

Toward Inclusion:

Researching Food as Harm Reduction in an Urban Foodscape

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Introduction

People Living with HIV/AIDS (PLWHA) who also use illicit drugs may put themselves at risk of physical, psychological, and structural violence by visiting unsafe places in order to access food, housing, and other resources. Conversely, spaces of care where people feel supported may offer safety, community, and inclusion. Yet, the types of programs these places offer are only temporary solutions to problems caused by health and economic policies that hinder efforts to improve the lives of PLWHA who use drugs. Based in Vancouver, BC, *Food as Harm Reduction: Documenting the Health Effects of Food Provision for People Who Use Drugs* (FaHR) is a collaborative research project that explores the role food provision may have for reducing the harms associated with drug use, and to propose ways of integrating food into a harm reduction framework. It has been designed as a community-based research (CBR) project in

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order to address the social marginalization faced by PLWHA who use drugs and provide them with a voice through critical praxis-oriented research.

In this chapter, which has been co-authored by the academic and peer researchers involved in the FaHR project, we consider not only the structural barriers that may limit the ability of municipal policies to promote inclusivity in planning for food security or harm reduction drug policies, but we also reflect on our experiences of designing a research project that promotes inclusivity through community partnership and the use of peer research associates (PRAs). In this spirit, the authorial voice shifts throughout this chapter, straying, though not entirely departing, from the traditional academic writing model. We have deliberately employed this strategy to stress the central role of the PRAs in the project's research design and execution.

The FaHR study is a partnership between geographers from Simon Fraser University and members of the Dr. Peter AIDS Foundation, out of which the Dr. Peter Centre (DPC) operates. The DPC is a not-for-profit health care facility that provides care and support to people living with HIV and coping with social disparities and concurrent health issues such as mental health conditions, addiction, hepatitis C, physical disabilities, homelessness, and trauma. The centre offers a broad range of services, including a seven-day-a-week day health program, a twenty-four-hour specialized nursing care residence, and an enhanced supportive housing program. Through these programs, the DPC provides access to advanced nursing care, nutrient-dense meals, support for adherence to antiretroviral therapy and other medications, supervised injection services, counselling, as well as art, music, and recreation therapy, all in a safe place for social engagement and peer interaction.

This chapter begins by providing an overview of the rationale for our research and use of a CBR approach. We then explore the notion of inclusion in two ways. First, we present the

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perspectives of two of the authors, PRAs who straddle the space between academic research and lived experience. We consider what it means for them to be included in the research process and examine some of the tensions that surfaced from their participation in the research study team. Second, we discuss how our research could address wider issues of inequality and social and spatial inclusion for PLWHA who use drugs, given the broader structural constraints that shape their daily experiences. We also highlight the potentialities and constraints of CBR that arise while implementing effective interventions through praxis-oriented research. Our project's contributions to critical praxis-oriented approaches to research entail our account of how the research team has negotiated some of the limitations of community-based academic research and our discussion of the role of CBR in fostering emancipatory social change. We conclude with some thoughts about how our research can be used to address the day-to-day needs of PLWHA who use drugs, and how it might contribute to future analyses of the wider structural constraints that shape these needs. This discussion includes our reflections on the co-constitutive relationships between municipal policies and spaces of harm reduction and food security—which directly and indirectly affect the health and well-being of PLWHA who use drugs.

Food, Harm Reduction, and Inclusion in the FaHR project

Inclusion is a fundamental goal of the research processes and outcomes of critical praxis-oriented research and participatory approaches are one way of countering exclusion within this often-opaque academic or biomedical research model (Pain 2004). Although inclusion can take many forms, the FaHR project promotes it in two ways. The first is through the active involvement of PRAs. We hired two PRAs to help administer our survey, work with academic researchers on the

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qualitative interview and mapping components, and assist with analysis. They provided insight, gained through life experiences, into the potential impact of being a PLWHA who uses drugs on food access and health. Including PRAs in research projects helps to break down traditional divisions between academic researchers, subjects, and the wider community, and allows for a greater diversity of perspectives to be considered in the research design. For our project, it enables everyday experiences related to issues of food security and harm reduction to be included in our analysis. At the same time, the use of PRAs in CBR is not without both practical issues and ethical concerns.

Second, inclusion is promoted by the FaHR project through its foundational assumption that improved access to quality food and eating spaces can reduce the multiple forms of marginalization to which PLWHA who use drugs are subject on a daily basis, and thereby increase their inclusion in the city's foodscape. The current food system that serves low-income residents of Vancouver, including PLWHA who use drugs, "does not support, and in some cases directly contravenes, the right of residents to make use of the city in the provision of their food in a way that preserves their health and dignity" (Drabble 2015, 97). Thus, creating spaces that provide food and community to PLWHA who use drugs can be viewed as important means of supporting their rights to the city as well as to food.

Food insecurity is a term that describes limited or uncertain access to nutritionally adequate and safe foods, and points to structural constraints such as economic, racial, or gender inequality, housing instability, or health disparities that curtail the ability of marginalized people to sustain themselves (Heynen, Kurtz, and Trauger 2012). People who use drugs are at an increased risk of food insecurity and poor nutritional status (Himmelgreen et al. 1998; Romero-Daza et al. 1999; Anema, Wood, and Weiser 2010). This is particularly salient for PLWHA who

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use drugs as food insecurity has been associated with negative health outcomes for this population including macronutrient and micronutrient deficiencies, immunologic decline, and increased morbidity and mortality. Moreover, it can contribute to depression, increased drug abuse, and risky sexual practices, potentially enhancing the risk of HIV transmission, incomplete HIV viral load suppression, poor adherence to antiretroviral therapy, and missed clinic visits; all of which are significant causes of poorer HIV health outcomes (Weiser et al. 2011). Given the prevalence of food insecurity and malnutrition among people who use drugs, some argue that all long-term drug users should be treated as potentially food insecure (Kaufman, Isralowitz, Reznik 2005, 29).

Previous research has indicated drug use as a major barrier to nutrition for PLWHA (Miewald, Ibanez-Carrasco, and Turner 2010), but whereas the relationship between food insecurity, drug use, and HIV/AIDS has been well documented, little work has been undertaken to explore the links between nutrition issues and harm reduction approaches. Rather than adhering to prohibitionist, moralistic, or absentionist paradigms, harm reduction seeks to mitigate the negative health consequences of risky behaviors like drug use (which can result in blood-borne disease, overdose, death, and so forth) through pragmatic interventions like clean needle provision, methadone treatment, or supervised injection. Some social supports, such as low-barrier housing, have been integrated in harm reduction programs (Pauly et al. 2013), but food provision has yet to be included, and uneven attitudes toward this practice have been found among harm reduction providers (McCann and Temenos 2015). A survey of harm reduction service providers in Vancouver revealed that although food provision is part of their programming, its constitution varies greatly—from granola bars and juice as part of street outreach, to the provision of hot, nutritious meals, to the operation of participant-led community

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kitchens. Whereas some harm reduction service providers view food provision as a means of fostering trust and a sense of community between staff and participants, others use food as a direct health intervention (McIntosh 2015).

We suggest that like other components of the drug user's "risk environment" (Rhodes 2002, 2009), food insecurity should be taken into account in evaluations of the relative harms of drug use. Improvements to the nutritional status of persons who do drugs have, to date, been focused largely on interventions, such as nutritional education, that do not take into account issues of poverty, inadequate housing, or reliance on charitable food programs. We are interested in where, how, and why people access (or do not access) food and how their strategies for doing so contribute or detract from their well-being. Using a *foodscape* approach, which addresses the relational and political aspects of the urban food landscape as well as intimate and everyday experiences with food (Miewald and McCann 2014; Miewald, Aiello, and McCann, forthcoming), our research seeks to describe the role of food within the wider environment in which low-income PLWHA who use drugs live.

The study so FaHR

Writing at this time – the midpoint of the research project – gives us the opportunity to reflect on what we have accomplished thus far, to think critically about how we will conduct the remainder of this project, and to make adjustments if needed. This is a necessary part of engaged research that allows us to learn from experience.

From the project's inception, the academic researchers were interested in working with a community organization and including peer researchers in the research process. The DPC has

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significant experience with including peers in its collaborations with academic researchers and, as such, has established protocols for how to ensure meaningful and equitable participation and compensation. Human resources at DPC wrote a job posting with input from the academic researchers that was then advertised at AIDS service organizations (ASOs) and other programs used by PLWHA who use drugs. Initially, applications were screened and ranked by a hiring committee of DPC staff, including one academic and one community representative. Interviews were then conducted with selected applicants and these were again scored based on criteria such as ability to work in a team, interpersonal skills, and interest in the subject. Having hired the PRAs, the completed research team began its two-stage research process (currently ongoing in March 2016).

The first stage has involved surveying a total of sixty PLWHA who use drugs, half of whom use the Dr. Peter Centre and half of whom do not. The survey, which is administered by our PRAs, is designed to measure levels of food insecurity, dietary quality, health status, and social capital in order to identify the effects that illicit drug use can have on food security as well as the potential role of food programs on reducing the harms of drug use. While an academic member of the team performs an initial screening to establish respondents' eligibility, they neither conduct nor attend the interviews. This allows the PRAs to have ownership of administering the survey. Once each survey is complete, an academic member of the team debriefs the PRA to discuss any issues or questions that might have emerged from the process.

In the second stage of the project, a smaller group of respondents is asked to participate in qualitative interviews that enable further exploration of the themes addressed in the survey. Central to these interviews is a map upon which participants are asked to draw their daily routes. As we write this chapter, the mapping aspect of the research, which has been tested and refined

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by the academic geographers in consultations with the PRAs, has begun. Each mapping interview is co-facilitated by one academic and one PRA. Thus far, we are learning about the daily routes used to access food, harm reduction services, and other resources, as well as the negative or positive effects that these spaces and the pathways used to access them can have on the respondents' health and well-being. This technique builds upon research into local foodscapes in Vancouver (Miewald and McCann 2014) and risk environment mapping projects conducted with sex workers and marginalized men and women in the city (Shannon et al. 2008; McNeil et al. 2014; McNeil et al. 2015). It extends this work by mapping not only sites and spaces of risk but also spaces of care (Johnson, Cloak and May 2005).

Community-Based Participatory Research: Lessons in Learning

Although its predecessors, Action Research (AR) and Participatory Action Research (PAR) have long been used in fields, including anthropology and sociology, health research has only recently adopted CBR, the most recent form of this framework. Within a health research context, CBR emphasises community participation from the initial research design through to data analysis and the distribution of information (Hayashi et al. 2012). The use of CBR is increasingly common in studies of certain populations such as PLWHA. In fact, it is often a fundamental part of a project's realization of the Greater Involvement of People Living with HIV/AIDS (GIPA) principle, which emphasizes the necessity of the participation of PLWHA in all aspects of their treatment, including the design, coordination, process, and analysis of research (Guta et al. 2014; Travers et al. 2008). Canada has become a leader in using CBR with PLWHA and other potentially marginalized groups in studies of, for example, the health effects of food security

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(Chittock et al. 2015), experiences of homelessness (Greene et al. 2009) and HIV prevention among women who use drugs (Shannon et al. 2008).

One rationale for using CBR in health research projects is that it is a means of crafting more effective interventions because it is better able to capture the lived experiences of those experiencing health conditions such as HIV/AIDS. Yet, it is important that CBR not simply be used as a shield against community criticism or as a technique to reach otherwise “hidden” populations. A significant element of CBR is its commitment to addressing issues of inequality, exclusion, and stigmatization (Wallerstein and Duran 2006). Therefore, outcomes of CBR should ultimately benefit the wider community. By creating knowledge that improves our understanding of the lived experiences of PLWHA who use drugs, with the goal of providing meaningful and potentially disruptive information, CBR projects hope to challenge both the political and the scientific status quo.

Occasionally, this desire to overturn existing conditions and patterns extends to how research is “written up” (a problematic term in its own right). Bearing this in mind, the co-authors (academic researchers and PRAs) decided that the best way to foreground the PRAs’ experiences, for the purposes of this chapter, was through a dialogue between one of the co-authors, Christiana Miewald, and the PRAs, Sean Grieve and Megan Woodward. The dialogue (recorded on October 7, 2105) was transcribed and direct quotes have been used herein. The following section thus highlights the PRA’s voices through quotes, whereas throughout the rest of the chapter efforts have been made to blend all of the authorial voices (see also Miewald, Grieve and Woodward 2016).

Megan is a forty-four-year-old woman who was diagnosed with HIV in 2012 and who has been a member of the Dr. Peter Center for approximately one year. Sean, a fifty-year-old

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man who was diagnosed with HIV in 1992, has been a member of the Dr. Peter Centre since 2012. In addition to being a PRA, he has a part-time job and has volunteered for several years with various ASOs. Our aim in hiring peer researchers is to incorporate the worldviews of individuals who have traditionally been excluded from academic and medical research because of their stigmatization. This approach has enabled us to include the insights and analyses of PRAs throughout our research with PWLHA who use drugs – unique contributions that can only come from their membership in this subject group. Although we have sought to include the PRAs perspectives in the research design and implementation, we have also attempted to keep two potential pitfalls in mind as the study has progressed. First, “‘inclusion’ in scientific decision making is a more complicated undertaking than is often described” (Guta et al. 2014, 257); by making marginalized individuals part of the research team, there is often the tendency to “instill in them the virtues of active citizenship and neoliberal entrepreneurialism” (Guta et al. 2014, 258) rather than to provide them with the opportunity to critique wider systems of oppression. Second, power inequalities between academic researchers and peers may create issues of trust that can affect working relationships in the project (Travers et al. 2008; Pain 2004).

As the project has developed, Sean and Megan have provided feedback on study materials, including the wording and organization of survey questions and the details of the map to be used in the qualitative interviews. When asked to comment on the level of inclusion he has experienced throughout the project, Sean responded, “You’ve been very inclusive even down to asking us if the questions were coming off right. If we’re involved [to this level], we’re going to make sure that when we administer the survey that we get really good results back too, instead of [you] saying, ‘Now you do this and this is your role and keep your mouth shut.’” Megan indicated that she also feels very involved in all aspects of the research, from training to survey

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design, and by participating in the Community Advisory Committee and attending and presenting project updates at regional CBR meetings. Although these are new experiences for her, she feels that they are valuable for enhancing her self-esteem.

This sense of inclusion has helped to break down barriers between the academic researchers and the PRAs, who see themselves as integral members of the team that values their input as experts on their community. Sean noted that equality has to do with valuing different perspectives and experiences: "I'm not necessarily equal [with an academic in a research project]. I haven't had nine years of university education, but I do have twenty years of community involvement, which is just as valuable and you guys made it possible for us to feel equal."

Including PRAs in academic research presents particular challenges. For example, their participation exposes them beyond the academic realm. In our research project, this meant that PRAs had to be willing to openly identify themselves as part of (an often stigmatized) HIV positive population, and whereas they were likely "out" in some circles, to openly confirm their status in this way might have dissuaded them from participating (Howard 2015). A PRA's health challenges may also hamper their ability to meet the demands of performing research. Moreover, as members of both a community and a research team, they must often "switch hats" and maintain boundaries, and can be confronted with responses from participants that may bring their own emotions to the surface.

Megan's experience of being a PRA has been quite different from what she expected. Rather than simply asking questions and recording the answers, Megan noted, "You invest so much of yourself in the interviews and the answers really affect you and you really have to take a lot of time with the participants." There is a good deal of emotional work that goes into being a

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PRA, not the least of which is managing one's own emotions while being sympathetic to participants' emotional needs. According to Megan, being a PRA has helped her to confront some of her own personal challenges when she encounters them during the interviews she conducts with others. "Sometimes when we're doing interviews, feelings come up like feelings of sadness, regrets or other feelings ... you can acknowledge them and work on those issues whereas before I would just push them aside, I wouldn't really work on them." Given that PRAs are clearly expected to take on a good deal of the emotional burden that comes with conducting CBR, emotional management – often couched in the language of self-care, which can take several forms, from talking with other peers to meditation to exercise (Howard 2015) – is essential. Furthermore, because research questions can elicit uncomfortable feelings and memories in all both interviewees and PRAs, the management of emotions –by maintaining boundaries, ensuring confidentiality, and engaging in self-care – is a critical and ongoing aspects of PRA training and support.

It is necessary for the PRAs to have ongoing support not only from other members of the research team, but also from a peer mentor – a trained individual who provides support to PRAs but who is not on the research team (Howard 2015). As PRAs are part of the community under study, they may be exposed to additional stressors when asked to interview someone they know or with whom they have a close personal history. In the FaHR study we have worked to ensure that the PRAs are supported through training opportunities and check-ins with a peer-mentor (hired specifically for this purpose), as well as regular check-ins with both academic research team members and DPC staff.

Although PRAs are meant to represent the community with which they identify and to which they belong, their liminal status can create divisions between them and other members of

the community, especially if they are thought to be receiving special treatment or access to resources. Adequate training and support prepares PRAs to navigate these situations. For example, Sean noted that he had to set limitations on his interactions with one survey participant: "I remember one survey participant saying that they really wanted to, I guess, forge a friendship with me ... to discuss life and everything else further with me and I thought, 'How do I answer that? There's a boundary there that I can't cross.' So I said to them, 'You know what? If I'm here [at the Dr. Peter Centre] as a [regular program] participant [not a PRA,] and you want to sit down and talk, that's cool with me.' And I thought, 'That's where we can leave the boundary.'" In terms of inclusivity, this means that PLWHA are at once included in CBR studies as PRAs, and at the same time, must negotiate and construct boundaries with other community members, which can exclude them from activities or interactions they might have otherwise enjoyed.

Both Sean and Megan chose to identify themselves as HIV positive at the start of each survey. Megan noted, however, that as a PRA, one cannot "cross the line about telling too much about yourself" because survey participants are not bound by the same confidentiality rules as PRAs. This disclosure boundary can be difficult to delineate and throughout the survey process PRAs must choose what to share with survey participants. Although emotional boundaries must be carefully maintained, Hardill and Mills (2013) suggest that emotions are an important component of research. Indeed, as we have suggested, emotions tend to be daily concerns for CBR teams.

Employing PRAs raises questions about who controls the outputs of the research: Do PRAs have the right to be included in authorship? How will results be communicated meaningfully to PRAs and to others who participated as respondents in the research? These questions, which complicate researchers' often-exclusive sense of ownership of their findings,

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have emerged in one way or another throughout the FaHR project. We have attempted to break down the usual barriers between academics and PRAs by including Sean and Megan as co-authors of this chapter and as participants in the teams' presentations at academic conferences. These forms of inclusion necessitated discussions about what academic publications and presentations entail, how they are structured, and what to expect when participating.

The use of PRAs in academic research has been critiqued for doing little to challenge structures of oppression and exclusion faced by the wider PLWHA community. In fact, it has been argued that the practice upholds the “neoliberal rhetoric of self-improvement,” and intervenes “into the lives of marginalized peers seeking to transform them into more productive citizens” (Guta et al. 2014, 257). This is evident in how PRAs must contend with both their jobs and their illness, including the potential effects of medication. For Sean, calling in sick can bring up feelings of guilt because he feels he is letting down the research team. As he expressed, “With my [other] job, I think to myself, ‘You’re nauseous, you’re not feeling well, don’t go in.’ Here though, with you guys, I feel, ‘Well, if I’m not there, then the team sort of misses out because the collaborative effort is short a person,’ even though I’ve been repeatedly told, ‘It’s just research, relax.’ That’s been my biggest challenge to get over the guilt of saying, ‘I’m not feeling well today.’”

Being included as part of a research project comes, then, with opportunities as well as struggles and costs for PLWHA. Many have already been excluded from workplaces because they have been unable to balance the demands of living with HIV/AIDS with the expectations of employers. However, as Sean indicated, being involved in work that is meaningful and also inclusive has evoked feelings of responsibility in him that have motivated him to show up to work even when he is not feeling unwell. His experience both recalls and challenges Guta et al.'s

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(2014) critique that CBR is complicit in a neoliberal agenda and therefore lacks emancipatory potential. Though CBR often aspires to be inclusive, this form of engagement necessarily comes with tensions and limitations that may prevent it from making a significant impact on inequality.

Inclusion Within Vancouver's Foodscape for PLWHA Who Use Drugs

Thus far we have discussed inclusion in terms of its character within this research project and how it has been experienced by our PRAs. We now address how the project might foster the inclusion of low income PLWHA who use drugs in the city's food provision and accessibility landscape. We explore what greater inclusion within the city's foodscape might look like and, in particular, the role that the City of Vancouver might have in creating both inclusive and exclusive spaces for PLWHA who use drugs.

PLWHA who use drugs are among the most socially, economically, and politically marginalized populations in Vancouver, even though the city has a well-deserved global reputation for innovative policy approaches to the care of people who use drugs (McCann 2008; McCann and Temenos 2015). Many live in poverty, are homeless or marginally housed, and suffer from comorbidities. The majority of PLWHA who use drugs live in Vancouver's Downtown Eastside and are often systematically excluded from public space elsewhere in the city and, increasingly, in that neighbourhood itself, through efforts by the city to manage "social disorder" (Wittmer and Parizeau 2016). They also encounter difficulties in accessing health and other services due to their drug use and the stigma associated with their health status. The combination of having HIV/AIDS, being of low-income status and using drugs makes securing

healthy food challenging, despite these fact that these are the very people most in need of nutritious food.

While some community based organizations, such as the DPC, attempt to address the gap between need for and access to food by providing healthy meals in a low-barrier setting, many PLWHA who use drugs remain unable to obtain healthy food on a reliable basis. They may, thus, be forced to place themselves at greater risk in attempting to find a meal, whether by having to stand in line-ups, which can expose them to personal harm, violence, and stigma, or by acquiring food from dumpsters, or by panhandling or stealing. One attempt to restructure this deficient foodscape is the Downtown Eastside Kitchen Tables Project's efforts to provide nutritious options for residents, such as affordable fresh produce, which is coupled with the project's ongoing critique of the unhealthy and undignified food provision conducted through line-ups and other practices (see Miewald and McCann 2014; Miewald, Aiello, and McCann, forthcoming).

Based on interviews we conducted with harm reduction service providers, we found that some PLWHAs experience a sense of inclusion by becoming peer support workers. These workers are paid staff or volunteers who assist organizations with providing services to their members. Organizations that provide harm reduction services in Vancouver face a variety of barriers, however, to including PLWHA who use drugs as peer support workers. Funding is the most significant obstacle because, although organizations would like to be able to provide wages, or stipends (in cash or as food vouchers) to their peer staff and volunteers, major funders are becoming increasingly reluctant to support peer-staffed programming. Furthermore, in organizations that do have funding for peer positions, budgets for wages and stipends have remained largely stagnant since the early 2000s, even though other financial supports for low-income PLWHA have not increased to match the rising cost of living.

Additionally, small budgets make it difficult for many organizations – particularly smaller organizations with one or fewer sites – to support peer personnel; in many cases, they simply cannot afford to employ a dedicated staff member to supervise and train peer volunteers and staff. Literature about labour in non-profit social services identifies accommodating increasingly professionalized member volunteers as a concern for staff whose time and resources are already stretched thin (Bowlby & Lloyd Evans, 2011). However, interviews conducted with harm reduction workers, managers, and executive directors in Greater Vancouver did not corroborate the hypothesis that incorporating peer workers was an undue burden on paid staff time. Instead, the interviewees were eager to highlight that engaging workers provided meaningful work opportunities for service participants, and helped to ensure that the services provided by these organizations were relevant to the needs of the community (McIntosh, 2016).

Some organizations employ PLWHA who use drugs in their food programming, often as cooks in commercial or community kitchens, but food programming has its own challenges to inclusion. Often operating out of older building in neighbourhoods like the Downtown Eastside, some harm reduction service providers have difficulty finding food preparation spaces that meet the city's zoning requirements related to the size and age of a kitchen as well as its suitability for food preparation equipment use. Other organizations struggle to find staff to coordinate community kitchens, and these employees tend to be social workers, rather than people with expertise in food provision.

The FaHR project seeks to enrich current harm reduction programs by making recommendations that frame food as an integral part of these strategies, and, more ambitiously, to make the Vancouver foodscape a more inclusive place for PLWHA who use drugs. However, the ability to create safe and inclusive spaces of food provision and consumption is affected by

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municipal policies. Since the early 2000s, Vancouver's city government has supported a harm reduction approach to drug use, which includes Insite – a supervised injection site that has been shown to have a positive impact on the health and well-being of people who use drugs (Urban Health Research Initiative 2009), and on the wider citizenry of Vancouver by providing a cost-effective public health service that also reduces street litter and petty crime in the immediate neighborhood (Andresen and Jozaghi 2012; Jozaghi and Andresen 2013).

The City of Vancouver also has a food strategy, developed by city staff and the Vancouver Food Policy Council to help guide the city to address issues of food security and sustainability (City of Vancouver 2013). It does not, however, make specific recommendations pertaining to food insecurity among vulnerable populations. Indeed, many of the entrenched structural issues that contribute to food insecurity fall outside of the direct influence of the city. Instead, the focus of its food strategy is on community-based food programs that work to address food insecurity, such as community gardens, farmers markets, and street vending. Whereas these measures are welcomed, to some extent, they all operate in spaces that are imbued with various degrees of exclusion, which can exacerbate the conditions and everyday stresses endured by marginalized people. As Kern (2015, 2) notes, “alternative consumption spaces, such as farmers markets, not only help create the conditions for gentrification, they require and promote particular forms of cultural capital and socialization techniques within an aesthetic code that favours White, middle class, young residents” (see also Sullivan 2014). The city's food strategy furthers such an agenda by not considering certain existing social policies like Vancouver's Four Pillars Drug Strategy (a harm reduction drug policy), in its attempts to address food security. Rather than promote the inclusion of marginalized citizens, the policy inadvertently implements

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municipal food security strategies for the middle class while deepening the ongoing exclusion of PLWHA who use drugs, among other groups.

Additionally, city development policies have been crucial drivers of the gentrification of the Downtown Eastside – the neighbourhood that is home to most of the city's food insecure. There has been an accelerating erosion of spaces where PLWHA who use drugs might feel comfortable and welcome. Concern about this change is underscored by recent evidence that gentrification and rising housing costs are linked to increased food insecurity among low-income PLWHA in San Francisco (Whittle et al. 2015). In Vancouver, ongoing tensions between long-term residents and higher-income “gentrifiers” have been manifest in protests related to the incursion of high-end restaurants and the loss of more affordable cafes and corner stores (Aiello 2014; Burnett 2014; Miewald, Aiello, and McCann forthcoming).

Thus, through various municipal policies, the City of Vancouver contributes to food insecurity while, at the same time, it attempts to reduce the transmission of HIV through harm reduction facilities such as Insite. The city's lack of a comprehensive strategy to address the nutritional needs of its citizens who use drugs, (whether or not they are HIV positive), means that an important factor in both the transmission HIV and morbidity related to HIV is being ignored by the city. A more inclusive foodscape would take into account the specific nutritional needs of PLWHA who use drugs and ensure that food is not only accessible but provided in a manner that is dignified, safe and appropriate. The lack of policy guidance around issues of food access for vulnerable populations thus continues to perpetuate an exclusionary foodscape for PLWHA who use drugs.

Conclusion

We hope that this project initiates a dialogue about including nutrition as part of harm reduction approaches among harm reduction service and food providers, local health authorities, and other policy makers, in a manner that “reflect[s] the community's vision of social change in both the social policy and practice arena” (Greene et al. 2009, 362). To be effective, we argue, this dialogue should address the admittedly more challenging structural issues that marginalize PLWHA who use drugs.

As Klodawsky, Siltanen, and Andrew (reference this volume) note, “Critical praxis-oriented research aims to examine whose values have the upper hand in structuring specific contexts of experience and by what mechanisms of power are these values given priority.” This type of research attempts to move away from decontextualized interventions that are meant to be widely replicable, toward more contextualized and emancipatory projects. To this end, when conducting CBR, we should be acknowledging and documenting power imbalances between the various members of a research team. Despite the goal of CBR to include community members within the research process, their inclusion is always partial and subject to conflict. We must also pay attention to the wider context of our research and provide a critique of the structural systems that lead to inequality and marginalization, and, in the community we are studying, food insecurity and ill health.

For academic researchers, PRAs are an important resource for understanding the wider community, particularly because they are able to relate to and communicate with survey respondents in ways that elicit responses that might otherwise be shared with academic researchers. As they operate in a space between lived experience and the academic or biomedical

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sphere, PRAs are important conduits between these worlds, helping to both make sense of and to disrupt research. In our case, PRAs have provided important input into research design modification. For example, they have offered their insights about the best way to structure interviews to reduce participant stress, they have helped to clarify names and terms used in the informal economy, and have pointed out questions that might appear confusing to participants. This information is not only valuable to our entire research team, but also more broadly, for researchers who are attempting to engage with marginalized populations. The very presence of PRAs in CBR should, ideally, hold academic researchers to account. Academics must not make assumptions or draw conclusions about lives that they are likely to never fully understand. By incorporating multivocality into the research process, we hope that our CBR co-produces hybrid knowledge that integrates our understanding of the lived experiences PLWHA who use drugs into sound policy recommendations as well as our critique of the structures that continue to negatively influence the health and well-being of this community.

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