193; Rhodes et al., 2012, p 208). Risk environments exist at scales from micro (e.g. places where people inject drugs) to macro (e.g. societal stigma, and drug law enforcement) (Rhodes, 2009). For research examining conditions faced by particular groups of people, like people living with HIV/AIDS who also use drugs, a risk environment and social epidemiology approach can be useful because it can illustrate how structural violence and vulnerability differentially impact health (Rhodes et al., 2012). Risk environment literature can be critical of harm reduction approaches, seeing them as manifestations of biopower that attempt social regulation of danger (Rhodes, 2009). For instance, methadone maintenance is critiqued by some for causing physical cravings and withdrawal symptoms that are stronger than heroin but without the euphoria of heroin use (Bourgois & Schonberg, 2009).

A disadvantage a risk environments lens is that it is overly focused on harms and risks and does not see the aspects of environments that can enable safety, harm resistance, and resilience (Rhodes, 2009; Rhodes et al., 2012). Shannon and colleagues advocate for "safer environment interventions" (2008, p 145) as one way to shift this emphasis to one more focused on safety. A therapeutic landscapes approach is another way of examining the urban environment with its beneficial aspects in mind.

Therapeutic landscapes are similar to risk environments in the sense that they deal with the environmental factors impacting individual, and population wellbeing. A therapeutic landscapes perspective understands that OHRO are sites of care for their participants. These sites can contribute to therapeutic landscapes, which can be understood as "... places, settings, situations, locales, milieus that encompass the physical, psychological, and social environments associated with treatment or healing" and have enduring physical, psychological, and spiritual healing characteristics (Williams, 1999, p 2, as cited in Wilton & DeVerteuil, 2006, p 650). While this area of study began by examining exceptional places known for healing, like pilgrimage sites, the field has expanded to include therapeutic landscapes analyses of everyday places that acknowledge embodied experiences of place (Masuda & Crabtree, 2010). Importantly, these healing qualities are relationally-produced, contested, and contingent on social position.

Wilton and DeVerteuil note that drug and alcohol treatment occupy only a marginal place in health geography literature (2006). They found aspects of therapeutic landscapes in abstinence-based social model alcohol recovery facilities, which had cultivated this landscape over time by expanding their services to encompass multiple sites. This therapeutic landscape is not, however, a simple aggregation of sites of care. It is experienced and produced at multiple scales, it may not always result in positive treatment outcomes, and, in a drug and alcohol treatment landscape, its sites of care may also be sites of restriction, and control (Wilton & DeVerteuil, 2006).

Complementing risk environments approaches, therapeutic landscapes can be applied to studies of marginalized groups in order to better understand place-specific experiences of healing (Wilton & DeVerteuil, 2006). Masuda and Crabtree attempted to investigate how the therapeutic qualities of landscapes of deprivation in Vancouver's Downtown Eastside were produced as resistance techniques against oppressive social, economic, and political structures (2010). Place-making strategies and the narratives they employ work as tools for producing the therapeutic landscape and public perceptions of residents of this landscape. They used photographs of both therapeutic, and harmful aspects of the neighbourhood, as identified, and photographed by community residents, with the goal of developing a "counter-hegemonic knowledge"

(Masuda & Crabtree, 2010, p 661). This alternative knowledge could be used to assert community goals and values in urban planning processes that traditionally defer to 'expert' knowledge and can result in gentrification and the elimination of therapeutic public gathering places for the local community. In addition to identifying several therapeutic and non-therapeutic qualities of the Downtown Eastside, Masuda and Crabtree (2010) illustrate how collective processes of place-making and reclaiming space can be therapeutic practices of solidarity in a marginalized neighbourhood. In focusing on the benefits and healing qualities of the urban environment, a therapeutic landscapes approach addresses the overemphasis on harm that is seen in risk environments approaches.

However, therapeutic landscapes literature can be inadequate for balancing the risky, and therapeutic aspects of different sites, spaces, and scales (Wilton & DeVerteuil, 2006). Over the past decade, therapeutic landscapes literature has expanded to include examination of scale, and the negative aspects of therapeutic landscapes. For instance, Masuda and Crabtree use the neighbourhood scale, as well as the urban scale, and investigate the balance between negative aspects of the Downtown Eastside landscape, along with those aspects that are therapeutic and emancipatory (2010). A better recognition of the relational power at play in particular places can be useful for uncovering the intertwined power and collective memory that constitute particular places, including therapeutic landscapes (Wilton & DeVerteuil, 2006).

The interplay of risk environments and therapeutic landscapes highlights how OHRO can have aspects of care, healing, risk, danger, and harm all at the same time. This complicated understanding of service provision environments is necessary to understand their roles in the lives of their participants. Although they may be places where participants experience trauma, violence, exploitation, and control, OHRO may also be sites of care, sustenance, and employment.

Thesis organization

This thesis is written in a paper format, with a methods chapter, two journal-style empirical papers with a short bridging section connecting them, and a concluding

chapter that synthesizes the ideas of both papers. Throughout this thesis, I draw on harm reduction, foodscapes, shadow state, and poverty management literatures in order to conceptualize how OHRO relate to my two paper topics: food programming, and peer work. Harm reduction, and foodscapes literatures are useful for contextualizing the service provided by these organizations. Through understanding the philosophical underpinnings for harm reduction-oriented service provision, and the interaction between individuals, organizations, food, and environment, I am able to theorize how these features work in the Greater Vancouver harm reduction foodscape. Shadow state and poverty management work provides a framework for understanding how OHRO organize themselves, providing the crux of my analysis of their food, and peer employment programming. Both shadow state, and poverty management literature are also important in constructing my understanding of how OHRO shape, and are shaped by their relationships with their funders (often the state), and their participants.

I elaborate on these ideas in subsequent chapters. I build upon my methodological approach to investigating this topic, and then detail my methods in Chapter 2. My first paper (Chapter 3) elaborates on the ways in which OHRO in Greater Vancouver understand their food programming, within foodscapes and poverty management frameworks. This paper investigates how organizations conceptualize the role of food in their services, and operational paradigm, as well as the strategies they employ to facilitate their food programming. Results in this paper indicate that OHRO provide food because of the acute need experienced by their participants. Further, almost all OHRO in Greater Vancouver provide food in some way. There is a wide variety of harm reduction-oriented organizations in Vancouver's Downtown Eastside that form a densely-networked low-income foodscape where most PWUD and/or PLWHA are able to get at least some food some of the time. However, outside of Vancouver, there are fewer harm reduction services, and corresponding food programs, meaning that many low-income PWUD and/or PLWHA are unable to access OHRO and their food programs. Further, funding anxiety, along with site constraints experienced by workers in OHRO mean that organizations are often unable to provide their ideal food programming in ways that support their harm reduction philosophies. Chapter 4 provides a link between those ideas, and my second paper about peer work in Greater Vancouver's harm reduction organizations. That paper, Chapter 5, engages with harm reduction,

shadow state, and poverty management literature in order to conceptualize how peer work simultaneously sustains, and contradicts a harm reduction paradigm. Results indicate that peer work is prevalent in OHRO in Greater Vancouver through peer volunteers, stipendiary volunteers, and some regular employment. I delve further into stipendiary volunteering to illustrate the ways in which funding conditions, and shadow state relations encourage OHRO to engage peer stipendiary volunteers. Finally, I explore some of the implications from these relations, including very low stipends for peer workers, and inability on the parts of OHRO to provide conditions that would allow a peer worker to exit welfare dependence. I conclude in Chapter 6 with a summary of my findings, and my contributions to the literatures in my conceptual framework. Finally, I provide some practical recommendations for policymakers, and service providers for ways in which harm reduction services can more thoroughly incorporate food, and peer workers in ways that further harm reduction goals in these sites.

Chapter 2.

Methodology and methods

Methodology

I used a case study methodology to gather data for this project. The group I used for my case study were organizations with a harm reduction orientation (OHRO) in Greater Vancouver. I attempted to contact every organization that provides harm reduction supplies, services, and philosophies in Greater Vancouver. Using a case study to address the research questions of this project provided a nuanced view of these organizations' perspectives as a whole because case studies approaches are open to the unpredictable, chaotic, and atypical realities of each organization (Flyvbjerg, 2006). Case studies are also well-suited to examining issues of practical rationality, difference, and conflict (Flyvbjerg, 2004), which were particularly important considerations when examining the strategies organizations and individuals used for addressing barriers to their goals.

Case studies are not dependent on simple rules or predictive theories (Flyvbjerg, 2006), and I used an inductive approach to analysis, which meshes well with qualitative case studies methodologies (Janesick, 1994). As such, case studies are undertaken "not in the hope of proving anything, but rather in the hope of learning something" (Eysenck, 1976, p9, as cited in Flyvbjerg, 2006, p 224). Case studies are also particularly useful for disproving existing theories, under the logic that if something is not true in once place, it will be untrue in others (Flyvbjerg, 2006). These qualities make case study research applicable to my project because of its exploratory nature, especially when I began to learn more about the roles of peer workers in the Greater Vancouver harm reduction landscape.

The case study methodology also fits well with a phronetic approach to research, as advocated by Flyvbjerg, which values pragmatism, real world examples, and action to communicate research products, rather than universalizing explanations (2004). This approach meshes well with my project, given the unique characteristics of not only Greater Vancouver's harm reduction landscape (and foodscape), but of the specific organizations of which it is comprised. As such, I am interested in learning about this particular example, and advocating for changes within it, rather than making generalized assumptions about service providers in any place, or any sector. Flyvbjerg asks four phronetic questions:

1. "Where are we going?
2. Who gains, who loses, and by which mechanisms of power?
3. Is this development desirable?
4. What, if anything, should we do about it?" (2004)

Although Flyvbjerg is posing these questions in planning research, they are also applicable to my project because I am also concerned with projects, programs, and institutions in the urban environment. I am rephrasing these questions as:

1. What is the obvious trajectory for food programming, and peer work in OHRO in Greater Vancouver?
2. Who gains, who loses, and by which mechanisms of power in food and harm reduction service provision, and its resulting landscapes and foodscapes?
3. Is providing food, and employing peers in spaces where harm reduction supplies and services are provided desirable?
4. What, if anything, should we do to address the currently existing landscapes and foodscapes?

These questions highlight Flyvbjerg's argument that phronetic research is problem-, rather than methods-driven (2004). There is no prescribed method for phronetic, or qualitative research (Flyvbjerg, 2004; Whittemore, Chase, & Mandle, 2001). Instead, in order to gain the most comprehensive understandings of the phenomena at hand, these questions are answered through a variety of methods and sources that "describe routine and problematic moments and meanings" for the subjects being studied (Denzin & Lincoln, 1994, p 2; Flyvbjerg, 2004), which I have attempted to do in the course of my research. By talking to OHRO about their day-to-day experiences in

running their organizations, I was able to determine key areas of concern for people providing harm reduction services. I could then analyze them in the contexts of academic literature to determine the causes and effects of these concerns.

Case studies can be criticized for their unpredictable nature. It is impossible to control the outcomes of case studies, due to the chaotic nature of everyday life. A side effect of this situation is that findings generated in case studies are highly context-dependent, and are therefore not generalizable to other populations, places, or institutions. Furthermore, case study findings are criticized for being grounded in the hypotheses of researchers, rather than the reality of the situation being studied (Flyvbjerg, 2006). While I am not intent on generalizing per se, Flyvbjerg, counters the critique about generalizability by saying that case studies can indeed be used to generalize, and test hypotheses by following the logic that if a condition exists in one place, it probably exists in others (2006). Validity can also be achieved in qualitative research, not through particular methods, but through grounding the arguments made based on a particular case in thoroughly detailed, contextual evidence (Flyvbjerg, 2006; Whittemore et al., 2001).

Other researchers disagree with the premise that generalizability is important, however, saying that qualitative research should not aim to be generalizable (Janesick, 1994; Wittemore et al., 2001). For instance, the strength of case studies is in their uniqueness, and ability to illustrate particular phenomena that may not apply to a larger population (Janesick, 1994). Stake goes even farther, explaining that looking for generalizable findings can result in obscuring or overlooking the particular details that make a case unique, and that "people find in case reports certain insights into the human condition, even while they are well aware of the atypicality of the case" (1994, p 241).

I take a middle ground between these stances. My case is unique, first and foremost because Vancouver has a longer history of harm reduction activism, policies, and service provision than most North American cities. Vancouver, and, to a lesser extent, BC, have a large population of PWUDs, and people living with HIV/AIDS (Wood et al., 2003), and a corresponding well-established, and largely centralized system for

distributing harm reduction supplies, and numerous harm reduction services (Harvard et al., 2008). The policy context here, through Vancouver's four pillar approach to drug use, and the Provincial mandate to provide harm reduction supplies makes comparison between urban regions somewhat irrelevant because these conditions that promote a wide range of harm reduction services and approaches do not exist in most other places. I am interested in the Greater Vancouver harm reduction landscape because it is diverse, and varied in and of itself, provoking opportunities for intra-regional comparison, and depth in the information gathered. Given the differences between institutions, and across the region, I can make recommendations, and explore diversity within the bounds of my case, rather than having to generalize.

However, many of the findings in this project are applicable to other social services provision contexts that are involved in shadow state, or poverty management relations. For instance, shadow state literature has looked at contexts such as immigrant citizenship services (Trudeau, 2012), and urban renewal initiatives (Fraser & Kick, 2014), among others. Similarly, work on poverty management covers areas, including geographies of urban survival (Mitchell & Heynen, 2009), gentrification (DeVerteuil, 2015), and neighbourhood characteristics (Roe, 2009). Using a case study approach within the contexts of these broader discussions, and other cases means that my project will have relevance to contexts outside of Greater Vancouver, and harm reduction, even as the results may not be generalizable in and of themselves. I attempt to attain validity, however, by interviewing multiple organizations in municipalities across the region that provide a wide range of services. Through conducting 27 interviews, I draw on numerous contexts that can illustrate commonalities and differences in service provision experiences.

Numerous authors have addressed concerns about the rigorousness of case studies. For example, Janesick identifies the role of the qualitative researcher as threefold: looking for the meanings and perspectives held by participants; looking for relationships between events; and identifying inconsistencies, and contradictions in findings (1994). Denzin and Lincoln describe the position of qualitative researcher as a bricoleur who uses the methods and information available to them to cobble together the most complete picture possible of the subject of interest (1994). The resulting bricolage

emphasizes the relations between the information gathered from the diverse sources and methods employed (Denzin & Lincoln, 1994). Furthermore, no single explanation is likely for even a single case, with the falsification of a theory being much more likely than its verification (Flyvbjerg, 2006). These approaches are applicable to my project because I use the perspectives of my numerous interviewees to understand both overarching trends, and specific experiences that can demonstrate contradictions, and unique issues in running food, and peer work programs. I also asked questions about the relationships between my interviewees, their funders, and other service providers, allowing me to describe how these organizations, and their programs work across the Greater Vancouver region.

Qualitative research is laden with the values of the researcher and the research participants (Janesick, 1994). Although case studies can be critiqued for their lack of objectivity, the relationships, and communication between the researcher and participants can be of benefit because the participants can correct any misinterpretations made by the researcher, resulting in a more complete and accurate study (Flyvbjerg, 2006). Rather than simply observing and interviewing, qualitative researchers are responsible for reflexively interpreting the information gleaned from participants (Janesick, 1994; Stake, 1994). The products of research are a co-creation between the researcher, and the participant (Whittemore et al., 2001), as demonstrated by my unpredicted focus on peer work. Additionally, when the researcher situates themselves in the study context, there is an opportunity for mutual learning, and the researcher will gain a deeper understanding of the case. Following this argument, I attempted to optimize my understanding of my interviewees by situating interviews in their service provision spaces. Flyvbjerg also argues that research based in phronetic, practical approaches can allow the researcher to become part of the phenomenon being studied, while still maintaining some objective distance that allows room for criticism (2004). Under these conditions, objectivity can be understood as using multiple perspectives and interpretations when searching for answers to the research questions (Flyvbjerg, 2004). I took an active role in data collection through asking for clarification of key terms, concepts, and experiences described by my interviewees. When combined with the diversity of perspectives expressed in my interviews, I gained a complex, detailed picture of how harm reduction organizations operate their programs.

Between the researcher and the reader, too, exists a reflexive, and interpretive relationship. Although the researcher-author is responsible for providing compelling narratives (Denzin & Lincoln, 1994) from the case, they must also provide nuanced interpretation (Janesick, 1994). The combination of narrative and interpretation frames the data for the reader (Janesick, 1994), but at the same time, enough thick description must be provided so that readers can make their own meaningful and insightful interpretations (Flyvbjerg, 2006; Stake, 1994). I attempt to meet these standards by providing direct quotes from so that my readers can understand my interviewees' perspectives in their own voices. I also acknowledge dissent, and contradiction that exist across my interviews to make the point to my readers that there are multiple narratives, and experiences within Greater Vancouver's harm reduction landscape.

Of particular use for the case study at hand is Stake's argument that it is often more useful to examine an exceptional case than one that is more representative of the norm (1994). He argues that it is possible to learn more about a phenomenon from an exceptional case because it illustrates the extremes, and complexities of a phenomenon to a greater degree than in most average cases. The exceptional case therefore provides an opportunity to learn more, which Stake sees as a better reason to study a particular case than its generalizability (1994). He concludes that "the purpose of case study is not to represent the world, but to represent the case" (Stake, 1994, p 245). My proposed study takes a similar approach because Vancouver's harm reduction environment is unique in Canada compared to the rest of Canada, including municipalities immediately surrounding the city, and the rest of the Province. Furthermore, other studies that serve as inspiration, and form parts of the conceptual framework for my proposed projects incorporate case study approaches (see, for instance, Wilton & DeVerteuil, 2006; Brown, 2009; DeVerteuil & Wilton, 2009; Rhodes et al., 2012; Alkon et al., 2013).

Methods

My project uses a case study of harm reduction service provision in Greater Vancouver in order to explore the perspectives of OHRO on the intersections between harm reduction and food (in)security for people living with HIV/AIDS who use drugs. Qualitative methods and techniques are ideal for this research because I uncover beliefs, attitudes, and understandings held by people who operate harm reduction services. Qualitative methods are useful for revealing these unquantifiable aspects of social processes because they work to "make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 1994, p 2).

Given that "qualitative research is inherently multimethod," this study explores the perspectives of harm reduction organizations on food through a variety of contextually-determined questions and approaches (Denzin & Lincoln, 1994, p 2). I used three main methods to collect data for this project. Firstly, I created a database of OHRO in Greater Vancouver using information drawn from web searches, and people at key harm reduction institutions in Greater Vancouver. As part of a larger project about the relationships between food security and harm reduction, I was able to draw on expertise of people on our Community Advisory Committee (CAC) who are involved with public health, and harm reduction organizations, along with peer members. I subsequently investigated each of the recommended contacts and organizations through further web searches in order to determine that they fit the criteria for this project. The organizations had to be primarily harm reduction-oriented in their service approaches, and be mainly focused on service provision that was not food. The resulting database listed 54 organizations.

I attempted to contact people at all of the harm reduction institutions identified by myself, and the CAC. I reached out to the people whose contact information I was provided by the CAC. In cases where CAC members did not have contacts, I used what publicly available contact information I could find to reach out to those I assumed would be the most likely to know about the organization's approaches and attitudes towards food, and its relationships to their harm reduction goals and services. Generally, these people were harm reduction coordinators, building managers, and/or executive directors.

My goal was to conduct least one interview per organization. Some organizations did not have contact information for specific staff members listed online, so in these instances, I emailed the main email address, or called the listed phone number, and asked to be put in contact with the person most knowledgeable with their harm reduction programs, and philosophies.

Some of these organizations are peer-run, meaning that people with shared life histories provide services for each other. These organizations comprise a small number of the OHRO in Greater Vancouver, but peer-led services have historically been at the forefront of innovative harm reduction practices in Vancouver, and internationally (Boyd et al., 2009). However, along with the growth of the shadow state, and its attendant formalized relationships between social services and the state, most OHRO are professionalized, rather than grassroots, or peer-run. Although generally not peer-run, most OHRO have initiatives that attempt to include peers in organizational decision-making. Peer involvement occurs across a spectrum, including peer-led programs like community kitchens, resident or peer advisory councils, resident or peer representatives on boards, informal peer input, or being entirely policy-driven at the expense of peer input. For this thesis, I interviewed two groups that are entirely peer-led, and one organization that uses peer decision-making to lead its initiatives, but also has professionalized, non-peer staff and management.

The second method used in this case study was qualitative, semi-structured interviewing. The questions asked in the interviews were directed towards understanding the perspectives of OHRO on the interactions between harm reduction; food provision; food (in)security and justice; service provision; and the broader policy environment (see Appendix for the full interview schedule). As much as possible, interviews were conducted in the organizations where the interviewees work. In some cases, the organizations I contacted wanted me to interview more than one person, either because of their organizational politics, or because of different areas of expertise and knowledge. As a result, some of my interviews were group interviews. In cases where the organization had a food program, I asked my interviewee(s) to show me the spaces where food is provided in order to gain an idea about the settings of food provision as they fit into harm reduction services. Interviews were usually between 30 and 60 minutes

in length. In total, I talked to 35 people at 27 organizations in Vancouver, Richmond, New Westminster, and Abbotsford, although some organizations' services were regional, or Provincial in scope (see Table 1 for the types of organizations interviewed).

Table 1. Interviews with organizations with a harm reduction orientation

Type of organization	Number of interviews
Advocacy	2
ASO (Harm reduction policy, supplies, and support)	5
Drop-in services	6
Drug consumption room	1
Health	4
Housing, and emergency shelter	8
Standalone needle exchange	1

Organizations interviewed for this thesis, broken down by type of organization.

My third method involved site visits, and photographs of food preparation and consumption spaces. Being able to walk through spaces like kitchens, dining areas, food banks, and pantries gave me a better understanding of how these spaces feel for the people who use them. Additionally, they provide evidence, and examples for the experiences described in my interviews about, for instance, cobbling together funding, receiving donated food and equipment, or lack of space to operate ideal food and peer employment programs. When permitted, I took photographs of these spaces to give my readers similar impressions of these sites, and in order to provide visual context for my arguments.

Analysis

Analysis involved systematic coding of responses for expected and emergent themes in the interviews using NViVo 11 software. I drew themes from literatures in my conceptual framework, as well as sentiments that arose in the interview transcripts. As my interviews occurred over a six-month period, I began to transcribe before completing data collection, a tactic that promoted reflexivity in the interview process. As a result, I began to emphasize some themes, like peer work, as I discovered their importance over the course of data collections. As described by Fontana & Frey, interpreting interview data requires reflexivity in order to avoid painting the researcher, and the data, as

neutral and objective (1994). As such, my analysis occurred iteratively, and reflexively with data collection, and conceptual development.

In analyzing the interview transcripts, I looked for: the links that service providers see between harm reduction philosophies, and food provision; if, and how service providers provide food; why they may or may not see a need for food provision; the role of geographical location in participant and service provider access to food; whether or not they think their participants are food insecure; what constraints exist to providing food; if they partner with other organizations to provide food; what their goals are in regards to food provision as a facet of harm reduction; and who provides their harm reduction, and food services. Table 2 provides a list of the codes I used to analyze my interview transcripts.

Table 2. Coding schedule

Codes	Subnodes	Number of references
Building/site/space		77
Decision-making/planning		85
Food security definitions/uses		24
Harm reduction definitions/uses		28
Food-related funding		40
Neighbourhood factors		33
Non-peer work		138
Other volunteering		10
Partnerships/relationships		73
Peer work		80
	Stipends	26
	Volunteer	23
Policy/planning/zoning		26
Reasons for food		116
	Caring/nurturing	6
	Choices/stress	10
	Feminist	3
	HAART	3
	Poverty mitigation	8
	Relationships/communication	11
	Skills/independence	6
	Social/community/routine	25
	Sustenance/nutrition/health	40
Regional variations		13
Welfare		10

Codes used for analysis of interview transcripts, and the number of references per code.

These streams of inquiry answered my research questions about the relationship between food security and harm reduction, as interpreted and implemented by the people providing harm reduction services. The themes related to these questions touched variously on food insecurity for particular subsets of the drug using population, networks and relationships between service providers, spatial and social relationships between service providers and participants, and policy issues. Furthermore, service

provider responses in these areas of investigation filled the context-specific gaps in my conceptual framework. Based on links between findings from the interview transcripts, and the information from the conceptual framework literatures, analysis rendered some policy, and programmatic changes that service providers, and policymakers could take to make their services more responsive to the nutrition, and employment needs of low-income PWUDs living with HIV/AIDS.

Chapter 3.

Food programming in organizations with a harm reduction orientation

Introduction

Food is a basic need, yet some people are more secure in their abilities to meet that need than others. This paper examines food security for some of the most vulnerable people in Canada: low income people who use drugs (PWUD) living with HIV/AIDS. I use the perspectives of people providing harm reduction services to people in this group in and around Vancouver, British Columbia, Canada in order to uncover the underlying conditions, challenges, and coping strategies that shape everyday survival. I begin by outlining some key terms, the regulatory environment for these service providers, and the methods I used for my study. I then explore the harm reduction settings in which food is provided to low income PWUD living with HIV/AIDS by asking why, where, and how food fits into harm reduction programming, and paradigms. I discuss the challenges, and make-do strategies employed in these settings to facilitate food programming in the contexts of harm reduction, foodscapes, and poverty management literatures. I conclude with some recommendations for food programming and policy based on my findings in Greater Vancouver's harm reduction service landscape.

Since the 1990s, HIV has gone from a disease affecting primarily gay men, to one of poverty, affecting PWUDs of all genders (Wood et al., 2003). Poor socioeconomic conditions faced by PWUDs are exacerbated by poor access to primary healthcare, treatment services, and housing (Krüsi, Small, Wood, & Kerr, 2009; Anema, Wood, Weiser, Qi, Montaner, & Kerr, 2010). These areas of social services have experienced cutbacks, chronic underfunding, and stigma from political environments hostile to

funding services for people with stigmatized conditions like HIV/AIDS, illicit drug use, and mental illness (Dear & Wolch, 1987; Bourgois & Schonberg, 2009). Harm reduction is a “pragmatic” approach to minimizing, and managing high risk behaviours, especially, and in this case, specifically, illicit drug use (Hathaway, 2001; Marlatt, Larimer, & Witkiewitz, 2011).

In British Columbia, Canada, harm reduction is a mandate of the provincial government, and must be provided, in one way or another, by all health authorities in the province (Harvard et al., 2008). A wide variety of programs and services are provided across the Greater Vancouver region under the banner of harm reduction, including PWUD-inclusive health services, and two supervised injection facilities. All of these supports take an approach that their providers conceive of as reducing the likelihood of blood borne disease transmission, along with curbing some of the other harms of illicit drug use. The on-the-ground manifestations of harm reduction philosophy emphasizes empowering individual choice, and “let[ting] people come as they are, meet[ing] them where they’re at, and recogniz[ing] the power of any positive change” (Collins et al., 2011, p 27), rather than demanding abstinence from drugs or alcohol to obtain, and maintain access to services. Harm reduction approaches have been integrated into a wide gamut of services for PWUDs, including harm reduction-oriented counselling, needle exchanges, safer (crack) smoking kits, and supervised drug consumption rooms and injection sites. However, harm reduction philosophies are incompletely implemented in addictions and social service providers (Harvard et al., 2008), and most drug and alcohol treatment facilities in Canada remain abstinence-based (DeVerteuil & Wilton, 2009).

PWUD also face a wide range of health impacts stemming from inadequate nutrition (Anema et al., 2010). As a population, PWUD are often underweight, and people who inject multiple drugs over long periods of time have especially high rates of malnutrition. In general, persistent drug use changes eating habits, with PWUD often skipping meals due to prioritizing drug consumption over food consumption for reasons including a lack of appetite while on some kinds of drugs. Mental health is also impacted by food insecurity, especially for people living with HIV/AIDS (Anema, Vogenthaler, Frongillo, Kadiyala, & Weiser, 2009; Anema et al., 2010). For people living with

HIV/AIDS, food insecurity has direct impacts on health through malnutrition, and reduced immune system functioning (Anema et al., 2009). However, food insecurity also increases several indirect, HIV-specific risks, such as: increased behavioural risk of HIV transmission (e.g. through risky sex), reduced access to HIV treatment, increased risk of mother-to-child transmission, adverse reactions to treatment, decreased treatment compliance, decreased effectiveness of antiretroviral therapies, higher viral loads, and increased mortality (Anema et al., 2009).

Food insecurity, and HIV are intertwined phenomena that magnify the impacts of each other on individuals affected by both. As detailed by the Food Security Factsheet for British Columbia compiled by a network AIDS Service Organizations (ASOs) across Canada (Food Security Study, n.d.), people living with HIV/AIDS (PLWHA) who have insecure access to food have poorer immune system functioning, worse physical and mental health (especially concerning symptoms of depression), feel more socially stigmatized, and are more likely to adhere to their medications. That study explored the impacts of food (in)security on health for PLWHA who access ASOs like those interviewed for this thesis. That study called for more research about the impacts of food security, along with increased awareness about food security and nutrition, and integrated nutrition with HIV interventions for PLWHA. In British Columbia, 77% of people living with HIV/AIDS accessing ASOs received food supports, but despite this help, 39% went a day without eating, and 61% skipped meals. Although 72% of people living with HIV/AIDS in BC who access ASOs experience food insecurity, they were twice as likely to experience food insecurity if they were unemployed; twice as likely if they were also injection drug users; three times more likely if they used non-prescription drugs; and six times more likely if they had an income below CAD $20,000 (Food Security Study, n.d.). Among people living with HIV/AIDS, food insecurity is gendered, with women more likely to be food insecure than men (Anema et al., 2009). Importantly, marginalized PLWHA, such as aboriginal women, are also unlikely to have their voices heard by healthcare practitioners, magnifying the health risks of HIV and associated conditions, like food insecurity (McCall & Pauly, 2012).

Hunger is widespread also in PWUD in Greater Vancouver, particularly for those also living with HIV/AIDS, indicating that food insecurity is of great concern in this

population (Anema et al., 2009; Anema et al., 2010). The majority of Greater Vancouver's PWUD in Anema and colleagues' study were food insecure, having accessed food banks, and food programs within the last six months (2010). An even larger majority reported being hungry, and unable to eat because they could not afford food. Factors impacting hunger for PWUD in Greater Vancouver included being low income, having to balance acquiring drugs and food, and reporting symptoms of depression. People who reported being hungry were also more likely to live in unstable housing than injection drug users in Greater Vancouver more generally (Anema et al., 2010).

Despite these concerns, issues related to food security and nutrition are often absent in literature about PWUD and harm reduction. When food is mentioned, it is often in passing, and not linked in a systematic way to other problems often faced by PWUD, like housing, physical health, and mental health (see, for instance, Dear & Wolch, 1987; Padgett et al., 2006; Bourgois & Schonberg, 2009; Marlatt et al., 2011). Furthermore, food provision is not considered to be a core approach to harm reduction. When food (security) appears in literature focusing on urban (harm reduction) services, and low-income PWUD, it tends to appear in passing, or implicitly as something obtained in settings separate from harm reduction services (e.g. Bourgois & Schonberg, 2009; McNeil et al., 2015); as something that is attained after entering supportive housing (e.g. McNeil, Dilley, Guirguis-Younger, Hwang, & Small, 2014b). This paper begins to bridge that gap through examining food security, and food provision in light of broader harm reduction services and approaches.

With these conditions in mind, food can be conceptualized as one of several facets to a harm reduction approach to the use of illicit drugs however, it is rarely recognized as such in harm reduction literature, leaving me with two main objectives:

- Investigate why, where, and how food is provided in harm reduction settings in Greater Vancouver
- Evaluate how organizations with a harm reduction orientation (OHRO) create, and shape the foodscapes of low-income people who use drugs living with HIV/AIDS.

I begin by describing my study area in Greater Vancouver. I then explore poverty management, food security, and foodscapes literatures to provide a background for understanding the gaps filled by this paper. The methods section explains how I found, and conducted the interviews informing this paper. My results are detailed in several sections that explain why, where, and how OHRO think about, and provide food, including its spatial ramifications at multiple scales, and sites. Finally, the discussion and conclusion section situates my results within the Greater Vancouver low-income foodscape, as well as academic understandings of harm reduction, service provision environments, and the role of food in social services, and participant survival. I conclude by providing recommendations, not only for academics, but for harm reduction policymakers, and service providers.

Study area

In Canada, health services for most people are administered at the Provincial level. The Province of British Columbia leaves the creation of most targeted initiatives and programs up to the regional health authorities, but also requires that they provide certain services. For instance, health authorities must have a plan to improve food security for their residents, and must also provide harm reduction services. However, the ways in which they provide these programs is not standardized.

My research is situated in Greater Vancouver, encompassing the City of Vancouver, and surrounding municipalities. This area is important when studying harm reduction because of its relatively long history of harm reduction programs and policies, and the diversity of services offered, including Canada's first legal supervised injection facility. The City of Vancouver is the largest municipality in the area. I conducted interviews in Vancouver (including the Downtown Eastside), Richmond, Surrey, New Westminster, and Abbotsford. This area is intended to reflect the geographic region within which the participants in this study regularly interact, migrate, and seek food and harm reduction services.

Vancouver's Downtown Eastside houses a density of the city's social services, including harm reduction services (Miewald & McCann, 2014) that is unparalleled in the

rest of the region. This neighbourhood has high concentrations of poverty, unemployment, use of social assistance, substandard housing, transience, homelessness, overdose, and HIV and HCV infection (Anema et al., 2010; Bornstein, 2010; Miewald & McCann, 2014). The Downtown Eastside is home to many marginalized groups, including: refugees; people reliant on welfare; a population that is 10% indigenous[1], compared to 2% for the City of Vancouver overall; PWUD; and people living with HIV and HCV (City of Vancouver, 2013).

Shaping experiences of addictions and poverty

I draw on poverty management, food security, and foodscapes literatures to lay the groundwork for my interviews with OHRO. These literatures simultaneously informed my academic understandings of these topics, and influenced the questions that I asked to my interviewees. These two bodies of literature approach problems of poverty, and social service/welfare reliance from different stances, but, when taken together, they provide an effective framework for analysis.

Poverty management

The sources I use to tease out the complex relationships between service providers, participants, funders, and the harm reduction policy environment come from a variety of backgrounds, and approaches (e.g. Dear & Wolch, 1987; Wolch, 1990; Wilton & DeVerteuil, 2006; Bourgois & Schonberg, 2009; Boyd et al., 2009; DeVerteuil & Wilton, 2009; Fairbanks, 2009; Rhodes, 2009; Love, Wilton, & DeVerteuil, 2012; Rhodes et al., 2012; Fraser & Kick, 2014; McNeil et al., 2014a; McNeil et al., 2014b; DeVerteuil, 2015; McNeil et al., 2015). In order to better understand the politics of how service providers organize themselves, and their management of participants, I look to poverty management literature about services for low-income, and vulnerable populations, as well as literature about the shadow state. Poverty management involves the regulation,

[1] Within the smaller areas comprising the Downtown Eastside, the proportion of Aboriginal residents ranges from 31% in Victory Square to 4% in Strathcona (City of Vancouver, 2013).

and management of spillover effects associated with poor, and marginalized populations through state, institutional, and other elite structures of power (DeVerteuil, 2015).

The composition, and causes of poverty and marginalization vary by region, and are therefore important for understanding the regional context (Dear & Wolch, 1987). Similarly, the composition of the voluntary sector is distinct to particular city-regions, as are the power and resources accrued by voluntary sector institutions, resulting in specific institutional cultures (Wolch, 1990). Some of the harm reduction organizations with which I spoke have mandates that are regional in scope, but even organizations with narrower purviews, when clustered, can lead to distinctive service and welfare cultures (DeVerteuil, 2015). For my project, the region is also an important scale, because health authorities operate at regional scales, encompassing multiple municipalities. Further, health authorities are required by the Provincial government to develop, implement, and monitor food security improvement programming (Vancouver Coastal Health, 2008). Importantly, therapeutic landscapes can manifest themselves at multiple scales as 'therapeutic environments,' extending from the region to specific sites through varying relational contexts (Wilton & DeVerteuil, 2006).

Neighbourhoods, especially historically poor ones, are contentious sites within the city, as planning initiatives, revitalization projects, and gentrification have resulted in low-income people being pushed from communities where they were previously able to live (Bourgois & Schonberg, 2009; Fraser & Kick, 2014). The socioeconomic conditions facing poor neighbourhoods such as deindustrialization, and racism lead to 'risk environments' that have been seen by social scientists to contribute to drug use, and a corresponding disproportionate burden of drug harms (Rhodes, 2009). Rhodes describes risk environments "as the space ... in which a variety of factors interact to increase the chances of harm occurring" (2009, p 193; Rhodes et al., 2012, p 208). He goes on to specify that these environments can be characterized as social, physical, economic, or policy spaces. These environments interact at micro scales, such as the places where people inject drugs, and macro scales, like marginalization and drug law enforcement (Rhodes, 2009). This approach understands individual, and community health as "an *embodiment of … social condition,* and … that health improvement requires *social and structural change*" (Rhodes et al., 2012, p 207, emphasis original), a

perspective that is useful for understanding the roles of service providers who mediate policy, and participant relations. Rhodes also refers to this approach as a social epidemiology, because it situates risk and responsibility within communities, and environments, as well as individuals (2009; Rhodes et al., 2012).

The risk environments approach can be seen as indicative of a broader shift in public health towards understanding health through social determinants of health, and inequalities, and away from biomedical, individual-level factors (Rhodes et al., 2012). Some segments of the population face more vulnerability to harm than others because of a "structuration of risk" that is linked to structural violence, and uneven power relationships that are embedded in everyday lives, both constraining, and enabling agency (Rhodes et al., 2012, p 208). Using this understanding, the risk environment is then embodied through participation. The links between individual health and social factors like marginalization have been shown to be particularly important in HIV (Rhodes et al., 2012), making a risk environments perspective especially useful for this paper. Structure is not external to individuals, but structural effects are often indirect, with reciprocal, multi-level, and dynamic interactions between individuals and social structures (Rhodes et al., 2012). Ultimately, a risk environment framework for illicit drug use "is a call to mobilise resources in social science towards reducing drug-related social suffering" (Rhodes, 2009).

Drug use, poverty, and homelessness, among other phenomena, shape, and influence how a neighbourhood is experienced (McNeil et al., 2014a). For instance, residents may associate a high prevalence of liquor stores with increased neighbourhood violence, resulting in feelings of fear, and changes in behaviour in neighbourhood space (Cannuscio et al., 2010). Similarly, residents' identities and positionalities impact how they navigate neighbourhood space, for instance, women, and 'marginal men' (i.e. men with physical and mental disabilities, or those who support themselves through stigmatized occupations like bottle collection) in the Downtown Eastside avoid parts of the neighbourhood where they are exposed to gendered violence from aggressive, or violent men (McNeil et al., 2014a). However, this behaviour has the effect of "severely limiting the scope of the spatial practices" of this very high-risk group

for drug-related harms, to harm reduction services like Insite, which is located in a block that is often perceived as very risky for gendered violence (McNeil et al., 2014a, p 4).

Although individual perceptions of spaces differ, public depictions of neighbourhoods like the Downtown Eastside lead to residents experiencing stigma when they venture out of the neighbourhood to access services. This phenomenon reinforces accessing services within the neighbourhood, even when individuals are 'red zoned' (prohibited from accessing certain blocks or corners by police, and court orders) from certain areas, or when they feel unsafe in some neighbourhood spaces. The overall effect of these processes can lead to PWUD feeling out of place in the neighbourhood in which they live (McNeil et al., 2015).

Partially in response to these conditions, historically poor neighbourhoods may develop high densities of social services, resulting in "welfare neighbourhoods" (DeVerteuil, 2005). As well as being service hubs, however, these neighbourhoods also acquire a disproportionate number of sites and services like alcohol recovery facilities that would fall victim to NIMBYism in neighbourhoods where residents have more power and social capital. Further, the ways in which these services relate to their participants shapes the social character of the neighbourhood, for example, through social surveillance and monitoring of participant and resident behaviours (Wilton & DeVerteuil, 2006; Fairbanks, 2009). As social services infiltrate a neighbourhood, however, a fear may arise that the people who live in these neighbourhoods are being reframed as 'clients' rather than residents (Boyd et al., 2009).

Finally, therapeutic landscapes approaches tend to challenge biomedically-based public health research because they often "lead to the conclusion that rational and professional intervention is necessary to improve the well-being of the neighbourhood's residents" (Masuda & Crabtree, 2010, p 660). Thus, researchers' claims that welfare neighbourhoods require interventions to improve residents' wellbeing can reinforce stigma about the neighbourhood. For instance, planning initiatives that impact outdoor public spaces where residents gather may actually undermine the therapeutic elements of the neighbourhood environment in places like parks, even as these interventions attempt to improve neighbourhood quality (Masuda & Crabtree, 2010). These initiatives,

along with other city-building schemes, can spur gentrification, and increased rents for organizations in the neighbourhood, threatening their ability to continue to provide services locally, as well as residents' abilities to continue living in their neighbourhood (Masuda & Crabtree, 2010; Fraser & Kick, 2014). However, having a high density of social services, and their clients in close physical proximity can improve the resiliency of the sector in neighbourhoods where they are established (Dear & Wolch, 1987; DeVerteuil, 2015).

Food security and foodscapes

While poverty management literature is useful for understanding how social service provision shapes the lived experiences of the people that provide, and access them, there are some unique qualities to food, and food provisioning that necessitate using complementary sources from foodscapes and food security literature.

The term 'food security' lacks a single agreed upon definition, however, most uses of 'food security' are concerned with many of the same issues. For instance, Campbell asserts that:

> "food security is access by all people at all times to enough food for an active, healthy life… 1) the ready availability of nutritionally adequate and safe foods and 2) the assured ability to acquire personally acceptable foods in a socially acceptable way" (1991, 408-409).

Similarly, Dietitians of Canada define community food security as: "…exist[ing] when all community residents obtain a safe, personally acceptable, nutritious diet through a sustainable food system that maximizes healthy choices, community self-reliance and equal access for everyone" (2007, 2). Community food security is therefore a logical extension of the food security concept that encompasses more subjective elements of food security, such as secure livelihoods (Heynen, Kurtz, & Trauger, 2012). In general, most definitions of food security encompass quantitative (having enough), qualitative (quality and diversity), psychological (fear, anxiety about restricted choice), social (practices, sources, roles, interactions) aspects (Wicks, Trevena, & Quine, 2006). Importantly, even definitions of food security that aren't explicitly centred on community approaches tend to acknowledge the social aspects of food through facets like culturally

acceptable food, and equity concerns in access and food quality. Some definitions also include elements of social and/or environmental sustainability in understanding factors pertinent to food security (Wakefield, Fleming, Klassen, & Skinner, 2013). Although my project uses food security as a lens with which to examine the experiences, and initiatives of OHRO, 'food security' as a concept, can be critiqued for not being sufficiently radical, or politically exigent, compared to terms like 'hunger,' or 'starvation' (Nally, 2011).

Geographical work on food has tended to focus on food deserts – places, particularly low-income neighbourhoods, "where the transportation constraints of carless residents combine with a dearth of supermarkets to force residents to pay inflated prices for inferior and unhealthy foods at small markets and convenience stores" (Short et al., 2007, p 352). Although access to food is an important consideration in nutritional decision-making, there are other factors at play, such as the effects of institutional racism, and neighbourhood disinvestment that shape food access, particularly for marginalized people (Alkon et al., 2013). Additionally, the main strategies employed to address food deserts, increasing prevalence, and access to supermarkets; encouraging alternative sources of food; and stocking (local) produce in convenience stores (Short et al., 2007) aren't helpful when people do not have an appetite (especially for whole, fresh produce), or have no money to spend on food in the first place. Given that these are common concerns for low-income PWUD, it is necessary to go beyond the food desert concept to address food insecurity in this group.

Foodscapes are a useful way to examine food-place relations because they encompass where food is obtained, its spatial variation across institutions, spaces, and scales. Importantly for this project, foodscapes approaches examine these relations in the context of geographies and politics of poverty, and survival (Miewald & McCann, 2014). The '-scape' part of foodscapes is important, because it takes into consideration the relationships between food, spatial context, and human experience (Mikkelsen, 2011). A focus on justice can lead to an 'ethical foodscape' that is premised on a sustainable food system achieved through ecological, and social justice, and integrity across geographical scales (Morgan, 2010; Mikkelsen, 2011). Although Morgan focuses on factors contributing to consumer purchasing decisions, such as fair trade labels, and

price, questions of ethics and justice are important for understanding foodscapes of all people, even ones who are not usually afforded the luxury of purchasing their own food. Morgan argues for reframing foodscapes approaches in terms of a public ethic of care. This strategy aligns diverse priorities concerning sustainability towards an approach that produces caring out of a desire to do justice, and "in turn requires that we think about the needs of all humans, not just those who are sufficiently powerful to make their needs felt" (2010). Further, food programming in social services can act as a form of caring, turning these spaces into sites of care (Miewald & McCann, 2014).

Institutional characteristics also shape individual foodscapes. For example, Bourgois & Schonberg (2009) note how most of the homeless people they studied did not make frequent use of soup kitchens, despite often facing hunger, because these spaces felt unwelcoming, and were time-consuming. Foodscapes are ultimately geographies of survival, because they are discursively navigated, and produced by people themselves to form the ways in which people meet one of their most basic needs – food. Taking this lens, institutions like foodbanks that support the survival of people who face food insecurity are under threat from policies favouring phenomena like gentrification, for instance, through attempts to ban public food distribution in many global North cities (Mitchell & Heynen, 2009; DeVerteuil, 2015).

Building on these ideas, Mikkelsen proposes a definition of institutional foodscapes as "the physical, organizational and sociocultural space in which clients/guests encounter meals, food and food-related issues, including health messages" (2011, 215). The 'institutional foodscape' perspective is useful because it acknowledges the mediating role that institutions play between people, and food, a shift that is particularly useful in sites like OHRO where other kinds of poverty management strategies are also being enacted (Mikkelsen, 2011). An institutional perspective is particularly important for this paper because I focus on the actions, and perspectives of people working within organizations that mediate the relationships not only between people, and food, but between policymakers and funders (who fund food-related programming), and participants who are reliant on these services to meet their food needs.

People who rely on free food programming in order to meet their nutrition needs are not food secure according to the academic definitions previously discussed. However, aspects that play into food insecurity for people who are, for instance, homeless, are somewhat different than those for low-income, but stably housed people. Most of the people accessing a soup kitchen who were interviewed by Wicks and colleagues ate fewer than three meals a day (2006). Factors contributing to food insecurity for people who relied at least partially on a soup kitchen for their nutrition included: poor health preventing them from purchasing and preparing food; poor dental health affecting what foods they could eat; lack of cooking and storage facilities (or fear of theft from shared food storage spaces); prioritizing paying for shelter before food; living alone; and "competing demands of sustenance and addiction" (Wicks et al., 2006, p 923). In particular, buying drugs instead of food "is rationalized by the fact that food can be obtained for free from distribution sites, but getting a 'fix' always costs money" (Anema et al., 2010, p 5), rendering participants reliant on free food at the expense of food security. Perhaps most importantly, however, the welfare benefits on which these people were reliant for their livelihoods were insufficient to pay for all of the essentials for human thriving, resulting in people needing to access free food services. Despite facing these barriers, low income people who relied on this soup kitchen were aware of the elements of a nutrition-dense diet, particularly the importance of fresh produce (Wicks et al., 2006).

Anema and colleagues propose measures to prevent the nutritional decline of PWUD, before nutritional support is needed (2010). These measures include improved access to drug treatment programs, initiating multiple integrated interventions that support the health and wellbeing of PWUD to reduce food insecurity, and mental health screening and support. Taken together, these strategies could "reduce the adverse effect of ongoing drug use on hunger, and vice versa" (Anema et al., 2010, p 6). Anema and colleagues call for more research into the effects of targeted food and income generation supports in combination with HIV treatment for people living with HIV/AIDS (2009). However, they note that lacking academic evidence concerning effective interventions for food-insecure PLWHA "should not impede efforts to expand nutritional and livelihood support to people living with HIV/AIDS. There is a need to 'learn by doing' and… compelling evidence linking food insecurity and HIV/AIDS points toward the need

for an urgent response" (Anema et al., 2009, p 229). These recommendations are in line with the questions I asked of my interviewees, not only about what (if any) food programming they offer, but also about the effects of providing food on their participants, and on their organization.

Concluding thoughts

Taken together, literature about poverty management, and about food security, and foodscapes informs the ways in which this paper approaches understanding the relationship between PWUD, food, and the organizations that mediate the relationships between them. Poverty management work aids in conceptualizing how service providers have a role in shaping the survival of the people who rely on their services, including food. At the same time, incorporating risk environments into this perspective complicates the relationship between sites of care, like OHRO, and their physical locations, which may be in places that are perceived as dangerous. Food security and foodscapes aid in understanding both the challenges experienced by people who rely on food programming, and the shared agency of individuals, and organizations in shaping how they meet their nutritional needs. In the next section, I expand on the methods I used to build on these literatures in order to better understand the roles of food security in harm reduction service provision environments.

Methods

This project emerged from a collaboration between the Dr. Peter Centre, an OHRO in Vancouver's West End, and an academic research team. The Dr. Peter Centre provides a wide range of services to PLWHA, including a day program, health services, and a daily meal program. They were interested in determining the impacts, and implications of their food program. Other facets of the project are investigating the lived experiences of low income, HIV-positive PWUD who were participants of at least one OHRO in navigating the urban Vancouver foodscape. These sections of the project included a survey, and a narrative mapping activity conducted with the help of peer research assistants. My work, meanwhile, was focused on service provider perspectives

in order to better understand some of the factors that shape participants' experiences of the foodscape.

Given that "qualitative research is inherently multimethod" (Denzin & Lincoln, 1994, p 2), this study will explore the perspectives of harm reduction organizations on food through a variety of contextually appropriate questions and approaches. I first created a database of OHRO in Greater Vancouver, using information drawn from web searches, and people at key harm reduction institutions in the region. This search yielded a list of 53 sites and organizations. I reached out to all of these sites and organizations via email and phone to attempt to set up interviews with the people who would be most knowledgeable about the organization's approaches and attitudes towards food, and its relationships to their harm reduction goals and services. Often these people were executive directors, food managers, harm reduction coordinators, or building/site managers. I attempted to contact these people at least three times, and conducted 26 interviews (see Table 1 for a breakdown of the types of organizations interviewed) in four municipalities in Greater Vancouver: Vancouver, Richmond, New Westminster, and Abbotsford (see Figure 1 for reference).

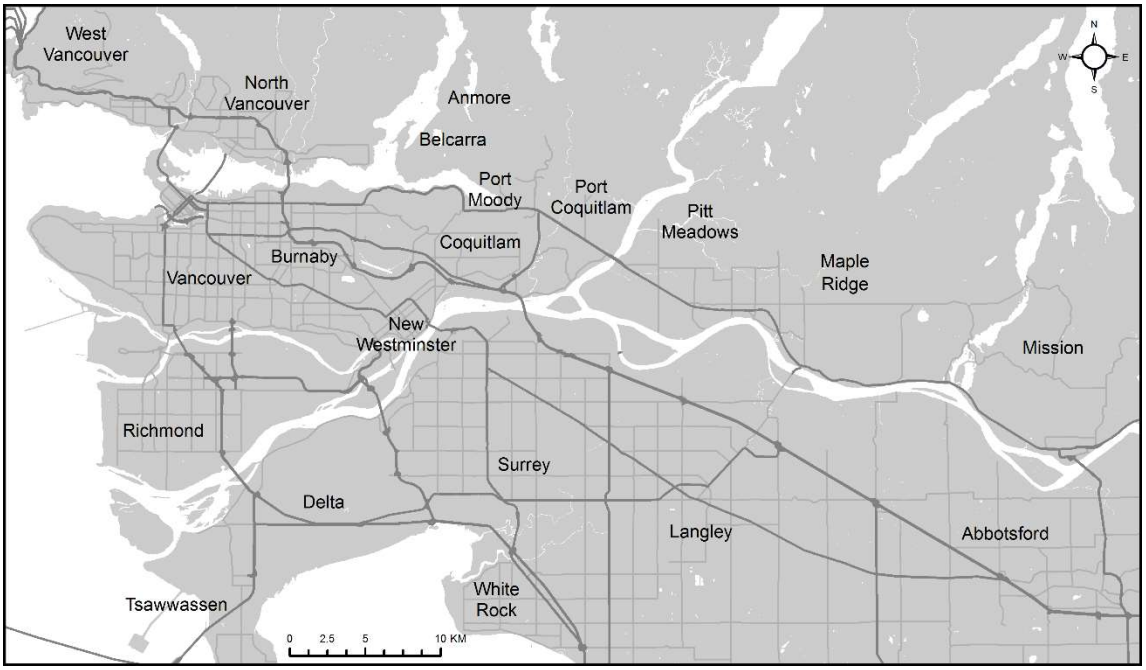

Figure 1. Greater Vancouver
Note: This map shows the municipalities refered to in this thesis as 'Greater Vancouver' (Ng, 2016). Used with permission.

I use qualitative, semi-structured interviews for my case study, asking questions directed towards better understanding how OHRO perceive interactions between harm reduction; food provision; food (in)security and justice; their roles as service providers; and the broader policy environment that they navigate. As much as possible, I attempted to conduct the interviews in the organizations where my interviewees work, and, where food was provided, I asked my interviewees to show me their spaces of food preparation and consumption. I wanted to situate my interviews within harm reduction and food provision sites because I wanted to gain a sense of these spaces, while simultaneously grounding my interviewees within their work environments – my main area of inquiry. I also asked my interviewee's permission to take photos of their food preparation and consumption spaces if there were no participants using them at the time of my interview. Some of those photos are presented here.

My positionality as a female researcher is important for the kinds of data I was able to collect. Researchers who are women may face discrimination, but can also be seen as unthreatening, which may result in interviewees divulging more information (Fontana & Frey, 1994). It is perhaps due to this reason, along with my initial

unfamiliarity with the Vancouver harm reduction context that led my interviewees to provide rich background information about their histories with harm reduction in the region. Additionally, being a woman also gave me access to women-only spaces, including tours of residential floors, and their cooking facilities, where men were not permitted. I was also granted access to a male-only drop-in space, perhaps because I was not perceived as a threat (Fontana & Frey, 1990). This experience is in line with practices in free and low-cost food providers in the Downtown Eastside described by Miewald & McCann (2014). Many women feel safer accessing women-only spaces, perceiving them as more welcoming, and offering higher quality food. However, some women-only service providers can make transgender women feel unwelcome unless they appear as very feminine (Miewald & McCann, 2014).

Making-do and taking what you can get: food provision philosophies and experiences

The interviews I conducted yielded rich results about organizations' reasons for providing food, as well as the ways in which food fit into their programming, and their spaces. Despite a province-wide mandate to provide harm reduction services, the ways in which harm reduction, including through food, is provided varies greatly across the Greater Vancouver region, a situation that was also highlighted by my interviewees.

Reasons why OHRO implement food programming

Almost all of the organizations I interviewed provided food in one way or another, either through planned meal programs, or in more ad hoc ways like snacks in the front entrance, or granola bars with outreach teams. It was difficult to ascertain the actual extent of food provisioning within many of these organizations because they often did not have a systematic approach to food provision. Even interviews with organizations that provided full meal services often incorporated food into other parts of their programming, such as incentives for participants to attend special meetings and groups, special event meals, or snack foods in social spaces. Most of the organizations I interviewed provided food because it is a basic need that they saw their participants

struggling to meet. When asked why they felt the need to provide food to their participants, a First Nations-oriented drop-in and clinic said:

> "the healthier a person is, the better they are to fight off opportunistic infections and such. Secondly, beyond their disease, we feel that if we didn't… we know that if we didn't offer, there would be people who did not have food."

Especially for organizations and programs that target people with significant health issues, nutrition-related goals went beyond sustenance to encompass health-specific objectives, a departure from the primarily hunger-focused objectives of sites like foodbanks, and soup kitchens (e.g. Davis & Tarasuk, 1994; Wicks et al., 2006). For example, a housing organization in Vancouver said that:

> "a lot of the mental health medicines that folks are taking, they're not tested… on malnourished… starving people. They're tested on healthy people who had eaten properly… are their medicines even as effective as they could be if you're not getting the nutrition?"

In these spaces, providing food is framed in a similar way to providing clean needles (e.g. Bourgois & Schonberg, 2009; Harvard et al., 2008; Roe, 2009) or abstinence-optional housing (e.g. Padgett et al., 2006), as a direct health intervention for a vulnerable group that is at risk for nutrition-related health problems like starvation, or less effective medications.

The reality that there are some people who just do not have food was further emphasized by a housing organization in Vancouver, who told me that "we did a survey of tenants in that building… [and] it was something like two to three healthy meals a week that people were eating… Even though they had a… kitchen for it in their unit." My contacts at this organization elaborated that issues preventing people from using the kitchens in their units included lack of cooking knowledge and skills; poor budgeting skills; and lacking money with which to buy food, even when they had multiple kinds of welfare benefits due to disability. These kinds of factors corroborate findings by Wicks and colleagues indicating that people accessing soup kitchens ate fewer than three meals a day, and often went a day without eating (2006).

Addictions issues also unsurprisingly impacted the other substances, like food, that an individual consumed, a finding supported by other studies (e.g. Anema et al., 2010; Bourgois & Schonberg, 2009; Wicks et al., 2006). As the manager of the food services at a Vancouver-based, multi-site health and housing organization told me:

> "if I've only got $10, and I'm addicted to crystal methamphetamine, or crack cocaine, I'm not going to go to [a high end restaurant], or I'm not going to get a salad from [a grocery store], I'm going to go buy some rock, and the next day I'm going to go buy more rock, and all of a sudden I haven't eaten for four, five days, and… the long term… disadvantages to… chronic malnutrition… leads to higher levels of hospitalizations as people age, and are managing a chronic illness."

Alongside goals of supporting basic nutrition for physical and mental health, interviewees commented on perceived nutritional quality of food available in charitable food programs. The people I interviewed were by and large not nutritionists, however, they tended to express beliefs that much of the free food available, especially in the Downtown Eastside was of inferior nutritional quality, but improving. Some other interviewees also expressed skepticism about the quality of their food programming, even when it was vetted by a nutritionist, and fit the recommendations in the Canada Food Guide. This individually-, and socially-constructed view of 'healthy' eating aligns well with findings that impressions of healthy eating are inflected with social class, and ethnicity to the extent that they can supersede health professionals' recommendations (Bisogni, Jastran, Seligson, & Thompson, 2012). For instance, the manager at a supportive housing facility for people with mental health challenges explained that:

> "for the community kitchen… we don't have any hard and fast rules, but just putting… what is healthy, and what isn't on the forefront of people['s minds] … we certainly don't use the Food Guide… because that's changed too in terms of what people think is healthy and not."

These kinds of views are important because they demonstrate the values of the people working in harm reduction service provision settings. My interviewees worked primarily in management, and executive roles, tended to be white, and appeared to be middle class. Their normative opinions on what constitutes a 'healthy' diet are a determining factor in the diets of the people who rely on their services for survival, but may not fit their participants' understanding of 'healthy' (Bisogni et al., 2012).

One way in which these opinions manifested themselves was through stated needs to conceal vegetables. Most of my interviewees told me that their participants did not want to eat the kinds of foods, particularly vegetables, that the service providers perceived to be nutritious. Dental concerns, along with lack of familiarity with fresh produce were commonly cited as reasons their participants tended to decline, or pick out fruits and vegetables. As noted by Wicks and colleagues, people who rely on social services for food are aware of the benefits of good nutrition, and care about the quality of the food they eat (2006). The contradiction between service provider, and service recipient understandings of healthy eating may be indicative of differences in social class, and cultural backgrounds between largely middle-class providers, and participants (Bisogni et al., 2012).

Service providers saw it as their role to enforce their understandings of good nutrition, a sentiment that emerged in statements like this one from a youth outreach, and drop-in centre:

> "if you really force it on them, where you're mixing the vegetables into the sauce, or stuffing them in there, they're not given another choice but to eat it, and they do like it, they just don't like the thought [of] eating a whole big chunk of vegetables."

Service providers attempted to minimize participant choice in what they ate to improve the nutrition they received, an approach that is simultaneously reducing the harms of drug use, while contradicting the underlying philosophy of harm reduction through involving, and empowering participant choice (Collins et al., 2011).

Applying harm reduction philosophies to food occasionally resulted in situations that conflicted with the values of service providers. For example, one of my interviewees at the shelter and housing organization in Vancouver explained that

> "none of us want to see folks stuffing their faces with pastries, but on the other hand, if that's what someone chooses to do, that goes back to the harm reduction to some degree, don't choke on it would be the harm reduction, not don't eat it."

Although this organization is one that conceals nutritious ingredients in prepared food in order to ensure higher levels of nutrition in their residents, they also acknowledged that

harm reduction imperatives of individual choice needed to be respected, even when they did not fit with service providers' nutrition goals.

Closely tied to food as a basic nutrition intervention, and normative ideas about 'healthy' food were statements about the impacts of food security, regular food provision, and nutrition on individuals' decision-making, and positive choices. The manager of a supportive housing facility explained:

> "…I would put harm reduction in… a big picture. So where food fits in is [in] supporting people in their personal health… helping them modulate their own behaviour. So where food fits in is sort of that sense of belonging one gets being part of a community, even if what I do in the moment is I'm able to stand in line, get my plate, and walk out of the kitchen without screaming at somebody. That is a huge piece of belonging to a community that people can learn around [a] food program."

Having a regular meal program at this site was important for fostering positive social behaviour in the residents. The building manager of the same organization also explained to me that its maintenance costs had decreased when it instituted a food program, because people were less angry, and subsequently less prone to hunger-fueled destructive outbursts.

An overarching finding from my interviews was that incorporating food, especially in the form of regular hot meals, into harm reduction services resulted in multiple benefits both for the organizations, and their participants. These findings incorporate previous research asserting that people feel better when they are eating food they perceive to be healthy (Bisogni et al., 2012); and that food within spaces of addiction-related care serves therapeutic functions such as supporting independence, team work, and self-esteem (Fairbanks, 2009). Although food programming often started as a way to meet basic needs, the benefits accrued went far beyond improved physical health for participants to include psychological, social, and economic effects for all involved parties. The food manager of a multi-site housing and health services provider in Vancouver explained:

> "the goals of the meal program at the [organization] are primarily to provide food security for otherwise visibly malnourished, hard target residents within our continuum… and to create an additional contact,

> point of contact with staff. As stable nutritionally, nutritionally impactful meal program that comes at no cost because most of our residents are living in abject poverty and have very little money to buy especially nutritious food, and are at various degrees of drug use that often leads them not to spend their money on food, but on drug use. And what we found was that providing a stable meal once per day has increased BMI, has reduced critical incidents of calls to 911, and contact with justice system, and has reminded the residents to eat."

The stated benefits to providing food are similarly wide-ranging to the benefits of instituting harm reduction-oriented services. And, as the above quotes illustrate, food can act as a form of harm reduction for illicit drug use. Although most of my interviewees had not previously considered their food programming as a part of their harm reduction programming, many of them began to make those connections over the course of our interview. For instance, the manager at a drop-in centre for drug users in Vancouver said "…harm reduction seeks to increase safety and dignity for people, and reduce harm. And so helping someone to have a healthy physical body, and a well-fueled physical body, and teaching people about nutrition is a huge part of that."

Where is food provided for low-income PWUD/PLWHA in Greater Vancouver?

Individual sites are parts of daily food routes, forming a foodscape of free and low-cost sustenance, and care. Miewald & McCann note that low-income foodscapes are not solely comprised of social services providers, but also include low-cost restaurants, and shops (2014). They also note that "analyses of foodscapes, hunger, and food insecurity must see beyond the food itself and must continue to approach food access as defined—but not determined—by a set of surrounding institutions and wider processes" (2014, p 552), in this case, the variegated urban geography of Greater Vancouver. The harm reduction foodscape in Greater Vancouver varies dramatically between the Downtown Eastside, the City of Vancouver, and the surrounding region.

The Downtown Eastside was often treated by service providers across the region as a sort of benchmark by which to compare accessibility to free food programming, and affordable groceries. The main feature that sets the Downtown Eastside apart from the rest of the region is the variety, and high density of food options available due to the

large numbers of harm reduction, and other social service providers in the neighbourhood.

Although I described our working definition of food security to the people I interviewed, and by in large the kind of participants they were describing would not qualify as food secure according to academic definitions (e.g. Campbell, 1991; Dietitians of Canada, 2007; Heynen et al., 2012; Wakefield et al., 2013; Wicks et al., 2006), some of my interviewees asserted that their Downtown Eastside-based participants were food secure. For instance, the executive director of a women's shelter, and advocacy organization with sites around the entire Greater Vancouver region explained that: "food security in the Downtown Eastside from my perspective, there's a lot of food, there's a high degree of food security…" As mentioned previously, one of the main reasons for the large number of free, and cheap food options in the Downtown Eastside is because organizations see hunger, and food insecurity issues in their participants. A contributing factor to the need for food programming in places like harm reduction organizations is that many people living in the Downtown Eastside do not have access to appropriate cooking facilities. For people living in single room occupancy hotels (SROs), appropriate and sanitary kitchen appliances, cooking utensils, food storage, and preparation space are all hard to come by (Masuda & Crabtree, 2010; Miewald et al., 2010; Miewald & Ostry, 2014). A board member from a Downtown Eastside-based, peer-led harm reduction advocacy and support organization told me:

> "I used to cook in my room like that, but sometimes they get bent out of shape about it, so some places they won't allow it, and… you gotta do it on the sly… makes it really difficult to have a decent meal on a regular basis."

As a result, people living in these kinds of buildings rely on outside sources of food, but as a board member of an Aboriginal peer-led harm reduction advocacy group explained that:

> "it depends on where a person's situated. If they're homeless… getting food down here is almost like a fulltime job. It's going from one lineup to another, and if you are starving, that's pretty much your own fault, because all the food here is at different time. Like breakfast, there's coffee at different places, there's snacks, there's… breakfast, lunch, dinner, sometimes a little bit later…"

Barriers like lack of cooking facilities, and lineups are indicative of the subtle barriers to attaining food security experienced by low-income, HIV+ PWUD (Drabble, 2015; Miewald et al., 2010; Miewald & Ostry, 2014).

For people who do not want to, or cannot line up for food, there are some options to purchase food in the neighbourhood, however, they come with their own challenges. As has been noted by McNeil and colleagues (2014a), low-income PWUD typically do not leave a relatively small area as part of their daily paths. In an interview at a Vancouver-based shelter and housing organization described a similar pattern:

> "many aren't ranging super far, right? The drop-in centre where everybody is, or the place where they get their money administered, or their mental health worker, or their welfare cheque comes from, all those places are within five, six blocks of where they live, usually, and within those blocks… there's [only] some cheap grocers…"

Although Vancouver's downtown has a higher concentration of residential land uses than most other North American cores, and the services, like grocery stores, that come with it, most of those stores are not affordable to people with low incomes, or those on welfare benefits.

One of the reasons that there are continued barriers to attaining food security, even in the service-rich Downtown Eastside is that there are other competing priorities for harm reduction organizations in the neighbourhood. A board member at the Aboriginal, peer-led harm reduction advocacy organization mentioned earlier explained that:

> "people rarely starve down here… we have people dying of fentanyl overdoses, jib [meth] is a very harmful drug… we're still trying to get a handle on harm reduction as far as methamphetamines, so nutrition really takes a backburner… It should be more important to us, but we just don't have the resources… if we had more money we could do it… it would help a lot of people who die of AIDS, or Hep C-related [complications], because as you know, more nutrition helps your chances always…"

Although organizations see that their participants are food insecure, their other harm reduction initiatives may take precedence over food programming, which isn't often billed as harm reduction.

There are fewer harm reduction services outside of the Downtown Eastside. This situation is partially due to less demand, however, there are still low income PWUD living with HIV outside of the city of Vancouver. While in the Downtown Eastside there are multiple service provider options, sometimes tailored for specific groups like Indigenous people, and women, outside of Vancouver, there is less access to harm reduction-oriented services, and comprehensive free food programming. The coordinator for an HIV-prevention outreach program serving the Fraser Health Authority described that through the course of her practice she has seen:

> "definitely lots of people completely food insecure, like truly no having access… wasting issues, things like that… it's very, very different from the Downtown Eastside, where I've also worked… Sometimes people are just going hungry… It's just such a huge geographical area... Transit gets more and more sparse out there, so even if you have a bus pass that could mean nothing, especially if you're living with advanced HIV… sometimes it's just not walking distance."

As alluded to in this statement, people outside of Vancouver often have to travel long distances to access harm reduction services, and free food programming. Although Greater Vancouver is largely a contiguous urban area, public transit becomes sparser outside of the City of Vancouver. The executive director of the women's shelter, and advocacy organization in Greater Vancouver elaborated further, saying:

> "When you're poor you can't travel very far. You rely on public transportation to the extent it's provided in your community. So from my perspective, food security varies broadly in the region we live in…. If you look at Abbotsford… [it] has a very sparse bus system. Food insecurity is significantly different there than it is in the city… The Downtown Eastside has the appearance of food insecurity to me, to many of our clients, but actually food is available there essentially around the clock. You can access cheap or free, with decent nutritional quality. That's not the case even if you go to Surrey, Langley, Abbotsford, Chilliwack, those are places we work, I think as you move further out of the Downtown Eastside... Nutritional quality decreases, of the nutrition that people are getting, and their access decreases."

Service providers outside of the Downtown Eastside were generally aware of the disparities in resources allocated towards harm reduction in that neighbourhood, compared to outside of it. They articulated strong need in their communities for more resources to go towards harm reduction initiatives, including free, and comprehensive

food programming that was not being met by their funders at different levels of government. One of the ways in which these disparities are evident are in the kinds of food donations available to organizations outside of the Downtown Eastside. I elaborate on the food options available to Vancouver-based service providers in the next section, however, these ready sources of fresh produce are not available to more far-flung service providers. While some organizations have partnerships with farmers, and wholesalers, OHRO outside of Vancouver noted difficulties obtaining fresh fruits and vegetables for their participants. Figure 2 shows a 'menu' of the snacks available at a drop-in centre for homeless women outside of Vancouver that is entirely comprised of processed baked goods and grains. Although services are supporting smaller actual numbers of participants, inequitable access to these services, and fewer service options means that participants outside of the Downtown Eastside may experience increased vulnerability to the effects of food insecurity.

Figure 2. Donated snack options
The snack offerings at this drop-in centre outside of Vancouver are generally comprised of nutritionally-poor donations. Photo taken by author.

A spatial manifestation of the ‘making-do and taking what you can get’ funding situations faced by OHRO is seen in their food preparation spaces. Similar to increased food insecurity experienced by low-income people with poorly stocked food preparation spaces (Miewald & Ostry, 2014), the abilities of OHRO to provide their desired food program was often impacted by their kitchen facilities. In organizations operating out of purpose-built spaces, kitchens tend to be more functional, and uniform in style, and appearance. However, these kitchens are often still not able to meet the capacity required by service providers, or their participants, to prepare food several times per day. For instance, a housing organization had a building that was only a few years old, but their main kitchen (see Figure 3) was already unable to match the capacity required for their food initiatives:

> “we have some big plans for that kitchen… I wrote [our funding body] a really heartfelt letter… just to give you some ideas, just in the 6 months from January to now… we’ve served over close to 2500 meals. And again that’s based on 40 participants three times a week, not including… bigger [special events], and also the baking we do to help [provide snacks]. So it’s… quite hard to do what we want to do in that little tiny space there… it’s equipped just like a regular home.”

Figure 3. New-build kitchen
This supportive housing facility has a relatively new kitchen, but it is not large enough to meet the capacity required to prepare food for all of their residents. Photo taken by author.

For other organizations, however, homey kitchens were desirable attributes that they sought out in their purpose-built facilities. The executive director at a women's shelter and advocacy organization in Greater Vancouver explained that "we try not to make things look institutional, so we have two regular stoves with the big hood over top, but they're two regular stoves so that people can cook [on]." These kinds of set-ups (see Figure 4) were important for this organization in fostering independence, skills-building, and adequate nutrition in their participants, who included women and their children.

Figure 4. Shared food preparation space
This short-term housing for women and children features open pantries, and house-style kitchens for food preparation. Photo taken by author.

Other organizations, however, have to make do with pre-existing cooking facilities when they move into older buildings. Some sites did not have the capacity or zoning to allow for kitchens, restricting the types of food programming that could be provided in these organizations. Others had kitchenettes, or otherwise minimal food preparation facilities that similarly limited food programming on site. However, some of the most dramatic examples of having to make-do with pre-existing facilities came from organizations who operated out of older buildings with dilapidated, unsafe, and unsanitary food preparation facilities. A drop-in centre for PWUD in the downtown eastside, for example, was no longer able to use their kitchen because it had originally been made of inferior materials, and overuse by their organization, and an emergency women's shelter who shared their space had degraded the space to the point of

endemic rodent and insect infestation. Their director explained that when she saw maggots falling from the ceiling:

> "Something snapped in my brain, and I called my funding body, and just said 'that is fucking it... I'm shutting this kitchen down. You will replace it.' Nobody is safe, I don't care that this is the most… poor and marginalized population in the downtown eastside. Nobody deserves to eat food that may be unsafe for them to eat. And… all of my cooking staff, they're all community members, so it's unsafe for them to cook in there… we've been fighting to get the health authority to rebuild us a kitchen ever since… it was inappropriate anyways for the volume of food it produces, both for my program, and the women's shelter… it [was] producing probably over 1000 meals in a 24-hour period."

As the health authority had not yet agreed to replace the kitchen at this site, their food program was currently operating out of a different building owned by the parent organization of the drop-in centre, and food was wheeled over to the centre in carts every day.

As such, food preparation spaces are indicative of relationships with funders, and the often precarious financial situations of OHRO These organizations tend to express a strong feeling of dependence on their funding bodies to support food programs through cooking facilities, and their maintenance. My interviewees also tended to feel like their funding bodies did not prioritize food as a harm reduction intervention, or a source of participant/peer support. Thus, when food preparation facilities need to be (re)built, organizations advocate strongly for the kinds of cooking facilities that they think will be sufficient for their preferred kind of food programming because they do not anticipate adequate funding to renovate or expand them in the future.

How is food provided in harm reduction settings?

Because it is not often explicitly recognized as a harm reduction intervention, food is provided through relationships and structures that are often haphazard, ad hoc, and cobbled together from disparate sources. Additionally, organizations have particular food philosophies that are more or less strongly articulated, and acted upon in their food programming.

For smaller organizations, food is often facilitated largely with the help of relationships and partnerships. Relationships with municipal foodbanks are prevalent, and often provide the bulk of the food used by an organization, especially for smaller OHRO with food programs. Relationships with foodbanks take two main forms: some service providers distribute specialized food bags for HIV+ people on behalf of the foodbank, while other service providers obtain food from the foodbank with which to prepare meals and snacks for their participants. In the City of Vancouver, a foodbank program, called Food Runners, will collect excess prepared and/or perishable foods from places like farms and restaurants, and deliver them on the same day to organizations like OHRO to serve to their participants (Greater Vancouver Food Bank, n.d.). Service providers can also get large orders of both perishable, and non-perishable food, as well as food preparation equipment from the foodbank in order to facilitate their food programming. However, this kind of relationship does not exist between service providers, and foodbanks outside of the City of Vancouver. Some organizations across Greater Vancouver provide HIV-specific food bags that feature more high-protein foods than would be found in a typical hamper. In general, this service is supposed to act as an alternative location from which people who would already be eligible to receive foodbank assistance can pick up their food.

Organizations, particularly smaller ones express several benefits to having relationships with other OHRO. For example, a women-only ASO has partnered with the main HIV foodbank in Vancouver to provide high-protein food bags to their participants. This partnership is advantageous to the women-only ASO because:

> "the women that access the program here, they'd be eligible to access it at [main HIV foodbank], so it's really just a matter of finding a way where for women it might be safer for them, because it's a women-only space, and we're much smaller, so… for some women they prefer to come… there isn't the same kind of line-up they have to deal with, and it's a little more confidential, and they can also access the food program, and the other programs we offer when they come here."

That interviewee also added that funders like to see partnerships in funding applications, and so when they work with other organizations that share their goals, they are more likely to receive funding.

For service participants, an important consideration in how food is provided concerns issues of (constrained) choice. Most of the OHRO I talked to were conscientious of the 'poor people should be grateful for what they get' discourse, and tried to take measures to challenge it. Some service provision models seem to do a better at providing real choice than others. In organizations providing full meals, those that incorporate peer-run community kitchens tend to prioritize participant choice, and decision-making, even if they usually require fairly involved facilitation by staff. However, two of the organizations that I interviewed, both women-only organizations outside of Vancouver, employ a pantry approach to food, where women can pick ingredients from fully stocked refrigerators, freezers, and pantries, and prepare them in communal kitchen spaces (see Figures 4 and 5). Both organizations reported benefits to providing food in this way because it fit their harm reduction philosophies of empowering women, and involving them in decisions impacting their lives. Conversely, one of the women-only OHRO that I interviewed in the Downtown Eastside who also had a communal kitchen kept padlocks on their refrigerators, and pantry, and required women to ask staff when they wanted to cook (see Figure 6). They explained that if they left the food unlocked, it would get stolen, but both of the organizations with open pantries explained that they invested time into building good rapport between staff, and participants, resulting in environments where participants felt like their access to food was reliable. These feelings were important in preventing food hoarding and theft, while simultaneously assuring real choice in terms of what participants eat, and when they eat it; and empowering women to attain, and maintain food preparation skills.

Figure 5. Open pantry
Participants can freely help themselves to pantry staples, and prepare meals in a communal kitchen space at this drop-in centre for women in Abbotsford. Photo taken by author.

Figure 6. Communal kitchen with locked refrigerator
Although billed as a community kitchen, residents of this supportive housing facility for women must ask staff to unlock the refrigerators where they keep their food. Photo taken by author.

Kitchen spaces and practices reflect organizational goals, and funding situations. Some organizations are not zoned to have food preparation spaces, or lack appropriate cooking facilities, situations on which I elaborate in the next section. However, for sites that have kitchens either for full-service meal programs, or in residents' apartments, these spaces reflect not only organizations' approaches to food, but also their philosophies more generally. Some organizations share their kitchen spaces with other groups, and programs that have similar goals. For example, a support program for men involved with sex work provides outreach, and help with food preparation at the meal program of another organization with similar target populations, and goals. In another form of partnership, a low-barrier counselling organization lends out their kitchen to community kitchen programs for specific marginalized groups, such as male sex workers of Vietnamese descent. In this way, their kitchen space is in use almost every night of the week, and helps them achieve their goal of supporting marginalized people in the community.

Kitchens reflect not only organizational goals, but are also spatial manifestations of the make-do strategies organizations employ in order to offer a range of services. Despite having programming in their kitchen almost every day, the executive director of the low-barrier counselling organization explained that their kitchen is

> "not as well equipped as I would like. It's not a gas stove… we can have two big pots on the stove at once, that's it, because it's just a regular kind of stove. We have been lucky over time. We've got donations and stuff of really great pots, and things like that… I would love a commercial kitchen."

Many service providers with cobbled-together kitchens wanted to have higher-capacity food preparation spaces in order to provide more food more often to their participants. Most of the service providers that were not purpose-built new residences had kitchens that were comprised of donated appliances of varying quality, capacity, and styles (see Figure 7). This situation is indicative of funding situations that do not prioritize food provision in harm reduction programming.

Figure 7. Make-do kitchens
This Downtown Eastside-based health drop-in has a small commercial kitchen that is largely furnished by donations, and other piecemeal additions. Photo taken by author.

However, organizations that were new-build, or had BC Housing funding to renovate were able to build kitchens that reflected organizational values. For example, the executive director of the women's shelter, and advocacy organization in Greater Vancouver explained their philosophy towards their different kitchens as:

> "We took the position that we instead made our washrooms communal, and we put kitchens in every single suite… what we wanted is for women to have the ability to cook for themselves… and it's important to be able to supervise your child and be with them when they're sleeping… I see food security as… architectural design… because that considers how people use it. You obviously don't have food security if you have a big communal kitchen because everybody's in it… It depends on our facilities, so a number of our [sites look like]… traditional houses. And so they look like your kitchen. We're constantly replacing kitchens because a home kitchen doesn't stand up to 14 people cooking in it around the clock… Here in this building… we also have a homeless shelter… they

> have essentially commercial kitchens… we try not to make things look institutional, so we have two regular stoves with the big hood over top… so that people can cook and do whatever."

Although many other organizations would disagree with the statement that communal kitchens cannot assure food security, this organization is an example of a service provider that wants to have stoves with electric burners, and other domestic-style appliance because they were familiar, and home-like, and therefore easier for their participants to use (see Figure 8 for an example of the kitchens in supportive housing suites at that organization, and Figure 4 for an example of their shorter-term family shelter kitchen). Further, they incorporate their feminist, and women-first principles into the design of their spaces, a privilege not often afforded to OHRO, particularly those repurposing older spaces.

Figure 8. Supportive housing kitchen
A supportive housing facility for women and their children outside of Vancouver has small kitchens like this one in every unit. Photo taken by author.

Outside of the organizations that were able to design, and build their own food preparation spaces, even service providers with relatively comprehensive meal programming, there was little systematic thought put into how food fit in with organizations' broader goals, or philosophies. This finding came out in the previously mentioned lack of immediate awareness of the extent of food programming. More explicitly, however, my interviewees mentioned that they had first thought about the links between their food programming, and harm reduction goals when I contacted them asking for an interview. Although I had prompted them to think about these topics in relation to one another, most of my interviewees enthusiastically confirmed that food programming, and harm reduction were mutually reinforcing approaches to improving quality of life for their participants. For instance, an HIV outreach program serving communities in Fraser Health told me "one of the most important human needs is food. So for that reason alone, giving people food who are food insecure is a form of harm reduction." Although these sentiments were common, challenges to providing food were prevalent, sometimes to the point of being too great a barrier to sustain a regular, or comprehensive food program. That outreach organization, for example, is only able to fund one food coordinator in a foodbank in Surrey, despite seeing acute nutrition needs in their participants in their more remote participants.

Challenges and barriers to food provision

OHRO are often limited in their ability to provide their ideal food programming due to several constraints. The main concern is a lack of appropriate funding, and other resources required to furnish a food program. The inadequate funding is due to several reasons. Firstly, service providers do not think that their funders are willing to fund food, and that their funders do not prioritize food provisioning. For example, a drop-in centre for PWUD in the Downtown Eastside that wished to rebuild their dilapidated kitchen facilities, but had been negotiating with their funder for over a year over that issue.

Perhaps as a result of this perception, organizations sometimes do not even request food funding, instead opting to rely on the foodbank, or reallocating other programming funds towards food. Despite this perception, there appears to be very different levels of food funding across the Greater Vancouver region. Some

organizations mentioned demanding funding, and receiving it. These particular service providers knew that they could do so successfully, in part because they had long-term relationships with people in funding bodies like the health authority, or histories of past successes in demanding funds. These situations highlight the importance of enduring relationships between service providers, and funders (Bowlby & Lloyd Evans, 2011).

Secondly, although most of the service providers I talked to characterized their food funding as 'stable but insufficient,' the cobbled-together nature of food-related funding, local growing season, and the non-profit funding cycle can mean that service providers face unpredictable budgets, and fluctuating food supplies, especially around the end of the fiscal year, when supplies can either run low, or program directors may be given large sums to spend quickly.

Importantly, however, organizations have developed strategies for managing, and sometimes subverting these challenges. The above mentioned partnerships are one way that service providers attempt to reinforce their food programs. Further, although food budgets tend to be insufficient, some service providers find ways to subvert their funding structures. For instance, a First Nations-oriented clinic and drop-in obtained food funding from the health authority to enhance their medication support program that is intended to help participants adhere to their HIV medication regimes. In accordance with First Nations principles of inclusion, they opened up that food program to all participants, even though it was earmarked for only a subset of them. While not common, this kind of strategy is important for service providers to operate according to their values.

Harm reduction sites are also often not ideal places to cook and prepare food. Sites may not be zoned to have full kitchens, preventing organizations from cooking on-site, a problem most frequently experienced in organizations operating out of neighbourhoods that are not social services hubs. For instance, the women-only ASO in Vancouver quoted earlier was located in an office tower where they were not zoned to have a kitchen, and instead had to rely on catering for their weekly meal program. Organizations can also be inhibited from having a functioning kitchen in spaces where (commercial) kitchens are permitted, but building are dilapidated, and unsafe for food preparation. For instance, after their kitchen was infested with rodents, and maggots, the

drop-in centre for PWUD in the Downtown Eastside was forced to close their kitchen, instead sending their peer cooks to prepare food in a different building, and deliver it to the drop-in site. The manager of that site explained, “Nobody deserves to eat food that may be unsafe for them to eat… all of my cooking staff, they’re all community members, so it’s unsafe for them to cook in there.”

Finally, the spaces and sites of harm reduction service provision are not always as low-barrier as a harm reduction model would imply, resulting in the potential for further marginalization of the people accessing these services. As explained in many of my interviews, as well as literature about poverty management and food security, food lines exclude people with mobility, and psychosocial issues; a lack of choice in what to eat, partially dictated by the insufficient food budgets of service providers is an affront to the dignity of participants; and, some spaces, due to their clientele, are socially exclusive to some groups like women, and indigenous people, who may fear violence from other participants (Drabble, 2015; McNeil et al., 2014a; Miewald et al., 2010; Miewald & McCann, 2014). All of these conditions serve to increase barriers to people meeting their basic needs in harm reduction spaces.

Discussion and conclusion

Studying the harm reduction foodscape in Greater Vancouver highlights how uneven food access can be for marginalized people, like PWUD, who are not empowered to purchase and prepare their own food. Further, it highlights how crucial these organizations are as nodes in the geographies of survival for low-income PWUD who are living with HIV, a particularly high-needs group. As such, these organizations exist at the precarious frontlines of nutrition for low-income PWUD, stretched between profound need amongst their participants, and insufficient funding conditions to provided ideal food programming (Miewald & McCann, 2014).

At regional, neighbourhood, and site levels, the harm reduction service provision environment in Greater Vancouver is important, but largely ignored facet of the low-income foodscape. OHRO often begin providing food because they see profound food insecurity in their participants. Although service providers recognize that PWUD

experiencing acute food security often rely on them for the bulk of their nutrition, they do not usually employ a systematic approach to food provision that acknowledges this fact, or incorporates it into their harm reduction philosophy. However, when seen through the lenses of poverty management, and foodscapes literatures, it is clear that OHRO shape how their participants meet their basic nutrition needs.

Regional disparities in funding, and density of services mean that although there are more people experiencing acute need in the Downtown Eastside, people in outlying communities may face more acute hunger, and have fewer, less accessible options for meeting that need within a harm reduction framework. Even in the service-dense Downtown Eastside, however, food provision in harm reduction sites is not unproblematic. Lack of coordination between service providers can create gaps in food availability, especially when issues of marginalization, and exclusion for some people in some sites is taken into account. The absence of standards for food quality, and quantity can also impact survival for people who rely on free food. Food is provided according to what service providers perceive to be 'healthy,' in combination with what foods they can afford, or procure through donation, in a similar manner to the ways in which alcohol recovery is structured according to the personal experiences, and environmental constraints mediated by the recovery house operators studied by Fairbanks (2009). These conditions minimize choice for service participants, contradicting harm reduction goals of individually-determined service usage. More systematic planning of food programming could result in more empowering formats for food provision, like the open pantry, and peer-led community kitchen models, which combine use of whole, fresh ingredients, with participant choice.

Partnerships between service providers are not only useful for securing funding, but are helpful for extending the reach of some food services, like HIV-specific food bags, to people who would be uncomfortable accessing them in other environments. These kinds of partnerships between organizations that share similar goals can expand the capacity of food-related harm reduction interventions in ways that likely benefit both organizations, and their participants.

Ultimately, harm reduction organizations should not have to subvert their funding structures, or rely on foodbanks, and other donors, in order to address acute needs in the people accessing their services. Although there are several facets of the Greater Vancouver harm reduction foodscape that should be improved, as Wakefield and colleagues point out, it is “important not to demonize the many intelligent, kind, and generous people who give their time… to food security initiatives as willing handmaidens of neoliberalism” (2013, 444). The relationships they have with their funders are framed on the service provider end as essential, if occasionally burdensome, or somewhat coercive. These relationships also may prevent them from addressing the root causes of food insecurity, and poverty for their participants, not least because they would rather serve their participants than lobby government for change (Wakefield et al., 2013). Additionally, they do not want to expend resources fundraising, or and they do not perceive funders as being interested in supporting the radical political work of challenging the systemic foundations of the welfare, health, and social services systems in Canada. In fact, in Canada, charitable organizations are only allowed by the Canadian Revenue Agency to spend up to 10% of their resources on political advocacy work (Wakefield et al., 2013).

Given these constraints, the entities that fund OHRO, like federal and provincial governments, and regional health authorities, should incorporate food into their understandings of harm reduction, and social services, and fund food accordingly. Increased food funding would not change how services are actually being provided, because food is already inextricably tied to harm reduction within service provision sites. Rather, it would improve nutritional standards, and confront the disparities in food security faced by low-income PWUD living with HIV. As stated by the people I interviewed, and reinforced by recent studies, improving food security for this group would have dramatic health, and quality of life impacts, benefitting real people who work in harm reduction organizations, and their high-needs participants.

Chapter 4.

Providing harm reduction: food and peer work

In my first paper, Chapter 3, I explain how food and harm reduction are intertwined in the sites of care that make up harm reduction service provision environments. In the next paper, Chapter 5, I delve deeper into how services are actually provided in organizations with a harm reduction orientation (OHRO). I investigate how organizations rationalize the role of peer work within their sites, and the conditions under which this work is carried out. The people providing services to marginalized participants in harm reduction environments are themselves often marginalized workers who are 'peers,' and participants themselves. I argue that engaging these workers has particular implications not only for the organizations and their peer workers, but also perpetuating shadow state relations and economic disadvantage for peer workers.

Conceptually, I shift from focusing on how food fits into harm reduction service provision settings, and philosophies to examining how services like food are provided through peer work. Elaborating from my initial description of the Greater Vancouver harm reduction foodscape, my first paper lays a groundwork by examining what harm reduction services are provided, to whom, and where. I used poverty management, and food security literature to highlight the ways in which institutions, and the people within them shape the lives of those who are reliant on social services; and to emphasize how survival opportunities are geographically articulated across an urban region. By exploring the service provider perspective on incorporating food into harm reduction services, including the challenges faced in funding, and running food programs, I describe how these services operate in context of harm reduction in Greater Vancouver.

In the next paper, I more closely examine the role of peer workers, and especially stipendiary volunteers within these services. Although, as demonstrated in the literature

review, peer workers are present in other addictions service provision settings, peer workers are common in harm reduction in Greater Vancouver. While the first paper focused on food provision because food is a basic need, the next paper examines the economic barriers built into peer work that enable survival at the expense of exiting poverty, and sustain organizations in insufficient funding conditions. This paper is concerned with examining this system because of its importance for individual livelihoods, and the functioning of vital harm reduction services. Therefore, it also concludes with measures that funders, and services providers can take to improve the capacity for their peer workers to thrive.

Chapter 5.

Doing the work of harm reduction: peer employment in social services

Introduction

Study after study have shown that harm reduction programs and policies work – at least for curbing blood-borne disease transmission rates, and reducing the social and individual harms associated with illicit drug use (see, for example: Harvard et al., 2008; Rhodes, 2009; Stimson & O'Hare, 2010; Marlatt et al., 2011). However, these programs and policies do not work without the workers who populate the harm reduction service provision landscape. This paper examines the ways in which food and other services are provided to low-income people who use drugs (PWUDs) and living with HIV/AIDS (PLWHA). Specifically, I explore the roles and implications of marginalized PWUD providing services for their peers (i.e. people with broadly shared life histories and experiences) (for considerations when engaging marginalized and vulnerable people in volunteering for their communities, see Bowlby & Lloyd Evans, 2011). I discuss this issue in the context of harm reduction services in Greater Vancouver, Canada, where peer work is used in many kinds of harm reduction services. This paper furthers previous work on sites of addictions care, and addictions treatment by exploring how peer work integrates harm reduction and shadow state relations.

'Harm reduction' encompasses "…policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption" (Harm Reduction International, n.d.). In practice, harm reduction-oriented services attempt to prioritise, and empower individual choice through "let[ting] people come as they are, meet[ing] them where they're at, and recogniz[ing] the power of any positive

change" (Collins et al., 2011, p 27). Participants do not have to be sober, or seeking sobriety in order to access, and maintain eligibility for services. In British Columbia, Canada, harm reduction is part of Provincial health policy through, for example, distribution of clean needles (Harvard et al., 2008). As a policy, however, harm reduction is implemented differently in different places, and venues. Each health authority in BC, for example, has particular ways of supporting harm reduction services. When harm reduction is provided by non-profit organizations, and social services, the types of harm reduction supports and supplies, and the extent to which harm reduction is integrated into the institutional character varies greatly.

This paper is concerned with the roles of peer labour in harm reduction service provision environments. My interest in this form of work emerged through my fieldwork conducting interviews about the relationships between food security and harm reduction with organizations with a harm reduction orientation (OHRO) in Greater Vancouver. My interviewees were forthcoming about the importance of peer workers in their organizations. It became clear to me that exploring peer work is important for understanding how these spaces work, and for understanding how food programming is deployed in harm reduction environments, the original goal of my research.

I am interested in the ways in which harm reduction services are provided, because institutional character, and the relationships that people have with staff in social services greatly impacts the quality of their experience in accessing services (Rowe & Wolch, 1990). These kinds of relations become all the more important when people are reliant on social services in order to meet some of their most basic needs, like food. Extending this notion, in cases like peer work where employees may also be participants of the same organization, harm reduction goals and ideologies may either be extended or undermined in the service provision environment, based on the way peer work is structured.

I begin this paper with a brief review of academic conceptualizations of the social services sector, and literature concerning peer work in sites of addictions treatment and care. I then move on to describe the methods I used for this project. My results are oriented around the ways in which OHRO engage peer volunteers, with particular focus

on stipendiary volunteers. I discuss these findings in light of my literature review, and conclude with recommendations for both policymakers, and service providers on ways to reconcile peer work with a harm reduction paradigm.

Peer work in social service contexts

I use literature that conceptualizes the social services, or voluntary sector, including shadow state, and poverty management through geographies of survival in order to tease apart the ways in which peer workers are ensuring their own survival, while simultaneously sustaining others. My research is situated in harm reduction environments, and this philosophy is important in how organizations incorporate, and relate to, peers. With this context in mind, I also examine literature about harm reduction, and other drug-focused environments to find other instances of peer work, and the relationships between peers, care, and work.

Ways of understanding the social services sector

DeVerteuil and Wilton (2009) use a relational geographies of poverty approach that emphasizes how both service providers, and participants are constantly adapting to new regulatory environments, and shifting relationships within care environments. They investigate how institutions that are sites of care are indicative of political and regulatory strategies, a situation that resonates with the organizational conditions faced by the service providers in this paper. DeVerteuil & Wilton (2009) use Peck & Tickell's framework describing how the state, in response to the failings of "roll-back neoliberalism," has implemented "roll-out neoliberalism" since the 1990s to reregulate, and manage the poor, rather than addressing root causes of poverty (2002, p 384). As supported by the importance of public agency funding to harm reduction organizations in Greater Vancouver, the state has been central in roll-out neoliberal poverty management, including by encouraging the voluntary sector to increase the scope and scale of services offered (DeVerteuil & Wilton, 2009; Mitchell & Heynen, 2009), as seen in the 'shadow state' (Wolch, 1990).

Wolch's 1990 conceptualizes the shadow state as "…a para-state apparatus comprised of voluntary organizations… administered outside of traditional democratic politics. It is charged with major collective service responsibilities previously shouldered by the public sector. Yet it remains within the purview of state control." (Wolch, 1990, p 4). Alternately, the voluntary sector can be understood as "a set of relationships dominated by voluntary action, and lying in tension among state, informal community and private market influences, but not reducible to their handmaidens" (DeVerteuil, 2015, 9). Further, Hogg & Baines (2011) understand the voluntary sector as providing necessary services that the private sector will not take on. Although the shadow state voluntary sector is providing services, the state still determines who can receive (social) services, and for how long (Trudeau, 2008). This format of service provision is now a normalized service relation by both service recipients, and service providers, as indicated in the ways in which OHRO in Greater Vancouver describe their relationships with their funding bodies, and peer employees.

The shadow state formed through a specific series of changes spurred by welfare state restructuring in the late 1970s and 1980s that resulted in a growth of the voluntary sector (especially in social services) (Wolch, 1990). All of these changes that led to the creation and expansion of the shadow state are important in providing context for understanding the contemporary shadow state. The increasing purview of the shadow state means that the voluntary sector has a growing role in shaping everyday life, and the directions of social change at the same time as they experience restrictions through state regulation (Wolch, 1990). By the 2000s, the shadow state had become the established stop-gap for state retrenchment from service provision for those who cannot afford private services (Bowlby & Lloyd Evans, 2011). The time that has elapsed between the birth of the shadow state in the 1980s, and its current form allows for researchers to study the effects of these changes in service provider structure (Trudeau, 2008). This paper furthers that work through examining how shadow state relations are manifest in peer work arrangements.

The shadow state is cheaper to administer than government-provided services, partially because voluntary sector wages are lower than public sector ones, and because of reliance on volunteers (Wolch, 1990). Even as costs increase, funding does not have

to, leaving organizations having to do more with less (Wolch, 1990; Baines et al., 2011). However, the shadow state can be understood:

> "not just as sites of control or punitiveness, but *also* as potential and genuine sites of help, caring and sustenance for people who cannot be easily absorbed into the capitalist order, sometimes working *for, alongside* or providing an *alternative to* neoliberalism (and the welfare state more generally) in the city,"

enabling resilience in their participants (DeVerteuil, 2015, p 10, emphasis in original). Shadow state organizations provide benefits such as increased citizen opportunities for community involvement, and decentralized decision making (Wolch, 1990). As well as acting in managerial ways, harm reduction organizations who use peer work enable participant influence on their service provision environments. Additionally, services provided through local organizations can be more responsive to specific, changing contexts. For Wolch (1990), the voluntary sector is best equipped to limit state power, and, although this characteristic may be under threat by how the shadow state is structured, it is a still an important site for political resistance, and social change. Understanding sites of care as political sites also reveals how service providers identify which citizens need, and deserve help (DeVerteuil, 2015). These benefits are tempered by some of the negative consequences stemming from the development of the shadow state, such as dependency of organizations on the state for public funds, and increased time and energy spent on securing grants. The shift towards a shadow state apparatus could limit its potential to foster social change (Wolch, 1990).

The punitive side of the voluntary sector may mean that services ensuring survival, and sustenance are not offered without mechanisms for abeyance, and control (DeVerteuil, 2015). Geographically, government, and voluntary sector social services work as sites of control, as well as spaces of care, while poor people, especially the homeless, face strict state-enforced "legal landscapes" of restriction and control on their use of outdoor spaces (Mitchell & Heynen, 2009, p 613; DeVerteuil & Wilton, 2009). For instance, detox facilities may be used by law enforcement as a place to take people who use drugs or alcohol as an alternative to jail. In this way, the person is removed from the public realm, and facility staff can provide a space of care through welcoming the individual. Spaces of care can be thought of as "relational therapeutic environments

designed to promote the wellbeing of the client" (DeVerteuil & Wilton, 2009, p 465). They can include many of the kinds of harm reduction services in this thesis, such as drop-in centres, homeless shelters, and meal programs (DeVerteuil & Wilton, 2009). For the people that use them, service providers can provide some structure, safety, social support, and close relationships with staff that may be lacking in lives marked by impermanent living situations and transient relationships (Rowe & Wolch, 1990; McNeil et al., 2014a). However, difficulty maintaining recipient status in social services like welfare can result in tensions with staff, and loss of the stability these services provide (Rowe & Wolch, 1990). The people who use these sites of care are often marginalized people, and the practices of the organizations that operate them can have both therapeutic and enforcement effects (DeVerteuil & Wilton, 2009). For example, service schedules of providers structure the meal schedules of those who rely on them for sustenance (Rowe & Wolch, 1990; DeVerteuil & Wilton, 2009).

Services like homeless shelters and food banks were originally intended to be temporary solutions to crises, however, they now act as cornerstones of the diverse, ad hoc social services that form marginalized peoples' "geography of survival" (Mitchell & Heynen, 2009). There are also expectations from service providers about how participants will use, and progress through their services. For instance, abstinence-oriented drug treatment programs expect detox, followed by treatment, followed by long-term sobriety. In practice, however, "people enter, navigate, leave and return to the treatment system in different ways," with different timelines, based on meeting their own needs rather than the idealized timelines of service providers (DeVerteuil & Wilton, 2009, p 467). Daily needs are met by participants through daily routines with service providers, but also through social networks, and intimate relationships (Rowe & Wolch, 1990; Mitchell & Heynen, 2009). Service providers also sustain survival through peer employment by increasing participant incomes beyond basic welfare rates, as well as providing some training, and flexible work environments that accommodate the capacities of their participant workers.

Wolch (1990) describes relationships between the state and service providers under the shadow state as primarily contractual, with state agencies paying voluntary sector organizations to provide specific programs and services. Because shadow state

organizations are not agencies of the state, they maintain a certain degree of autonomy (Wolch, 1990), and the institutional structure of shadow state/voluntary sector agencies is one of its advantages (Hogg & Baines, 2011). The ambiguous, and hybrid natures of many shadow state organizations, where lines between employer, staff, volunteers, and participants lead to a sector that can be flexible and responsive to needs. Formal relationships with the state through contractual mechanisms can also increase organizations' resources through funding (Trudeau, 2012). However, this autonomy is constrained by reliance on the state for funding and support, and by state regulations that govern the ways in which services are provided (Wolch, 1990). These constraints can limit the potential for shadow state organizations to engage in radical activity, one of the advantages of the voluntary sector (Trudeau, 2012). The voluntary sector is neither inherently nor exclusively co-opted into the neoliberal shadow state, but it is also not intrinsically positive or progressive (DeVerteuil, 2015), as evidenced by some of the peer work conditions that are commonly valued in Greater Vancouver's harm reduction organizations. Bowlby & Lloyd Evans advocate for a relational understanding of labour in the shadow state that understands these actors as "located not only between state organizations and civil society groups but also between these and market organizations" (2011, p 418). This approach highlights that multiple, and contradictory interactions between actors are based on multidirectional, multiscalar influences embedded in (social) place (Trudeau, 2008). This approach is helpful understanding the contradictions, and alliances that exist between the decision makers within OHRO in Greater Vancouver, their peer employees, and their state agency funders.

Service providers in the shadow state are implicitly treated as if they are providing statutory services, and that the conditions under which personnel work in the shadow state are similarly professionalized like those of public employees (Wolch, 1990). In Greater Vancouver, where harm reduction is almost entirely administered through the voluntary sector, this situation is the norm. As the divide between state and shadow state blurs, service recipients can become unsure of who is accountable for service provision (Wolch, 1990). At the same time, the heavy dependence of service providers on government funding reduces their ability to criticize government policies, and aligns them with these policies through providing the services they mandate. In British Columbia, for example, health authorities fund harm reduction programming

because it is mandated by the provincial government, but, in general, they do not provide much formalized harm reduction programming themselves. Importantly, harm reduction services have always existed alongside, and as part of the shadow state, because harm reduction-oriented responses to HIV, and other blood-borne diseases have only been formalized in Vancouver since 2001, long after shadow state relationships were established in social service provision (Harvard et al., 2008; Wood et al., 2003).

Ultimately, state and voluntary sector relationships cannot be said to be top-down, or unidirectional. Instead, the 'relational shadow state' emphasizes the "evolving and constitutive nature of relationships between institutions of the state and civil society" (Trudeau, 2008, p 670), recognizing lines of influence that intertwine, and intersect between actors. For instance, the state can influence voluntary sector policies and mandates, but voluntary sector organizations can negotiate the level of state involvement in their organization, and influence government policies (Trudeau, 2008). These relations are evident in descriptions from interviewees of seeking out funding for specific facilities, amenities, and initiatives from state agency funding sources that are allocated for particular purposes.

These conditions should not serve to paint the social services sector as entirely effective, or beneficial, or the state as controlling and punitive. Organizations and initiatives within this sector experience failures, however, they often go unrecognized due to the "halo effect" around the voluntary sector, leading this sector to be presented, and thought of, in a largely positive light by the general public, and the organizations themselves (Hogg & Baines, 2011, p 346). At the same time, when examining social services, it is "important not to demonize the many intelligent, kind, and generous people who give their time (professionally or as volunteers) … as willing handmaidens of neoliberalism" (Wakefield et al., 2013, p 444). Trudeau (2008) concludes by emphasizing that although there are opportunities for resistance and subversion, the relationships between the state and shadow state remain asymmetrically aligned in favour of the state.

Peer work

Literature discussing relationships between marginalized people, and employment identifies several factors contributing to widespread unemployment in this group (e.g. DeVerteuil, 2005; Trudeau, 2008; Bowlby & Lloyd Evans, 2011; Hogg & Baines, 2011; Bennett, 2015). In 'welfare neighbourhoods,' or "places where welfare payments have deeply insinuated themselves into the local economy and survival strategies of the poor," low-income people struggle with a sheer lack of mainstream employment options (DeVerteuil, 2005, p 24). Further, in these neighbourhoods, the employment options that do exist do not pay high enough wages for employees to escape poverty (DeVerteuil, 2005), reflecting shifts in the welfare state since the late 1970s that tend to privilege people who are already employed compared to people outside of waged labour (Bennett, 2015). In Canada, welfare rates are tied to income, so waged employment can disqualify a person from social security benefits, making the attraction of low-wage employment even smaller. Despite these conditions, however, peer work (either paid, stipendiary, or voluntary) is evident in every kind of OHRO in Greater Vancouver, indicating benefits to this kind of work.

Peer work simultaneously engages participants in work within sites of care in which they are participants, and reorients the caring relationship. Different kinds of workers are desirable for different tasks in voluntary sector organizations. Bowlby & Lloyd Evans found that permanent, paid staff were useful for maintaining strong, consistent relationships with the state, for instance when it came to ensuring renewal of funding (2011). However, this kind of consistency was threatened by short-term funding cycles that resulted in many paid positions being temporary contracts. Private sector pay is generally higher than that of the voluntary sector, adding another challenge for organizations to retain high quality staff. Further, smaller organizations felt more disconnected from both government agencies, and networks of service providers (Bowlby & Lloyd Evans, 2011). Wolch found that the most common personnel changes made to accommodate the new financial realities of the shadow state were to reduce paid staff positions (including shifting to more part-time positions), and engaging more volunteers (1990). These changes reflect a move towards more flexible staffing patterns that reduce organizations' personnel (Wolch, 1990). Political orientations amongst

OHRO in Greater Vancouver's harm reduction may explain why many volunteer positions are paid in this sector, albeit at rates far below those of regular staff positions. In response to reduced personnel, remaining staff devoted less time to planning and administrative activities, focusing mostly on service provision (Wolch, 1990). Unpredictable and constrained funding led to unstable operating environments that provided a barrier to maintaining and expanding service levels.

An advantage of the community-based nature of many shadow state organizations is their ability to engage "bicultural workers" (Trudeau, 2008, p 682), meaning staff and volunteers that can relate, and translate hegemonic state, and privileged voices, and those of their participants. These kinds of workers are valuable because they can aid in facilitating culturally-appropriate service provision (Trudeau, 2008). The concept of biculturalism is important for peer work in harm reduction, because the peers hired to work in social services bridge PWUD identities with participation in formalized, professionalized social services. As described by Bowlby & Lloyd Evans (2011), the roles of volunteers in the voluntary sector have also shifted to become increasingly professionalized through mechanisms like application processes. Ironically, these processes, along with volunteer management, require more staff time to administer, with paid (emotional) work existing "to create the conditions for unpaid work to take place," and offsetting some of the increased capacity gained from engaging volunteers (Bowlby & Lloyd Evans, 2011, p 423). Volunteers require consistent support from staff to keep them engaged with the organization, and effective in their roles. Vulnerable volunteers, like the peer volunteers involved in harm reduction service provision in Vancouver, require even more staff support.

Peer work can also facilitate survival. Fairbanks (2009) describes how alcohol recovery houses in Philadelphia are operated by recovering alcoholics, and the ways in which they structure the recovery space. Although these facilities are abstinence-based, the ways in which operators develop their programs, and relationships with the state are useful for understanding peer subjectivities. The operators themselves have to work their way up a peer work ladder, although these roles are not often framed as labour, and are usually unpaid. In these spaces discourses of 'giving back' to their (recovery) community through residents doing chores around the house, or house managers going unpaid are

seen at least partially as therapeutic, and remedial practices that builds life skills (Wilton & DeVerteuil, 2006; Fairbanks, 2009; Love et al., 2012). In these recovery houses, confrontation by peers surrounding problematic behaviour was seen as the most effective form of intervention, incorporating all actors in the recovery network into an individual's treatment (Fairbanks, 2009). This social approach based in achieving self-improvement through service to others is somewhat different from the individual-centric harm reduction philosophies employed by the organizations I interviewed. However, peer workers in harm reduction organizations are valued for being relatable, and having experience with the situations in which participants find themselves.

Fairbanks argues that these kinds of unpaid peer work within the recovery house instills values of self-responsibility, and good citizenship in people seeking addictions treatment, a form of neoliberal governmentality that makes use of mentorship, and voluntarism underpinning civil society (2009). However, it also raises questions about the lack of compensation for peer work in recovery houses, and other addictions services, since the operators of these facilities extract capital from this labour through government grants, and other forms. The recovery house system emphasizes that individuals are gaining the skills to achieve paid positions, or run their own recovery houses. However, ideas of the value of 'skilled' and 'unskilled' labour can serve to reinforce capitalist relations that may undermine the importance of peer expertise (Pratt, 2004).

Further, the prevalence of casual, un(der)paid peer work that occurs outside of any sort of formalized labour regulation raises questions about the necessity of unemployment under capitalism (Harvey, 2005), and about the roles of workers as commodities (Marx, 1844), given their simultaneous roles as welfare-dependent service consumers (participants), and service providers. Fairbanks concludes that this kind of "marketized voluntarism" is a systemic failure that encourages recovery house operators to perpetuate the vulnerability of their residents in a disciplinary form of poverty management (2009, 187). There are contradictions between goals of treatment, and the strategies employed by the state through the criminal justice, and welfare systems, but both sides attempt to foster neoliberal goals of self-management, self-control, and becoming a 'productive member of society' with recovery houses as "nodal points

situated within complex and unpredictable networks of regulatory power" (Fairbanks, 2009, 99). As such, spaces of addictions care are important sites for promoting the existence and survival of PWUD within and alongside neoliberal goals and strategies. Although they are not profit-generating enterprises, OHRO in Greater Vancouver end up promoting the existence of PWUD within, and alongside capitalism in similar ways.

Recovery house operators in Philadelphia saw themselves as entrepreneurs, taking pride in navigating the welfare system, rather than being dependent on it. Fairbanks adds that "they act as a new form of market-driven social worker, operating in the shadows welfare state" (2009, 91). However, low welfare rates also pushed operators to force their residents into the formal and informal labour market, intermingling treatment goals with workfare, and coercive labour (Fairbanks, 2009). A similar process is seen, albeit to a lesser extent, in harm reduction in Greater Vancouver, where some service providers will use paid staff resources to escort supportive housing residents to perform stipendiary peer work at other organizations in exchange for currency like grocery vouchers as a way to support independence for their participants.

Earlier work on the shadow state, social services sector, and the roles of peer workers in these environments is useful for understanding how peers work in harm reduction settings. It is easy to see peer work as an expression of empowerment in harm reduction environments, given the value that approach places on individuals. However, there are other factors at play that complicate peer work in social service providers that tend to go unacknowledged in Greater Vancouver's harm reduction landscape. This contextual information guides my investigation, and analysis of service provider perceptions of peer work in harm reduction sites across Greater Vancouver.

Methods

My project is one facet of a research project conducted in partnership between the Dr. Peter Centre, a harm reduction-oriented ASO in Vancouver's West End, and an academic research team. The service provider wanted to determine the impacts, and implications of their food program on their participants. More broadly, they were

interested in the relationship between food security and harm reduction initiatives for PWUD and PLWHA. Other parts of the project investigate the lived experiences of low income, HIV-positive PWUD accessing harm reduction services, and food in Greater Vancouver. Those sections of the project involve a survey, and a narrative mapping activity conducted with the help of peer research assistants. My work, meanwhile, was focused on exploring service provider perspectives on food provision, and the relationships between food, and harm reduction. Through the course of conducting these interviews, it became apparent that peers were an important subset of worker in OHRO, providing truly vital services like food that help PWUD meet their survival needs. As such, understanding their role is essential for understanding how these spaces work.

I used qualitative, semi-structured interviews for my case study. In total, I spoke with 35 OHRO workers and board members in 27 interviews (refer back to Table 1 for a breakdown of the types of organizations interviewed). My interviewees worked across the Greater Vancouver region, including in Vancouver, Richmond, New Westminster, and Abbotsford, although some organizations had harm reduction sites in other Greater Vancouver municipalities as well (refer to Figure 1 for a map of Greater Vancouver). The broad swath of interviewees, and sites, ensured that I developed a strong sense of the harm reduction landscape in Greater Vancouver, including prevailing attitudes, and practices. The composition of the voluntary sector (e.g. in rates of volunteering) differs depending on the urban contexts, as does its relationship to welfare bureaucracies (DeVerteuil, 2015). Vancouver is a unique urban context for its density, and breadth of harm reduction service organizations, allowing me to draw on a diversity of service provision environments. To the extent it was convenient for my interviewees, I conducted my interviews in the sites where my interviewees work. I wanted to situate my interviews within these sites in order to gain a sense of the working environments in which harm reduction services, and supports are administered.

Working to reduce harm: implications of peer work in OHRO

Through my interviews with harm reduction organizations, it became clear that these kinds of work were integral to the functioning of many harm reduction organizations. My interviewees were keen to mention their peer work programs, and

were enthusiastic about the perceived benefits these programs brought to their organizations, and their participants. I followed up with my interviewees to determine the prevalence of peer work in OHRO in Greater Vancouver. Of my 27 interviewees, 23 used peer work in some capacity. Of those, 15 provided some kind of compensation for peers working or volunteering with the service providers. I was unable to follow up with 3 organizations to determine whether or not they provided compensation for their peer workers and volunteers.

Broadly speaking, work done by peers, in this case people with personal histories of drug use, and/or living with HIV, can be divided into two main types: volunteering, and stipendiary volunteering. Some organizations used multiple kinds of peer workers depending on the activity, for instance, providing a stipend for participating in research, but using uncompensated volunteering on day-to-day basis. Each of these varieties has its own characteristics, and organizations have particular rationale for using engaging peer workers in each of these kinds of employment.

Volunteers

Organizations have many ways to integrate peer work into their services. In some cases, peer volunteers are part of a specific program, while smaller organizations tend to have fewer, less formalized volunteers.

Harm reduction organizations have multiple rationales for including peer volunteers in service provision. The director of an HIV+ program at a First Nations-oriented clinic described her reasons for changing their peer volunteer program to expose volunteers to multiple roles within the organization as:

> "The philosophy behind it is… self determination… clients have a lot of potential that they haven't tapped into… I believe if we give people the ability to show what they can do, and… help them to develop that confidence in what they can do… we're always going to have a segment of the people that are dependent on… all of our services, but there's a lot that can be living the life they want to live, so that's the whole idea behind it."

Although many of their participants would always be reliant on services, this organization recognized that they could be independent, and impactful in their volunteer roles. These understandings echo discourses noted by Fairbanks (2009) in recovery houses around creating productive members of society, and skills building where people in alcohol 'give back' to their communities through working in the houses, and serving their peers. The director of women's drop-in centre in Abbotsford added that "We have a peer program [because] we believe in the value, and the power of peers when it comes to women supporting women." The solidarity experienced between peers was worth the effort of coordination on the part of paid employees. Similarly, an HIV/AIDS service organization (ASO) that provides support for women explained that they had peer volunteers because:

> "I think lots of women will say things like they want to give back to the community. A lot of women will literally say that it gives them something to do, gives them a focus for their day or their week. They may be in a position where they're on income assistance, so they might want to have like a part-time job where they can make their limited amount that they can make while still on disability benefits, but then they also want to volunteer because they feel like they're really connected to this organization. And it provides a sort of a peer support for them as well."

Although their participants demonstrated a desire to contribute to the organization this ASO was unable to develop a large peer volunteer program because they did not have the capacity in their paid employees to coordinate volunteers. Instead, they relied on a small number of relatively independent peers. Similarly, there are differing levels of peer volunteer autonomy in OHRO. Some organizations, like the First Nations-oriented clinic, have close counsellor supervision of volunteers to do things like plan, shop, and cook for one of their lunch programs. The need expressed on the parts of service providers to supervise, and closely manage their peer workers supports Bowlby & Lloyd Evans' (2011) arguments that social service providers in the shadow state feature increasingly professionalized volunteers requiring high levels of paid staff supervision.

Another benefit to engaging peer volunteers was to provide them with job training that could lead them to regular employment. For instance, being given FoodSafe training (basic certification in the safe handling, and preparation of food), and kitchen experience

lead to some peers going to culinary school, or finding jobs in kitchens. Other organizations hired peers to be regular staff, or program directors because of their shared experiences, knowledge, and expertise, as well as for political reasons. These organizations demonstrate the potential to create inroads for peers to gain stable employment that can be difficult to attain for PWUD. Job training and skills-building initiatives support stability for PWUD and PLWHA, a goal of harm reduction. However, these kinds of positions are rare, and are only accessible to the most high-functioning peers who are able to work regular hours. As such, many of these positions are filled by people with histories of drug use, rather than current PWUD.

Although they are using peer volunteers to provide some services, organizations faced challenges when facilitating their peer volunteer programming. Service providers identified a lack of staff time to coordinate volunteers as a main reason for not having peer volunteer programs, or for only using a handful of relatively independent peers. Even though peer volunteers are a source of cheap or free labour for organizations with already stretched budgets, underfunding and understaffing (Bowlby & Lloyd Evans, 2011) can limit the abilities of organizations to use peer work in ways that are beneficial to both staff, and volunteers. Another challenge was described by an organization that provides support and services to women who are sex workers:

> "Often [volunteering] starts in the kitchen so they can integrate into what we do, then they move to the clothing room, or the makeup room. But in the kitchen they can't be manipulated or influenced by other women, so they can get a strong connection, because when you go to the clothing room, you get a certain degree of manipulation, same with the makeup room."

That quote highlights how volunteering at an organization where an individual is also a participant can complicate the social relationships between participants as they negotiate their different roles within the organization, particularly in one-on-one interactions like in the clothing, or makeup rooms at that organization. Discussions of the relational, and multidirectional interactions within social service providers tend to focus on the relationships between workers and funders (e.g. Trudeau, 2008), however, these kinds of interpersonal relationships are also important considerations within organizations that want to engage vulnerable peer workers.

There are also barriers created by volunteering that may prevent some people with limited resources from choosing to volunteer. Literature about volunteers in shadow state organizations recognizes that low-income volunteers can struggle to meet volunteering schedules because of conditions like unpredictable shift work (e.g. Bowlby & Lloyd Evans, 2011). However, for vulnerable peer workers in harm reduction organizations, volunteering can sometimes get in the way of meeting basic survival needs. As a board member, and peer volunteer at a grassroots First Nations-oriented harm reduction organization explained:

> "…we are sometimes super busy during the day… If you live in supportive housing, like for me, they have different kinds of food programs, and that, but I never get to them because I'm either here… or with [another program at the same organization]."

Because this individual was busy with volunteering activities, they were unable to use accessible resources in their residence to meet their needs for basic nutrition.

Stipendiary volunteers

It is relatively common amongst OHRO in Greater Vancouver to provide stipends in the form of cash, or grocery vouchers in exchange for volunteering. A director at a large housing and health organization in the Downtown Eastside indicated that "as someone who's traveled a lot around harm reduction conferences, and that kind of thing, I'm not aware of another city where there's as many peers employed as there are in the Downtown Eastside." The rationale, along with the amount varies for stipends, however, there are some important commonalities in this practice that illustrate the tension between empowerment, and exploitation that exists in many facets of social service provision (e.g. Fairbanks, 2009; Love et al., 2012).

The director at a large housing and health organization described how they took over the contract for providing food to their residential programs:

> "…if we could get this contract, and do this, and have peers working there, people living in our buildings… it provides them with community, and a job that's flexible, in terms of hours. People have cycles of their mental health and that kind of stuff. We can work around all of that, most jobs can't… because we don't need to make a profit. We do need to

> break even, we're not being subsidized by the government, but all we need to do is cover everyone's wages, and our costs, and so it's quite a different thing."

Employing their residents in the kitchen was simultaneously a way to keep meal costs at under $2 per plate, while providing a source of community, and income for people who had few opportunities, and ability to manage regular employment. That food program hires between 7 and 12 people per day, at a rate of around $5 per hour for a 4-hour shift, although this organization engages peer stipendiary volunteering in other programs as well, at a rate of up to $7 per hour. The manager of their food program added that volunteers are attracted to the food program for reasons beyond the stipend, including that:

> "the majority of the folks that work in our kitchen here have done quite a substantial amount of time in prison… so a lot of them have done inventory, or dishwashing… so the kitchen's a really great place because they're familiar, they know their way around, and of course there's a great therapeutic opportunity when you're working side by side with someone, and not having eye contact, people tend to unpack more comfortably, and… we've worked side by side, we've [metaphorically] walked together, and we can share stories without having to be… like feeling of one on one."

There are social, and therapeutic benefits for both service providers and volunteers that go beyond monetary considerations. The director of a drop-in centre for PWUD also noted the benefits past experience in kitchen work for volunteers, saying:

> "…we need to check in from time to time because we're working with active drug users, so things can get colourful, but generally they're very committed, they're very skilled. Most of our kitchen team has had food service, or food preparation experience in a past life kind of thing. And they love it. They take a tonne of pride in the work, and really understand, and value the beauty of nutrition and beautiful food, and are just… they kill the program."

Similarly, an ASO in Vancouver runs a volunteer program because "it's getting people out of isolation, and we know that a lot of people who are living with HIV are isolating, and are not coming out as much, and as populations are ageing, it's even harder." This ASO provides grocery vouchers in exchange for volunteer work that often takes the form of help around the office. This policy has been in place since 1990, and was originally

conceived to ensure that their volunteers were able to eat during their shift. Volunteers are given vouchers worth $6 for each day of volunteering a minimum of 2.5h. The vouchers work at a handful of local restaurants and grocery stores, providing simultaneous nutrition, and social benefits for peer work in a supportive environment. The Provincial government also supports volunteering by people living on disability income by providing a stipend with a maximum between $50 and $100 per month in exchange for volunteer hours, however, the two programs providing this funding are being phased out, and are no longer taking new applicants.

Stipends are viewed as so beneficial to PWUD that some service providers who do not run stipendiary peer volunteer programs will facilitate their participants getting stipends at other service providers through referrals, or more hands-on assistance. For example, staff at a supportive housing facility for women will escort their residents to a low-cost food provider, where they volunteer in office activities for a $13 voucher at the food provider's grocery store. The manager at the supportive housing facility explained that their residents generally need staff supervision in order to volunteer at the food provider, and that it can be especially difficult for women with mobility issues, or pulmonary disease, but that $13 goes a long way at the low-cost grocery store. These strategies are a less overtly exploitative version of those reported by Fairbanks (2009) in alcohol recovery houses where house operators facilitate their residents' work under the table as day laborers. Within their own site, residents of the women's supportive housing facility can volunteer by helping to unpack and sort food bank donations for their community kitchen, and that they are allowed to take some food for themselves in exchange. They also employ a resident as a harm reduction representative, paying an honorarium to one of the women for attending meetings, and providing recommendations to management.

Despite the stated benefits of stipendiary volunteer work, there are some significant drawbacks that get considerably less recognition, even amongst OHRO. The most obvious problem with these volunteer programs are the exploitatively low wages. Minimum wage in British Columbia is $10.45 per hour, but the living wage for the Metro

Vancouver is $20.64 per hour as of June 2016[2] (Living Wage for Families Campaign, 2016). As illustrated above, volunteer stipends in OHRO in Greater Vancouver range from about $2.40 to $7 per hour for very part-time, and casual hours of work. Importantly, as I elaborate on below, service providers do not wish to underpay their peer workers, and government funding bodies do not seem to want to maintain or increase the numbers of people reliant on welfare. Instead, low pay for peer workers is unintentionally encouraged through funding social services like harm reduction at rates insufficient for ideal levels of service provision

There were two main reasons that service providers felt that they had to provide very low levels of compensation for peer work, as helpfully described by the director from the drop-in centre for PWUD:

> "It's an honorarium, more than a wage, because my budget doesn't permit me to pay living wages… we're a bit hemmed in between the ministry, and reality... The ministry is constantly hounding people to get work, to stop relying on social assistance, and people are having to prove periodically that they're looking for work, they have a resume, where are the places you've applied… if you don't report that in a satisfactory way to the ministry, your welfare is in jeopardy, or they can cut you off, or hold your cheque… So the other thing they want to know is are you working or volunteering anywhere else, because you're only allowed to make a certain amount of money above and beyond your ministry cheque. So if people… [are] making too much, then they get cut off, but again the reality is that society… actually doesn't want them in the workforce because of the way they look, or because they may still be… occasional drug users, and also because they would never be in the running for a job that would pay them enough to actually participate in the rental economy the way it is here. I have to keep my wages low enough to not put people in jeopardy of losing their 'livelihood.'"

Similar sentiments were repeated by other directors of harm reduction programs that use peer workers. Funding for peer work often comes from government sources, as do their closely monitored welfare benefits. Issues with maintaining welfare eligibility for

[2] Per adult in a family with two adults and two children. Although this kind of family is not representative of the living situation of most of the PWUD accessing harm reduction services in Greater Vancouver, the Living Wage for Families Campaign notes that the living wage for a single adult is likely a similar figure (http://www.livingwageforfamilies.ca/living-wage-calculation-single-person).

people engaged in addictions programming (whether abstinence, or harm reduction-based) are important for ensuring the survival of both individuals, and the organizations in which they are participants (see Fairbanks, 2009 for detailed engagement with this problem in alcohol recovery homes). Lack of recognition of the empowering potential of peer work means that resources to pay peers are scarce, and must also be closely monitored by the service provider so that their peer workers do not lose their main source of income – welfare benefits.

Additionally, there were fears amongst directors about stagnating, and declining funding. Most of the service providers I talked to characterized their funding as stable, but insufficient, meaning that their funding had generally remained at the same rate for several years, even as inflation, and costs went up. These problems are common in the shadow state, as organizations are forced to do more with the same, or less money in order to maintain contracts with the state that form essential, and sizeable portions of their funding (Bowlby & Lloyd Evans, 2011; Trudeau, 2012; Wakefield et al., 2013; & Wolch, 1990). As indicated in the quote above, these low funding rates were a reason for stipends to peer volunteers that were far below even minimum wage. However, some service providers expressed a fear that their peer volunteer programs were so under threat that they might be defunded entirely. For example, the manager of a needle exchange explained: "I do worry about the future about funding peer staff… I've seen you know, throughout the neighbourhood that they're cutting a lot of peer-based programming, which is really… distressing." This needle exchange used peer workers to fill almost all of the positions in the program because, as the manager explained:

> "…trying to… stabilize hepatitis, HIV, all of those nasty things… the equipment takes care of that, but it's our workforce that really gets the job done. We can easily set up a… like a vending machine that's free, and just distribute stuff that way, but it's that person to person interaction that's the most important… our staff are very knowledgeable about all of the resources we have in the Downtown Eastside… They know what's going on more than anybody else."

Using peer labour was integral to providing their services because of their particular knowledge, and experience, but yet was under constant threat of funding cuts.

Discussion

As illustrated by the statements above, volunteering, and voluntarism in harm reduction environments are less centred around sentiments of civic duty, and public citizenship than discourses around 'giving back' would assume (Fairbanks, 2009; Wilton & DeVerteuil, 2006). Instead, they are fraught with tension between empowerment, and exploitation. Spaces of addictions management and treatment are understood to be sites of care in some instances, and sites of fear in others (DeVerteuil & Wilton, 2009; Wilton & DeVerteuil, 2006). Discourses around 'giving back,' providing work experience, monetary need, and flexibility in employment for people who would often be ill-suited for regular employment provide an impetus for peer work programming that is tempered by low budgets, and a welfare system that prevents people from attaining the kind of employment that provides a living wage. Marginalized, and vulnerable workers are kept in the margins through management practices like paying low wages, and providing few options for advancement. Perhaps most importantly, encouraging peers to work for free, or below minimum wage also subsidizes the harm reduction service sector as part of a shadow state facing declining funding.

Volunteer roles in the shadow state are increasingly formalized through application processes, stipends, and doing jobs previously, or also done by middle-class, paid employees (Bowlby & Lloyd Evans, 2011; Wolch, 1990). Peer volunteering is also formalized by service providers through applying for funding to support their peer work programs. It is these very same processes that threaten peer work, as funding for peer programming stagnates, and is perceived to be at risk of being cut entirely by some harm reduction organizations in Greater Vancouver. Although these kinds of organizations are valued for reaching marginalized populations, like PWUD, they are also expected to provide more services with fewer resources (Baines et al., 2011). Peer workers are already less costly than regular employees because of low rates of pay, but harm reduction organizations still struggle to fund these programs.

Overall, making peer work more like a job, and less like volunteering indicates service provider goals of empowering their participants, while at the same time enforcing normative ideals of behaviour, and productivity. Service providers often view peer work

as the most effective way to provide services, because peer workers, as a kind of 'bicultural worker' are people who can identify with the experiences of service recipients (Trudeau, 2008). Additionally, any funding or resources that can be allocated to that kind of service provision ends up doubly benefiting service providers' participants, because peer workers are often also program participants. Further, service providers can be flexible, and understanding with the number of hours worked so that their peer workers who often face multiple mental and physical health barriers are not overwhelmed by their work responsibilities.

However, funding bodies do not seem to value peer work to the same extent, as demonstrated by stagnant, low levels of funding, and the perception amongst service providers that their peer funding is at risk. Experiences of service providers attempting to establish supportive and empowering peer work programs demonstrate another way in which the services that promote survival for vulnerable groups are at risk (Mitchell & Heynen, 2009). Peer workers do not make minimum wage, much less a living wage. When combined with low numbers of hours worked, it is clear that no one is escaping poverty through these kinds of peer employment opportunities. There is a contradictory logic at play here, with service providers paying low wages so that their peer workers do not make enough money to disqualify them from welfare benefits when the money for peer worker wages often comes from places like health authorities, which are funded by the same Provincial government that pays welfare benefits.

These mechanisms render peer work less as an activity undertaken selflessly in the service of their communities, and more into a poverty management technique that reproduces social inequities (Fairbanks, 2009). Marginalization, vulnerability, and poverty are maintained and sustained through this kind of volunteer work, even though it is valued, and desired by peer workers, and framed as a bridge to employment, and independence. As such, while peer workers are more easily able to meet their basic survival needs through this kind of employment, their reliance on social services like harm reduction, and welfare benefits is not necessarily reduced because they have a source of income within formal institutions.

Conclusion

I conclude by mapping out the beginnings of initiatives that I think would alleviate the imbalance between empowerment and exploitation that currently exists in peer work in OHRO in Greater Vancouver. It is not my goal to undermine peer work in OHRO. The benefits to service participants, and peer workers cannot be minimized. However, the ways in which it is currently administered present some serious drawbacks that undermine the harm reduction project, as much as the workers themselves.

Peer work should be encouraged to the extent that participants want to get involved, but some practices need to be changed in order full empower peer workers. Reflexivity on the part of organizations and funders about their goals and rationale for employing peers would create opportunities to minimize exploitation, and create meaningful inroads out of poverty. Paid labour, and especially valorizing paid labour over other kinds of work, is a practice that enables the structures that result in low-income, HIV+ PWUD being marginalized, and vulnerable in the first place. However, for the time being, paying workers fairly for the work that they do would be a good first step to expanding opportunities for this group of socioeconomically disadvantaged people to attain an acceptable standard of living. As agents in the shadow state, OHRO are providing services mandated by the Provincial government. They should use what limited power this gives them to demand appropriate resources, echoing Wolch's (1990) argument that the shadow state is best equipped to limit state power.

Peer workers in OHRO often do work that helps participants meet their basic survival needs. Their working conditions should also ensure their own survival. Not only should service providers demand that their funders support their peer programs enough to pay a living wage for the vital work done by their peer workers, they should pay enough per hour to ensure an annual liveable salary without relying on welfare. For equity reasons, these rates should take into consideration the low number of hours worked by peer workers who face multiple barriers to full-time employment. Finally, initiatives to improve working conditions for marginalized people in social services should also be conscientious of efforts to improve working conditions for people in other sectors that indirectly help their participants meet their basic needs, such as in food

production. At the same time, low pay for other employees in the harm reduction shadow state should also be challenged so that people that are providing these essential services are fairly compensated for their important work, and encouraged to develop their capacities within this sector.

Chapter 6.

Conclusion

Greater Vancouver's harm reduction foodscape is uniquely positioned for this investigation of institutional approaches to food security and peer work because of the high number of services, and people accessing them. As a practice focused on acceptance, reducing immediate problems as they present themselves, and 'meeting [individuals] where they're at' (Collins et al., 2011, p 27), harm reduction philosophies can also be productively expanded to address other acute needs. As described by my interviewees, expanding understandings of what is entailed in harm reduction improves the wellbeing of people accessing these services, and organizations' experiences of service provision. Two areas in which harm reduction can be more systematically applied are food provision, and peer work programs.

Focusing on organizations with a harm reduction orientation (OHRO) shows how they are simultaneously shaped, and shaping relationships with the state, and their participants through their roles in the shadow state, and low-income urban foodscape. Incorporating food into harm reduction services addresses the rampant nutritional deficits in this population, while peer work can provide inroads to improved self-esteem, skills-building, and community. Both of these kinds of programs are common in Greater Vancouver. However, the empowering potential of food and peer work in harm reduction contexts is often undermined by the ways in which OHRO operate as the shadow state, and use tools of poverty management.

Greater Vancouver's harm reduction foodscape is co-created by institutions, and the people accessing them (Miewald & McCann, 2014; Miewald & Ostry, 2014). However, given the constrained economic, and social situations of the low-income PWUD living with HIV/AIDS who access OHRO for supplies, and services, including

food, these institutions have considerable influence on participants' nutrition. As highlighted by my interviewees, many of their participants would not have food if food was not provided in these spaces. Despite harm reduction being a core service of public health in British Columbia (Harvard et al., 2008; Pauly et al., 2013), in places outside of the Downtown Eastside, participants have few choices in terms of places to access supports, services, and food programming that employ a harm reduction paradigm. Beyond a dearth of these services, poorer public transportation infrastructure can keep socially marginalized people in physically marginalized places.

OHRO are also poverty management organizations because the services they provide shape how participants are able to survive. As with foodscapes, there are multidirectional lines of influence between participants, service providers, and funders that impact what services are provided, in what ways, and who is welcomed into these spaces. Within the voluntary sector, "there is genuine caring and sustenance [that] can ensure not only survival but also potentially a step up [for participants]" (DeVerteuil, 2015, p 229). However, the balance of power is shifted away from participants. This power dynamic is demonstrated in practices like concealing nutritious ingredients, and low-wage peer employment. Peer workers have the opportunity to contribute to organizations that are not only meaningful to them, but can provide flexible work that accommodates the needs of their participants. However, peers are unable to exit poverty because they do not make a living wage, and in fact must make so little money that they retain their welfare eligibility. Further, shadow sate relations can disadvantage not only participants, but service providers as well, as demonstrated by funds that must be demanded, rather than being offered, and consistently stressful funding situations that keep organizations providing a basic, rather than ideal level of services, and employment.

Contributions

The chapters in my thesis offer a conceptualization of urban survival for low-income PWUD who are living with HIV/AIDS through the harm reduction organizations that serve them. In Chapter 1, I provide the rationale for this thesis through outlining the barriers faced by low-income PWUD/PLWHA. I then outline the conceptual framework,

based in harm reduction, foodscapes, the shadow state, and poverty management that guided the questions I asked in my interviews, and the direction taken in my analysis. In Chapter 2, I describe my methodology, methods, and strategy for analyzing my interview transcripts. Chapter 3 is my first paper, which examines the roles of OHRO as sources of food for low-income PWUD/PLWHA in Greater Vancouver. Food in these spaces has many benefits for both service providers, and participants, but is not always provided in ways that are consistent with harm reduction philosophies. Chapter 4 bridges my arguments about food provisioning in Chapter 3 with my exploration of peer work in OHRO, the topic of Chapter 5. In that chapter, I examine peer work, an unintended topic of conversation for my interviews. Peer work present across a broad range of harm reduction settings, and has benefits for both organizations, peer workers, and participants. However, as with food programming, peer employment programs are often not organized in ways that are in line with service providers' broader harm reduction goals. Taken together, these chapters provide a view of the Greater Vancouver harm reduction landscape that highlights its potential to ensure survival and improve lives of marginalized people. At the same time, I also bring attention to some of the ways in which the organizations comprising this landscape undermine their harm reduction goals. The insufficiencies of food and peer employment programming are not due to malicious intent, however, the effects of the relations that exist between service providers and their funders can systematically undermine service provider abilities to operate their ideal programs.

Conceptually, I extend the use, and application of harm reduction to include food programming. Although, as this thesis shows, food is an integral part of harm reduction supports and services, it is not recognized as such in literature about harm reduction. Further, the harm reduction applications of food programming were recognized on a practical level by the service providers I interviewed, but was not thought of as a harm reduction intervention. The disconnect between the conceptual and practical relationship between food security and harm reduction results in food programming that is at times contradictory with harm reduction aims. For instance, reliance on food from food banks to furnish meal programming supports discourses that people who are poor should 'take what they can get,' or are worth less. Although food may be provided in therapeutic, caring environments, the food itself may not be optimal, particularly for people with poor

physical, and mental health. A focus on food aligns well with harm reduction principles, but food should be provided in ways that are intended to reduce harm, empower marginalized people, and are personally, and culturally appropriate. In other words, food provision needs to be enacted with harm reduction goals explicitly in mind.

This thesis also furthers foodscapes approaches by exploring service providers' perspectives on their roles within the foodscapes of low-income PWUD and PLWHA. Decision-makers within these organizations recognize the important role they have in the foodscapes of their participants, but are often unaware, or unable to provide these services in ways that enable meaningful choice, and agency for the participants. In emphasizing the service provider side of low-income PWUD and PLWHA foodscapes, I highlight the ways in which constrained choice, and constrained agency of these populations is manifest in the urban environment. Knowledge, and awareness of these conditions could improve not only the organizational experience of food provisioning, but also the food security, and wellbeing of participants.

Similarly, my work contributes to poverty management literature by emphasizing the importance of harm reduction settings in the geographies of survival for low-income PWUD living with HIV. As well as being sites of control and restriction due to often limited nutritional options, and some methods of food provision that contradict a harm reduction paradigm, these kinds of spaces can also be sites of empowerment, and care (DeVerteuil & Wilton, 2009; Fairbanks, 2009). Some service providers' formats for food service provision, particularly pantry-style communal kitchens, are indicative of the potential for empowering relationships in these spaces. However, discourses around healthy eating that result in service providers concealing ingredients; and reliance on donated food that creates health risks, and perpetuates impressions that people who rely on free food are not worthy of good food reveal uneven, and oppressive power relations. Similar dynamics also exist in peer employment, with evident tension between empowerment and exploitation. Hiring and management practices that enable flexible opportunities for peers to 'give back' to services that they use and their communities exists in tension with low wages, and other forms of compensation that allow peer workers to remain reliant on welfare for their livelihoods. Peer work practices in OHRO in Greater Vancouver also contribute to richer understandings over the modern shadow

state, as it illustrates different kinds of peer work (i.e. waged, and stipendiary) than the strictly volunteer labour that is highlighted in shadow state literature.

Empirically, my thesis contributes a richer understanding of the links between service participants, and funding contexts through focusing on the organizations that mediate these relationships. Gaining service provider perspectives on their roles within networks of harm reduction policies, and services, I expand not only on work previously conducted about policymaker, and participant experiences of harm reduction services in the Downtown Eastside, but also on academic work on the shadow state, poverty management, and foodscapes. Additionally, although most of my interviewees were concentrated in the Downtown Eastside, my thesis goes beyond that neighbourhood to examine regional variations in service provision. Methodologically, the relatively high number of interviews I conducted demonstrates the utility of this level of thoroughness. Firstly, I was able to demonstrate differences in service provider experiences across the Greater Vancouver region. Secondly, the diversity of responses provided me with information about phenomena like peer work that would likely not have appeared as readily in a smaller sample size, but were nonetheless important for understanding harm reduction service provision. Additionally, using site visits and photographs proved fruitful for demonstrating concepts around funding, and service provision philosophies that could have been overlooked had there not been visual evidence of these factors.

These empirical and methodological considerations lead me to some recommendations for policymakers and service providers. First and foremost, as demonstrated across my interviews, food needs to be considered an essential harm reduction service, and high quality food should be provided by OHRO. Not only does food provision, and, by extension, supporting food security fit well into a harm reduction paradigm, but participants, who already face multiple barriers to service access, benefit from being able to meet many of their survival and service needs in the same spaces. As harm reduction services and supports look somewhat different depending on the service provision environment, food provision should also occur in diverse ways that accommodate dietary and cultural diversity.

As indicated by my interviewees, partnerships can ease the burden of food provision in harm reduction services when multiple agencies that share similar mandates and philosophical approaches work together. Partnerships and communication between organizations can increase the number of participants who access food services (e.g. through providing HIV-specific food banks out of multiple ASOs with slightly different participant profiles), and may make it easier to get funding.

Policymakers should recognize that harm reduction organizations are already important facets in the low-income foodscape of Greater Vancouver, not only as a nutritional intervention, but as a social benefit to services as well. As a basic human need, and as a social and cultural artefact, food is an essential aspect of human existence, however, its underfunding, or neglect in harm reduction environments undermines the varied benefits experienced by participants and service providers when food is part of harm reduction services. Furthermore, food can provide work for participants, allowing opportunities for peer empowerment through supported employment. Just as food is a valuable asset in harm reduction environments, peer workers can be the most effective way to provide services that are appropriate for participants. Both food, and peer work should be valued by funders in ways that allow harm reduction organizations to provide their ideal food and peer work programs, rather than bare minimums.

As access to harm reduction services varies greatly across large metropolitan regions like Greater Vancouver, access to other supports for low-income PWUD living with HIV/AIDS varies as well. Policymakers should ensure that people who need services have access to them, even in parts of the region with lower populations of potential participants. Similarly, access to harm reduction-oriented services and supports like appropriate food, and peer employment opportunities should also be more equitably distributed across the region to ensure the best possible lives for people who rely on these services to meet their needs. People who want and need harm reduction supplies and supports, food, and employment should be able to access them.

Taking a harm reduction approach, funders, who are often the same bodies that pay welfare benefits, should recognize that peer work should be funded at rates that pay

a living wage. Even in situations where peer workers are unable, due to physical or mental health issues for example, to work fulltime or regular hours, they should be compensated at rates that exceed welfare benefits. Rather than keeping peer workers in poverty, reliant on meagre welfare benefits, and paying them well below minimum wage, the important work that peer workers do should be valued with wages that allow them to thrive.

Expanding understandings of what it means to reduce harm opens up multiple channels for improving service options for low-income PWUD living with HIV/AIDS. In addition to more systematic consideration on the parts of service providers about their roles within the low-income foodscape, and as employers, funders should support these organizations, and their participants to an extent that provides inroads out of the situations that led them to need these services.

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Appendix.

Interview Schedule

Food as harm reduction: documenting the health effects of food provision for people who use drugs

Sample Interview Schedule for Harm Reduction Organizations

Agency/Organization Background/Food Security General [Ask ALL]

I'm going to begin by asking a few background questions about your organizations and about your participants.

1. Can you begin by telling me about the organization you work for/represent?
2. What are its primary goals and who are its participants?
3. Are your primary participants people who use drugs? What percentage of your participants are current drug users?
4. What kind of harm reduction programs or services does your organization provide? [including needle exchange, peer support, substitution therapies]
5. Do you feel that your participants are food insecure? Why or why not?
6. Where do your participants get their food? [prompts: restaurants, other HR organizations, food bank, binning]
7. Do you feel that your location impacts your participants' abilities to access food?
8. How about your organization's abilities to access food for programming purposes?

On-site Food Provision

9. Do you provide food of any type to your participants? This includes snacks, meals or food bags.

IF YES, CONTINUE TO # 10, if NO SKIP TO #19

Since you indicated that food is provided at your organization, I'm going to ask a few questions about what that food program looks like.

a. Please describe the frequency and type of food distribution.

10. Why does your organization feel the need to provide food to is participants?
11. Where do participants eat the food you provide [own dining area, common space, indoor/outdoor on-site or go elsewhere]?
12. Do you have a space to cook/prepare food? If yes, please describe cooking/food preparation equipment.
13. Do your staff/volunteers have the time and/or expertise to prepare food and/or facilitate food provision?
14. How is your food programming supported/funded?
15. Do you rely on donations for food?
16. What kind of donations [prompts: food, money, volunteer time, food service supplies]?
17. What is the state of your food-related funding?
18. Have you entered into partnerships with any other organizations to better facilitate food provision?

IF FOOD IS NOT PROVIDED

Since you indicated that your organization does not provide food, I would like to explore some of the reasons for this.

19. What are the reason(s) for not providing food? [prompts: space, funds, need of participants for food]
20. Is lack of sufficient/appropriate space a concern?
21. Have you ever considered partnering with another organization in order to provide food to your participants?

Role of Food as Part of Harm Reduction [ASK ALL]

Now I want to talk to you about what role, if any, you feel that food can play in reducing drug-related harms.

22. Could you speak about how issues of food and nutrition would match with the harm reduction priorities your organization serves/advocates for? [Prompt: how would you rank food/nutrition among other HR priorities you serve/advocate for?]
23. Do you feel that food provision should be a part of harm reduction programs? Why or why not?
24. If you do feel that food provision should be part of harm reduction, what do you think should be done to support the inclusion of food in harm reduction programs?

[If the interviewee is knowledgeable about policy-related issues, ask policy-oriented questions here.]

CONCLUDING QUESTIONS

25. Who are important people in the field?
    a. If I were to interview the people you mentioned, would I be able to mention that I've talked to you?
26. If I have follow-up questions, may I contact you in the future?

Alternate questions for policy-oriented organizations:

- Could you talk about what you see as links between food and harm reduction?
- How do you think providing food and harm reduction services in the same location would impact the day-to-day lives of people who use drugs?
- Do you think current policies promote or discourage the coexistence of food provision and harm reduction service?

- What capacity-building policies/practices/opportunities exist to facilitate partnerships/sharing resources for food and harm reduction organizations? Do they work? Is this a beneficial approach?
- Does your organization recommend any food-related policies for harm reduction service providers?
- Do you think that there are other policy approaches to assuring food security for people who use drugs?

[Return to concluding questions.]