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Food for Thought: Perceptions of Food Access and Heathful Eating in The Masxha Community

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Abstract

This study aims to begin to understand the perceptions of food access and healthful eating within the Masxha community, located in the Cato Manor Township. Food insecurity has recently been gaining attention as a problem in urban areas, however, there is still a lack of literature addressing specifically urban food insecurity.

Study data was collected through 10 interviews with participants in the Masxha community. Conversations focused on food habits, what participants consider healthy, food buying habits, food access, and potential solutions to food insecurity. Interviews intended to learn whether food insecurity is experienced among participants in Masxha, as well as how community members thought about healthy foods, with the aim that this information would help fill gaps in existing literature to approach the broader goal of finding solutions to the issue of urban food insecurity.

Very few participants seemed to be experiencing or at risk of experiencing food insecurity. More research is needed, however, to fill gaps in the literature on urban food insecurity in South Africa and potential solutions. Community gardens could present a reasonable response to urban food insecurity, however, more research is also needed to determine whether community gardens are helpful in improving both nutrition and food access.

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Explanations of Frequently Used Anagrams and Terms

- Phutu: a crumbly porridge (Swart & Swart, n.d.)
- Pap: a porridge made from maize (Swart & Swart, n.d.)
- Samp: ground corn, sometimes refers to a porridge made from ground corn
- FBDGs: Food-Based Dietary Guidelines

Introduction

This project aims at addressing the question of how food access and nutrition are perceived by members of the Masxha community, a section of the Cato Manor Township in Durban, South Africa. The researcher conducted interviews in the Masxha community to better understand the perceptions of access to food (in relation to both location and affordability of food) and the standards by which community members deem certain foods healthy and others unhealthy.

Food security was defined at the World Food Summit in 1996 to exist "when all people, at all times, have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life" (Food Security (Policy brief 2), 2006, p. 1). The Food and Agriculture Organization of the United Nations (2006) further expounds upon this definition to bring about four main aspects of food security. The first dimension of food security is food availability, referring to enough food physically being available. Food access is also implicated, meaning that individuals and families have the sufficient resources with which to acquire enough food. Food security also occurs when food is utilized "through adequate diet, clean water, sanitation and health care to reach a state of nutritional well-being" (Food Security (Policy brief 2), 2006, p. 1). Lastly, stability is indicated as being essential to food security in that when an individual or household is food secure, they are able to access food at all times, even if a sudden shock occurs (p. 1).

South Africa is experiencing "a rising incidence of overweight and obesity and the associated consequences such as hypertension, cardiovascular disease, and diabetes" (Roadmap for Nutrition in South Africa, 2013, p. 11). The Roadmap for Nutrition in South Africa (2013) states that "Within the context of the HIV and AIDS pandemic and food insecurity, the high

prevalence of under-nutrition, micronutrient deficiencies and emergent over-nutrition presents a complex series of challenges" (p. 11). 26.6% of South African women are overweight, and an additional 24.9% are obese (Roadmap for Nutrition in South Africa, 2013). Moreover, rates of obesity in children are higher in urban areas, with 5.5% of children in urban areas experiencing obesity compared to 4.8% nationally (Roadmap for Nutrition in South Africa, 2013, p. 11). Non-communicable diseases counted for 37% of all deaths in 2000, with cardiovascular disease and diabetes making up 19% and cancers making up 7% of NCD deaths (Steyn, et al., 2006, p. 259). Obesity has been shown to contribute to the development of these non-communicable diseases. The World Health Organization (n.d) states that "Overweight and obesity lead to adverse metabolic effects on blood pressure, cholesterol, triglycerides and insulin resistance," and also that "Risks of coronary heart disease, ischemic stroke and type 2 diabetes mellitus increase steadily with increasing body mass index (BMI)."

This study aims to address the double burden of food insecurity and increasing levels of overwight and obesity in urban areas by collecting perceptions of food access and healthful eating in an urban South African community. The purpose of this study is to fill gaps missing in the literature on food insecurity and perceptions of what food is healthy in urban South Africa to help get a better understanding of where solutions lie.

Context and Literature Review

Food Access

Food access is currently an issue of interest in South Africa due to the ongoing drought. Statistics South Africa (2016) states that South Africa is experiencing the "worst drought in 23 years," requiring imported maize to meet demand and consequently creating concern over the inflation of food prices, especially with "rand weakness driving up the prices of other imports such as wheat" (Rising food prices, 2016). Food prices have been steadily increasing since November 2015, when the food inflation rate was 4.8%, to 5.8% in December, 7% in January, 8.8% in February, and 9.8% in March (Taking stock of food prices, 2016). Notably, the prices of vegetables and fruit "were both 18.7% more expensive in March 2016 than they were in March 2015" (Taking stock of food prices, 2016). This leaves households that were already struggling to pay for food more susceptible to food insecurity.

Urban food access in South Africa has only recently been drawing attention. Crush and Caesar (2014) note that "food security has been given precious little attention in research and policy formulation in relation to poverty and livelihoods in Msunduzi (and urban KwaZulu-Natal more generally)" (p. 166) due to issues with uneven development left from the apartheid legacy. In addition, the majority of attention towards food insecurity has been given to rural areas; Battersby (2011) notes that "the ANC included food security as one of its top priorities in its 2009 Election Manifesto, but located it in the section on rural development" (p. 546). Even though there hasn't been much attention given to urban food insecurity in South Africa, it has still been occurring. The African Food Security Urban Network (AFSUN) study, which place in Msunduzi from 2008-2009, found that 60% of surveyed residents were severely insecure, with another 27% being moderately food insecure (Crush & Caesar, 2014, p. 170). The AFSUN

conducted in Cape Town found that 77% of households were either severely or moderately food insecure (Battersby, 2011, p. 549). A study done in Klipplaat, a rural area, using the same tools to measure food insecurity found 100% of households to be severely or moderately food insecure, however the severity of food insecurity was found to be higher in urban areas, as there is a greater dependence on the cash economy by individuals and families living in the city (Battersby, 2011, p. 549).

Community Gardens

In this study participants are asked to comment on whether they think that gardens would help address food insecurity in Masxha. A study done in a Toronto community garden found several benefits that participants experienced due to involvement with the garden. The study found that one of the main benefits of working on the garden was that of better access to food. "Most participants spoke of improved access and cost-saving in some way," (Wakefield, Yeudall, Taron, Reynolds, & Skinner, 2007, p. 97). Participants also benefited from involvement with the garden as a "contribution to healthy living, in the form of better nutrition and increased exercise" (Wakefield, Yeudall, Taron, Reynolds, & Skinner, 2007, p. 97). However, even though these findings were reported by individuals, further research into the health benefits of community gardens in needed (Wakefield, Yeudall, Taron, Reynolds, & Skinner, 2007, p. 100). Wills, Chinemana, and Rudolph (2009) point out that "the nutritional impact of garden projects has seldom been measured, partly because of the small amount of produce initially harvested but more importantly because it is difficult to do so" (p. 39).

Methodologies

Sampling Plan

Because a knowledge of purchasing food is required by participants in this study, only participants over the age of 18 were interviewed, as they are the most likely to know the food buying habits of their household. 9 out of 10 participants live in the Masxha community, and the remaining participant was visiting the community and lives in Westville, about 15 minutes away from Masxha. Participants were primarily found through the researcher's homestay family, with whom she stayed for 5 weeks in February and March and then another 3 weeks in April. The researcher's family introduced her to many of the study participants from April 12 to April 26. This presents a potential limitation to the study, as the family might tend to associate more closely with people who have a certain socioeconomic status close to their own.

The researcher aimed for participants to represent different households, as data collected on the ability to access food would, in theory, be different between households but not among them. Two sisters were both interviewed, however, presenting a limitation to the study. In total, 10 participants were interviewed, 9 women and 1 man. The ages ranged, however the interviewer did not ask about age, because it is not directly relevant to the topic, unless the participant appeared to be around or under 20 years of age to ensure that informed consent could be adequately given by the participant.

Participants had to be fluent in English in order to participate, which presents a limitation to the study. As such, this study is not representative of the entire Masxha community.

Data Collection

Data was collected through interviews. Eight interviews were one-on-one, and one interview was a group interview in which two family members participated. The group interview created limitations, as one family member would often dominate the conversation, even though both participants were asked each question. All of the interviews took place in the homes of the participants. In order to collect information, the researcher asked each participant a set of 18 questions (see Appendix 1). The questions fell under the categories of eating habits and what they consider to be healthy, food buying habits, food accessibility, and solutions to food insecurity. Even though the questions are presented in a certain order, some interviews varied in terms of what order the questions were asked in, as some participants started speaking on a certain topic of interest and the researcher would consequently follow up on that topic, sometimes straying from the initial set of interview questions. Some participants asked for the clarification of some of the interview questions, in which cases the researcher reworded the question. One limitation of the study is the form of the questions. Some questions were broad with the intention of generating conversation, however some participants were confused by the wording of some questions. The researcher did not ask every participant each question, as throughout the interview some participants answered some themselves without having to be specifically asked. The researcher gave each participant her cell phone number in the event that they wanted to withdraw their input or receive a portion of the completed study. Each interview was conducted in English, presenting a limitation in leaving out those who could not speak English fluently.

Initially, food experts were going to be a part of this study to help in triangulation of the data coming from Masxha community members. The researcher contacted four food experts

under the guidance of her advisor, however, there were barriers in speaking to each of the experts and consequently the perspectives of experts in the fields of food access and nutrition will not be included in this study.

Data Analysis

In the data analysis process, each interview was first transcribed by the researcher. The researcher then put all of her collected data together to begin coding and finding common themes throughout the data. Some data was then organized into tables or charts, as ideally this makes the information easier for the reader to visualize and understand the patterns that come from the interviews. The data gained from primary sources was then compared and analyzed using secondary sources to being further meaning to the information found in the study.

Ethics

Participants in this study each gave informed consent after a conversation about the rights that they have in participating in the study (see Appendix 2). Each participant gave verbal consent after it was ensured that they understood what was being asked of them. All participants remain anonymous in this study, and have been coded as Anonymous 1-10. Responses to interview questions have remained confidential, and the identity of participants is in no way revealed in this study.

This study was approved by the Local Review Board (LRB) (see Appendix 3) and has followed the ethical protocol given in the SIT Study Abroad Statement on Ethics (see Appendix 4).

The only risk presented to participants in this study was the risk of embarrassment at the experience of food insecurity. For that reason the researcher purposefully left out questions directly asking about participants' income levels and whether they themselves, or their families, worried about food insecurity. Participants were also informed that they had the right to refuse to answer any question which they did not want to answer, or stop the interview at any time. The participant affirmed the feedback given by participants, and tried to relate to participants when possible to help reduce potential power differentials between the researcher and participants.

Findings

Food Habits and Perceptions of "Healthy"

The first question participants were asked was "what is your favorite meal?" Table 1 below depicts the answers of the participants, as answers were varied in terms of how participants reacted to the word "meal," with 3 out of 10 answering with one food item.

Table 1: Favorite meals of participants

Food type	**Number of Participants**
Curry with rice/phutu	3
Pork/sausage/meat	2
Chicken with rice	1
Steamed bread and red meat with greens	1
Cabbage (prepared with chicken) and samp	1
Green salad with chicken	1
Roast chicken	1
	10

Participants each named a meat as either part or the whole of their favorite meal, and 7 out of 10 included a side to the meat, either a grain (6 out of 10) and/or a vegetable (2 out of 10). Participants then either justified their answer with their reasoning, or they were asked why the meal they named is their favorite. 6 out of 10 participants said or implied that they liked the meal or food because of its taste, 3 out of 10 said that they preferred that food because they thought it was healthy (one participant specifically said that he liked chicken because of it being "high in protein" (Anonymous 9, pers. comm., April 22, 2016)). One participant said that rice and curry is her favorite meal because "it's what we eat almost every day" (Anonymous 1, pers. comm., April 13, 2016).

The second interview question was "Do you eat this and how often?" to start learning whether food insecurity occurs in this community. Every participant answered "yes" to this question, however, the frequency of consumption of their favorite meals differed. 2 out of 10

individuals reported that they eat their favorite meals every day, 2 out of 10 said that they eat their favorite meal three times a week, 1 participant said twice a week and 1 participant said once a week. Others were less specific. One participant said that she eats her favorite meal "a lot" (Anonymous 2, pers. comm., April 13, 2016). One individual noted that while she is able to eat her favorite meal, she does not eat it often for variation. Two participants said that they do not eat their favorite meals very often because they take a long time to prepare, with one woman noting that she prepares her favorite meal "if I just want to spoil myself" (Anonymous 5, pers. comm., April 15, 2016). Anonymous 5 (pers. comm., April 15, 2016) also said that although red meat is her favorite, her family usually eats white meat due to the higher price of red meat.

The third question asked whether participants thought that their favorite meal was healthy. The responses to the first question are shown in Table 2 below.

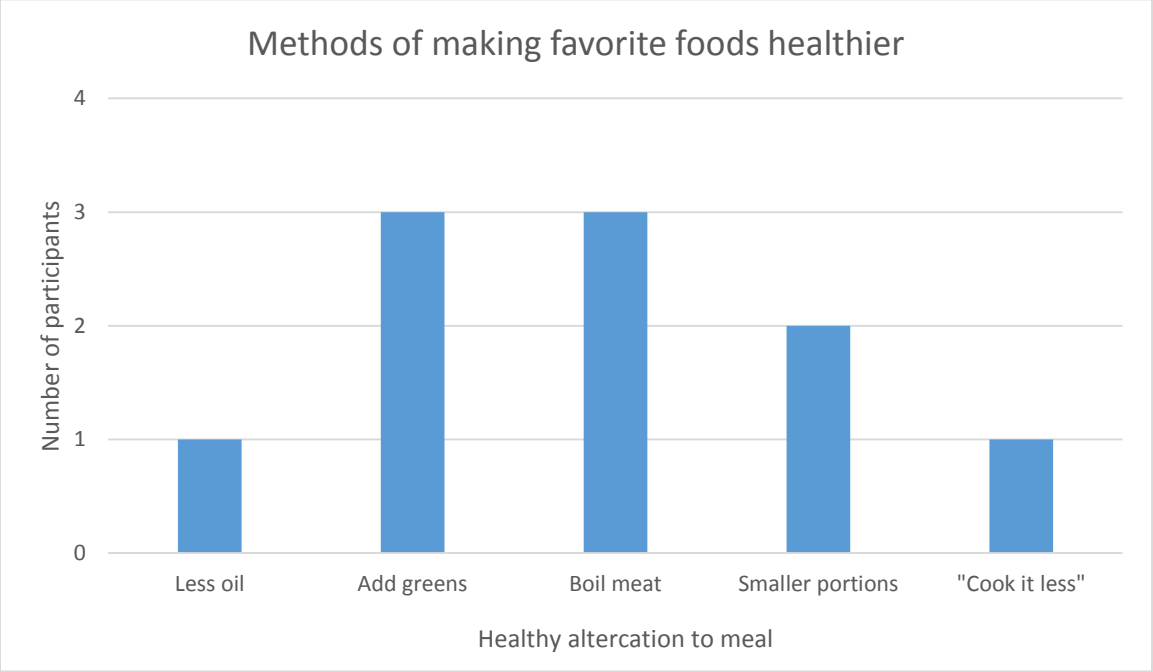
Table 2: Perceived health of favorite meals

Participant	**Meal**	**"Do you think it's a healthy meal?"**
1	Curry and rice	No
2	Pork	No
3	Curry and phutu	No
4	Green salad with chicken	Yes
5	Steamed bread, red meat and greens	Greens are healthy but "bread has starch"
6	Roasted chicken	Yes
7	Curry and phutu	No
8	Cabbage and samp	No
9	Chicken and rice	Chicken is, "I'm not sure about rice"
10	Sausages	No

The majority of participants, 6 out of 10, answered that their favorite meals are not healthy. 2 out of 10 participants answered that their favorite meal is healthy, with both participants already responding that the meal they gave is their favorite for health reasons. 2 out of 10 participants answered that a portion of their meal was healthy but the other was not.

Question four asked how participants thought their favorite meal could be made healthier, and results are shown in Figure 1 below.

Figure 1: Methods of making favorite meals healthier



3 out of 10 individuals answered that their favorite meal would be healthier if the main component (either meat or cabbage) was boiled rather than cooked in oil. When asked why she thought that cabbage prepared with oil and onions is unhealthy, Anonymous 8 (pers. comm., April 22, 2016) answered “Because oil is not healthy, unless you use olive oil, that’s what they say, olive oil is much healthier than the oil that we use, the sunflower oil,” and she later added that “that’s what I’ve heard from TV and dieticians, boiling food is much healthier.” Another participant, when asked how her favorite meal could be made healthier, said “Maybe boiling it,

but agh. Yeah, I think boiling it, but you wouldn't boil beef, you couldn't eat boiled beef, I think it tastes funny" (Anonymous 10, pers. comm., April 26, 2016).

3 out of 10 individuals said that adding greens or a salad would make the meal healthier, 2 out of 10 participants said that smaller portions would make the meal healthier, and one participant named less oil as making the meal healthier. One participant was unsure, saying "What do I think could make the meal healthier? That's a tough one. Hmmm... That's a tough one, you know. That's a tough question" (Anonymous 9, pers. comm., April 22, 2016). After thinking for a few seconds he answered "I think cooking it less." The interviewer asked "Cooking it less, like for less amount of time?" for clarification, with which the individual responded "Yeah, I think cooking it less makes it healthier. I mean, not overcooking it" (Anonymous 9, pers. comm., April 22, 2016).

The fifth interview question asked participants whether or not they could eat their favorite meal every day. 4 out of 10 participants answered that they either could or do eat their favorite meal every day, with 2 of those being the participants who answered that their favorite meal is healthy. The remaining 6 participants said that they could not eat their favorite meal every day for various reasons. 2 out of 10 participants answered that they could not eat their favorite meal every day due to physical effects of the nutritional value of the meal. Anonymous 2 (pers. comm., April 13, 2016) answered "Hell no, never, no, no, no, no, no" and when asked why she answered "Aye, it's got so much fat, that means I would go to be like [motions] this big." Anonymous 3 (pers. comm., April 13, April 16, 2016) said that "sometimes you have to feel light, and that's a heavy meal, so I can't eat them every day." 3 out of 10 participants said no for reasons relating to food preparation. Anonymous 6 (pers. comm., April 16, 2016) said "No, because I'm a lazy person to cook," and Anonymous 8 (pers. comm., April 22, 2016) answered

that “Samp, it takes a lot of time to prepare, yeah, I don’t have much time because in the morning I have to drop the kids, come back, do whatever I need to do, go fetch them, you know, I don’t have much time at home.” One individual answered that he could not eat his favorite meal every day because he needs variation. One individual, who said that her favorite meal takes too much preparation time, also said that her favorite meal includes red meat, but she can’t eat that every day because red meat is expensive.

The sixth question asked participants what they ate the day before the interview. The answers are listed in Table 3 below.

Table 3: “What did you eat yesterday?”

Participant	**Favorite meal**	**“What did you eat yesterday?”**	
		Grains	**Protein**
1	Curry and rice	Rice	Beans & sausages
2	Pork	Phutu	Beans
3	Curry and phutu	Rice	Baked beans & red meat
4	Green salad with chicken	-	Ribs & wings (at Spur)
5	Steamed bread, red meat and greens	Nothing- “I didn’t eat anything, there was no electricity!”	
6	Roasted chicken	Pap	Beef stew
7	Curry and phutu	Phutu	Fried meat
8	Cabbage and samp	Rice	Mince
9	Chicken and rice	Bread	Fish

10	Sausages	Nothing- "I never had supper… I was full"

7 out of 10 participants answered with only a grain and form of protein. One participant answered that she had ribs and wings at Spur, a restaurant, but did not mention a grain component. 2 out of 10 participants said that they did not eat anything, with Anonymous 5 (pers. comm., April 15, 2016) naming a power outage as the reasoning and Anonymous 10 (pers. comm., April 26, 2016) stating that she was full when it came time to eat supper.

Food Buying Habits

Six questions about participants' food buying habits were discussed as a way to help the researcher better understand experiences of food security or insecurity in the community. Table 4 below summarizes the results from the seventh question asking where participants buy their food. Participants that answered with two different places are counted twice.

Table 4: "Where do you buy food?"

Location	**Number of Participants**
Checkers or Pick n' Pay at the Pavilion	8
In town	3
Woolworths	3
Bluff Meat, Oxford	1

The majority of participants (8 out of 10) answered that they get their groceries at different stores in the Pavilion, and an additional participant answered that her family shops at the Pavilion if they need food but aren't going on their monthly shopping trip. One participant said that her

family shops exclusively at shops in town for groceries, and two said that they shop at both the Pavilion and at shops in town. Three participants said that they shop at both shops in the Pavilion and also specifically Woolworths (which is also located in the Pavilion), saying that "they keep it fresh" (Anonymous 4, pers. comm., April 13, 2016). One participant said that her family shops at Bluff meat for meat, and at Oxford for vegetables. When asked why her family chooses to shop there, she answered

> "Because the meat is very fresh, good price, and we just feel that everything is there so we can buy anything we want. And as I said, it is cheap. It's a good place. And it's clean. Well, I don't want to lie, I'm a person who's full of herself, I may say that, I don't want to buy meat anywhere, hygiene, to me, it's very important, you know, because at some butcheries or somewhere, wherever they sell meat, you find out there's flies there, I don't want to lie there may be flies at Bluff meat, but just that when you get there it's clean, cleanliness there, that's very important. It's very clean. So I just prefer going there, even though sometimes it will be like when you go there we'll go with public transport, and then when we come back we have like a lot of packets and then we just have to take public transport, but it's okay" (Anonymous 10, pers. comm., April 26, 2016).

When asked how far it takes her to get to where she buys groceries, Anonymous 10 said that it takes her 45 minutes to an hour when using public transport. Individuals who shop in town, Anonymous 1, 2, and 5, answered that it takes them 15, 15-30, and 20 minutes of travel time respectively. Those who live in Masxha, shop at the Pavilion, and use public transport, Anonymous 2, 3, 4, 6, 7, and 9, all answered between the range of 10-20 minutes travel time to the Pavilion. Anonymous 8, who lives in Westville, answered that it takes her 5 minutes to reach the Pavilion when she drives herself, using her own car. Anonymous 3 and 4 reported that sometimes their mom drives them to the Pavilion, in which case it only takes 5 minutes of travel time.

Participants were then asked how often they buy food and whether they buy in bulk. 8 out of 10 individuals answered that they buy groceries once a month, and the remaining 2 answered that they buy food twice a month. 2 out of 10 participants also added that they will shop an

additional few times a month for fresh foods, and 1 individual added that she may shop throughout the month if their food runs out. 10 out of 10 participants answered that they buy in bulk, and 4 out of 10 participants added that they buy fresh food in smaller quantities throughout the month.

The next question asked participants how much they spend on groceries every month. One participant answered that his household spends 850 rand on groceries every month. 3 out of 10 individuals answered 1,000 rand, with 2 of those 3 a starting point in a range. 1 of those 2 participants said between 1,000-1,200 rand, and the other answered 1,000-2,000 rand. 3 out of 10 participants said that they spend about 1,500 rand on groceries every month. Two participants, who live in the same household, spend 2,500 rand on one monthly trip, and then 1,000 rand on smaller, weekly trips throughout the month. When asked whether they factor transportation to buy groceries into their total spending budget for groceries, 9 out of 10 participants said no, and 1 participant said that she does, as she has a certain allotment of money for food and then takes her transport money out of that.

Food Access

Four questions were involved in each interview to further determine whether individuals were experiencing food insecurity, and their perceptions of those experiences. The first question in this theme was "Do you think that it is difficult to access food around you?" with the intention of learning whether participants thought that it is easy or difficult to physically get to food. 6 out of 10 participants said that it is not difficult for them to access food. 2 of those 6 participants said that sometimes they will buy an extra seat in the taxi to help get their groceries home, and an additional 2 participants, of those 6, said that they sometimes ask for help with pushing the

trolley or loading the taxi if they need it. 1 of those 6 participants lives in Westville, closer to the Pavilion than Masxha, and she also has her own car and drives to the Pavilion when she grocery shops. 1 participant answered the question by first saying that it is not difficult to access food because she and her daughter are both working, and then later said that it is not difficult to get to food "because even the supermarkets, it's nearer" (Anonymous 7, pers. comm., April 18, 2016). 4 of 10 participants said that it is difficult for them to access food. 2 of those 4 participants expressed frustration with the minibus taxi system, with one participant saying "It gets frustrating, it does. Because sometimes, even the wait, like waiting for a taxi, it takes long" (Anonymous 4, pers. comm., April 13, 2016), and the other saying "They get those bad, bad, bad, bad taxis, so the transport to go to the Pavilion, aye, aye, I don't trust it" (Anonymous 3, pers. comm., April 13, 2016). Both of these participants stated that they spend 2,500 rand on their big grocery trip, and 1,000 rand on smaller trips throughout the month, the most of all of the participants. Another participant stated that it is difficult to access food because "Around here we don't usually have like supermarkets, pavilion is the closest mall to us, so it is hard to get food around here" (Anonymous 6, pers. comm., April 16, 2016). This participant stated that her family spends between 1,000 and 2,000 rand every month when they go grocery shopping, and 2,000 rand is on the high end of the spectrum of participants' monthly grocery spending. The last participant said that it is difficult to get food "Because, I mean, here, now for myself, so I'm unemployed at the moment, so it is difficult, so I find that I want something but I can't afford it. Yeah, so it is difficult" (Anonymous 9, pers. comm., April 22, 2016). Later in the interview he said that taking taxis is "easy," so he does not think it is difficult to physically access food, but rather it is difficult to access economically.

Question fourteen is “Do people in the community ever worry about not having enough food?” 8 out of 10 participants said that yes, people worry about not having enough food. 1 out of 10 participants said no, and 1 out of 10 participants answered that she did not know. When asked whether a small or large amount of people worry about having enough food, 6 out of those 8 participants said that a lot worry, and 2 out of 8 said that a small amount of people worry about food. 3 of the 10 participants additionally said that neighbors help people who are struggling to get food. 4 out of 10 individuals added that people struggle to afford food because a lot of people are unemployed. One participant added,

> “People cannot afford. Even our pension, that the government gives, a child, a small child, is given 350 rand (for a month), and then the adults, which are from 60 years, get 1,500 rand. You cannot live with that money. You cannot… Yes, even us here, we are relying on it. Like we have someone who is working but most of us are not working. We actually rely on that money. But we are surviving” (Anonymous 1, pers. comm., April 13, 2016).

Participants were then asked how their access to food has changed. 9 out of 10 participants said that food is more expensive than it used to be. 2 of those 9 individuals mentioned the drought as increasing the prices of food. The other individual said that “Yeah, I don't think it, it hasn't been much of a problem to me, yeah. I haven't had a problem” (Anonymous 8, pers. comm., April 22, 2016). Anonymous 4 (pers. comm., April 13, 2016) also added that “there’s more genetically modified food now, and it’s not really healthy.”

Question sixteen asked participants what their diets were like when they were a child, to help get an understanding of how and why peoples’ eating patterns have changed. The answers are listed in Table 5, below.

Table 5: "What was your diet like when you were a child?"

How diet has changed	**Number of Participants**
Used to be healthier	4
Used to eat more "junk food"	2
Used to eat bigger portions	2
Used to be controlled by parents, now able to eat according to preference	1
Used to eat same thing every day, now changes for variation	1
Diet hasn't changed	1

Participants responded with a wide range of reasons as to why their diets have changed since they were children. 3 out of 10 individuals answered that their diets used to be healthier because they ate foods that were grown in gardens either by their parents or grandparents. One individual said that her diet used to be healthier and that "Now I eat a lot of junk food. Cuz I can even afford to buy my own take-aways, so I can eat anything I want at any time" (Anonymous 1, pers. comm., April 13, 2016). One individual said that "Because, now I am supporting myself, I buy what I like… it's different from supported by parents" (Anonymous 5, pers. comm., April 15, 2016). 2 individuals said that they now eat smaller portions, with Anonymous 2 (pers. comm., April 13, 2016) saying "When I was a child, I could like eat everything, chips, food, everything, but right now I know how to limit myself and food." One individual stated that "I mean, it hasn't changed, because when I was little, you know, I ate porridge, you know what porridge is? And I still eat that s*** now. It hasn't changed, it is pretty much still the same" (Anonymous 9, pers. comm., April 22, 2016). Another participant stated that her diet has

changed because “I think it's because I got used to them, you know, I used to eat them every day… I’ve had enough with them,” and she added “I used to have like porridge with peanut butter, and not I really don't like peanut butter. I used to eat corn flakes, I used to have them a lot but now I don't like them at all” (Anonymous 10, pers. comm., April 26, 2016).

Food Access Solutions

Two questions about food access solutions were involved in the interviews, to see what ideas participants have for improving their own community’s access to food. Answers to the first question are listed below in Table 6.

Table 6: “Is there anything that could help you get food more easily?”

“Is there anything that could help you get food more easily?”	**Number of Participants**
More shops around the neighborhood	2
Feeding scheme	2
Community garden	1
More jobs	2
Money	1
No	2

3 out of 10 participants named more money and jobs as helping with food access in the community, and 2 out of 10 participants said that they already have enough access to food and answered no. Two participants (from one household) said that a feeding scheme would be useful, and described it as “Like if we, there’s a bunch of people in the community, they volunteer to cook and bring food, maybe like, very week, at a certain time, so that other people, that cannot afford, and then they like cook for them, they dish up, they also have like fruit” (Anonymous 4, pers. comm., April 13, 2016). One participant described that a garden would be helpful,

> "Maybe if we have a yard somewhere, where we could like go, like have a garden. Maybe if we could have a garden where we like plant everything we need, especially veggies, okay I understand with meat you can't plant meat, but with veggies where we could like plant some cabbages, some carrots, some broccoli or whatever, it would be easier because you wouldn't have to go to shops and buy, you'd just have to take from there, from the garden" (Anonymous 10, pers. comm., April 26, 2016).

Next, participants were asked what they thought about gardening as helping to improve their access to food. 9 out of 10 individuals said that gardens would be helpful. One participant said that "I prefer food from the garden than from shops because other shops, they manufacture food… And sometimes you like eat a particular thing, and then you get allergies and so forth" (Anonymous 2, pers. comm., April 13, 2016). Another individual added that gardening would be beneficial because "It's healthy food, it's fresh food from the ground. There's no other chemicals or things put into the food, so it's fresh" (Anonymous 4, pers. comm., April 13, 2016). Another participant explained why she thought that gardening would be beneficial,

> "So for you to have your own garden, it saves you money and the shortage of vegetables and all other things. And you can also help people in the community, like most of them don't have money, some of them can't afford to buy most food every day, or food for the whole month because they don't have money so for you to have a garden you are also able to donate a few vegetables and help out in the community" (Anonymous 6, pers. comm., April 16, 2016).

2 out of 10 individuals said that there was no space for gardening, with one saying,

> "It's just that there's no place in townships for gardening. I know some people who just look for an empty, vacant place, and plow there, but nobody is taking, is watching for your, for what you planted. Because I go up there, to the corner of the road, and plant, and who is going to look for it? Anybody can take it. So there's no place in townships (Anonymous 5, pers. comm., April 15, 2016).

The other participants said that "Yes, it would help, but can you see, where can you garden your food here?" (Anonymous 1, pers. comm., April 13, 2016). Another individual, who thought that gardening would be helpful, also added that "it's just that it's a lot of work, and people don't want

to work or something because gardening takes a lot of work, you need to do a lot of things, yeah" (Anonymous 8, pers. comm., April 22, 2016).

Traditional Foods

The last question of the interviews asked participants whether they eat traditional foods. 8 of the participants answered this question, and all of them said that they do eat traditional foods. Table 7 below lists the traditional foods that participants named and their frequency.

Table 7: Traditional foods

Traditional Food	**Number of times mentioned**
Ubhatata (sweet potato)	6
Amadumbi	4
Tripe	4
Imifino (greens/spinach)	4
Beans	3
Samp	3
uJeqe (steamed bread)	3
Cabbage	1
Dumplings	1

In 2 interviews the conversation followed to discuss whether participants thought that traditional foods are healthier than non-traditional foods. Anonymous 8 (pers. comm., April 22, 2016) said that they are healthier "because most of the traditional food, when you prepare it you don't use oil." When asked whether she thought traditional foods are healthy, anonymous 10 (pers. comm., April 26, 2016) said,

> "Some of them are, like sweet potato, amadumbis, greens, yeah, some of them are, I would think. Because usually they boil them, but when it comes to greens, greens you have to put a lot of oil, that's not healthy I don't think."

Analysis and Discussion

Knowledge of Healthy Eating without Behavior

The participants' complete knowledge of healthy foods cannot adequately be analyzed, as participants named healthy altercations to one meal rather than over a longer period of eating, however this information can still be used to gage a portion of the knowledge that participants have on healthy eating. Participants named a number of altercations to their favorite meals when asked how they thought they could make their favorite meal healthier (see Figure 1). Adding greens and boiling meat were both named 3 times, eating smaller portions was named twice, and less oil and cooking the food less were both named once. Some of these suggestions fall in line with the Food-Based Dietary Guidelines for South Africa (2012) (FBDGs). The FBDGs suggest:

- "Enjoy a variety of foods.
- Be active!
- Make starchy foods part of most meals.
- Eat plenty of vegetables and fruit every day.
- Eat dry beans, split peas, lentils and soya regularly.
- Have milk, *maas*, or yoghurt every day.
- Fish, chicken, lean meat or eggs can be eaten daily.
- Drink lots of clean, safe water.
- Use fats sparingly. Choose vegetable oils, rather than hard fats.
- Use sugar and foods and drinks high in sugar sparingly.
- Use salt and food high in salt sparingly." (Vorster, Badham, & Venter, 2013, p. 7)

Participants were accurate in 4 out of 5 of the main healthy food changes to the meals that they named. Less oil and boiling meat address the FBDG of using fat sparingly. Additionally, one participant said that "oil is not healthy, unless you use olive oil, that's what they say, olive oil is much healthier than the oil that we use, the sunflower oil" (Anonymous 8, pers. comm., April 22, 2016). The FBDGs suggest using vegetable oils rather than hard oils and do not differentiate between different types of vegetable oils, as this participant did. Adding greens is also a recommendation offered by the FBDGs, which suggest to "eat plenty of vegetables and fruit

every day" (Vorster, Badham, & Venter, 2013, p. 7). There was little mention of fruit in the interviews, with only Anonymous 7 (pers. comm., April 18, 2016) specifically saying that she buys fruit every two weeks.

The recommendation to eat smaller portion sizes, given by two participants, was not included in the main list of the FBDGs, however it is specifically mentioned later when concerning the portion sizes of meat (Schonfeldt, Pretorius, & Hall, 2013, p. 72). The Roadmap for Nutrition in South Africa (2013) does not mention portion sizes anywhere in the recommendations. One participant said a portion size would make the meal healthier "because it's like so much fat," suggesting that Anonymous 2, pers. comm., April 13, 2016), which could also be influenced by the FBDG recommendation to "use fats sparingly" (Vorster, Badham, & Venter, 2013, p. 7), rather than a specific recommendation to eat smaller portion sizes. And although the South African FBDGs don't specifically mention certain portion sizes, other health recommendations do, such as the American Heart Association guidelines (Suggested servings from each food group, 2016), meaning that the participants were accurate in pointing out the importance of portion size. Another participant also recommended eating smaller portion sizes and said "I think it can be healthier if you can cook with maybe little bit of phutu, [motions small amount with fingers] little bit of curry" (Anonymous 7, pers. comm., April 18, 2016). Both participants also added that adding a green salad would make the meal healthier, referencing the recommendation to "enjoy a variety of foods" (Vorster, Badham, & Venter, 2013, p. 7).

One participant said that "I think cooking it less makes it healthier. I mean, not overcooking it" (Anonymous 9, pers. comm., April 22, 2016). The researcher attempted to clarify by asking "the rice or the chicken?" and the participant responded "Both. No, well you have to cook the rice properly, so I think the chicken" (Anonymous 9, pers. comm., April 22,

2016). Chicken must be properly cooked for food safety, and as such this suggestion, as interpreted by the reseacher (there could have been a misunderstanding in language use), is not a way to make a meal helathier. Overall, participants identified 3 of the 11 recommendations given by the FBDGs, as well as the additional health recommendation of eating smaller portions.

It is evident that participants possess some knowledge regarding healthy eating behavior, however, the behavior of eating healthy food was not always followed through. After the interview, one participant said

> "I'll add that if, I don't know how to put it, but if I'm not the, the greens person, but if I can say one thing I recommend I could say that it's better to put just a piece of meat, greens, a salad. To eat salad every time, so that, and boil, I don't like to boil, I fry, but people must go for boiling" (Anonymous 5, pers. comm., April 15, 2016).

She said that she is "not the greens person" and "I don't like to boil," yet she was still saying that people must boil their meat and eat greens, showing a gap between the knowledge of healthy eating and the behavior of eating healthy foods. Another participant, who named less oil and adding a salad to make her meal healthier, said later in the interview that "Now I eat a lot of junk food… I'm not a healthy person. I'm not concerned about my weight and everything, I just eat anything at any time" (Anonymous 1, pers. comm., April 13, 2016). Her healthy food suggestion was accurate, however, even with that knowledge she still chose to eat "junk" food.

This disconnect between having the knowledge of healthy foods and the behavior of actually eating them suggests that there are barriers in place that prevent people from choosing healthy foods. One barrier might be availability. Anonymous 1 (pers. comm., April 12, 2016) said that "Now I eat a lot of junk food. Cus I can even afford to buy my own take-aways, so I can eat anything I want at any time. Here we have a lot of shops that sell takeaways, fried chips… sausages, no I don't have a healthy diet." Her immediately available food sources are fried chips and sausages, and so even though she knows that "less oil, and maybe get used to salad"

(Anonymous 1, pers. comm., April 13, 2016), her most available foods are unhealthy ones and so she eats those. Another barrier between knowledge of healthy foods and behavior could be preference. Anonymous 5 (pers. comm., April 15, 2016) said that "They say we must boil it, you must steam food so you must be healthy, but we like to fry." Her personal preference kept her from translating her knowledge into a behavior.

Perceptions of Food Insecurity

Although this study did not intend to specifically find how many individuals experienced food insecurity, the experiences that individuals shared can shed some light on the frequency of food insecurity experience among those interviewed. Food security entails that nutritious, safe, and preferred food is available, accessible, utilized properly and stable (Food Security (Policy brief 2), 2006, p. 1). The question asking participants if they could have their favorite meal every day intended to determine whether some individuals were experiencing food insecurity. One participant answered that she cannot eat her favorite meal every day due to the cost being too high, while the other 9 said yes or no according to preference and not necessity. Within the context of this question, one out of ten the participants had the potential to be experiencing food insecurity.

The question of buying in bulk also aimed at understanding whether food insecurity was experienced among participants. It was expected that most participants would use the minibus taxis as transportation to the grocery store (9 out of 10 individuals did say that they use the minibus taxis), and it was expected that because of this, individuals would buy less groceries for the sake of being able to carry their food. The study found, however, that all of the participants buy at least some of their food in bulk during once or twice a month grocery shopping trips. One

participant, when asked if taking bags onto the taxi influenced how much he buys, answered "No, it doesn't. We don't care. [Laughs] We don't care. Sometimes we can buy a seat, you know, I buy a seat, just for my groceries, in a taxi" (Anonymous 9, pers. comm., April 22, 2016). The question asking whether participants added the cost of transport to their money for food aimed at determining how accessible food is for community members. One individual answered that she factors her transport money into her food budget, while the other 8 said that they do not.

When participants were asked if they thought it was difficult to access food around them, it was expected that individuals experiencing food insecurity would answer that it is, however, the opposite occurred. The 3 individuals that spend the most on groceries every month, indicating a potential higher income (however without household size factored in it's not assured), answered that they think it is difficult to access food around them, while the other 6 participants that live in Masxha answered that it wasn't difficult for different reasons, namely the perceived ease of minibus transportation: "I just go to the bus stop and take a taxi" (Anonymous 5, pers. comm., April 15, 2016). Individuals who expressed that food is difficult to access around them gave reasons relating to transport by minibus taxi, and all 3 said that on their way home from grocery shopping they sometimes call a taxi (which costs R80 (Anonymous 3, pers. comm., April 13, 2016)), rather than take the minibus taxi (which costs R6 (Anonymous 1, pers. comm., April 13, 2016)) to make the transport of groceries easier. Because they spend more on groceries it may be more difficult to use the minibus taxis as transport due to having more groceries, or it could be a matter of personal preference, more research is determined.

The trends found from the responses to these questions indicate that a low percentage of participants in Masxha experience or risk experiencing food insecurity. These results cannot be

generalized to the entire community, as a very small segment of the population was involved in the study, and biases unintentionally existed in choosing participants.

Community Gardening

Most participants thought that food gardens were good ideas, with 9 out of 10 saying that they would be helpful, and naming that healthy food, saving money, and having accessible food would be tangible benefits of having a garden. 2 participants said that food gardens would be helpful because the food that comes from them is healthy. A study that took place in the US and followed 42 Hispanic farmworker families in planting and maintaining organic gardens found after two growing seasons that the adults' vegetable intake increased four-fold, and the children's vegetable intake increased three-fold (Carney, et al., 2011, p. 877). Another study done in 2007 in Denver, Colorado, found that both community and personal gardens increased participants' consumption of fruits and vegetables. Participants that took part in a community garden were found to consume fruits and vegetables 5.7 times per day and home gardeners were found to consume fruits and vegetables 4.6 times per day. Nongardeners, alternatively, consumed fruits and vegetables 3.9 times per day (Litt, et al., 2011, p. 1466).

Participants also named saving money as an advantage of having gardens. A qualitative study done with African refugees in Australia followed 13 participants that kept gardens and found that they reported saving money as an advantage to having a garden. One participant said regarding growing his own traditional foods that "It enables me to save. When I grow them I get them from my own garden. I do not use money to buy them… I have saved money on my garden" (Gichunge & Kidwaro, 2014, p. 272). Another participant said that "I save money. If I

need something that is in my garden I do not have to worry about where I will get it" (Gichunge & Kidwaro, 2014, p. 272).

Participants in this study also said that food would be more accessible if they had personal gardens, with one individual saying, referring to gardening, that "It's easy for you to get even the fresh vegetables" (Anonymous 7, pers. comm., April 18, 2016). Participants in the Australia study commented that they had better access to food while gardening, with participants commenting that "If I need something that is in my garden, I do not have to worry about where I will get it" (Gichunge & Kidwaro, 2014, p. 272), and "I am able to get vegetables. I do not have to buy" (Gichunge & Kidwaro, 2014, p. 272).

Conclusions

This study aimed to recognize perceptions of food access and healthy eating as experienced by members of the Masxha community. The findings cannot be generalizable to all of the Masxha community, however, as this study was done on such a small scale. Using information gathered from interviews, very few participants were found to be at risk of experiencing food insecurity, with only one participant out of ten answering questions positively for food security. Perceptions of what food is "healthy" mostly followed the South African FBDGs, however, even though the knowledge of healthy eating is evident, healthy eating behaviors are still lagging behind knowledge. Barriers, namely available foods and personal preference, can dictate whether an individual eats healthily. Urban food insecurity in South Africa is gaining attention, however, more research still needs to be done to determine what reasonable solutions might be.

Recommendations for Further Study

Further study needs to be conducted on the prevalence of food insecurity in urban areas of South Africa. This study touched the surface of a much bigger issue that needs exposure. Further study could also explore the eating patterns of urban South African communities to assess their nutritional status and eating patterns.

The motivation for further study should be to ultimately find unique solutions to the unique experiences of urban food security. This study mainly asked participants about community gardening, however, in future studies, participants could be asked about what solutions they want, and how they can be involved in the process of bettering their community through unique solutions that the community suggests fit their own experiences.

References

Battersby, J. (2011, October). Urban food insecurity in Cape Town, South Africa: An alternative approach to food access. *Development Southern Africa*, *28*(4), 545-561.

Carney, P. A., Hamada, J. L., Rdesinski, R., Sprager, L., Nichols, K. R., Liu, B. Y., . . . Shannon, J. (2011). Impact of a community gardening project on vegetable intake, food security and family relationships: A community-based participatory research study. *Journal of Community Health*, 874-881.

Crush, J., & Caesar, M. (2014). City without choice: Urban food insecurity in Msunduzi, South Africa. *Urban Forum*, 165-175. doi:10.1007/s12132-014-9218-4

Food Security (Policy brief 2). (2006, June). Retrieved from Food and Agriculture Organization of the United Nations: http://www.fao.org/forestry/13128-0e6f36f27e0091055bec28ebe830f46b3.pdf

Frayne, B., Battersby-Lennard, J., Fincham, R., & Haysom, G. (2009). *Urban food security in South Africa: Case study of Cape Town, Msunduzi and Johannesburg.* Midrand: Development Bank of Southern Africa.

Gichunge, C., & Kidwaro, F. (2014). Utamu wa Afrika (the sweet taste of Africa): The vegetable garden as part of resettled African refugee's food environment. *Nutrition & Dietetics*, 270-275.

Global Health Observatory data: Obesity. (n.d.). Retrieved from World Health Organization: www.who.int/gho/ncd/risk_factors/obesity_text/en/

Litt, J. S., Soobader, M. J., Turbin, M. S., Hale, J. W., Buchenau, M., & Marshall, J. A. (2011). The influence of social involvement, neighborhood aesthetics, and community garden participation on fruit and vegetable consumption. *American Journal of Public Health*, 1466-1473.

Rising food prices: where are the most vulnerable? (2016, February 9). Retrieved from Statistics South Africa: http://www.statssa.gov.za/?p=6135

(2013). *Roadmap for Nutrition in South Africa.* Pretoria: Department of Health, South Africa.

Schonfeldt, H. C., Pretorius, B., & Hall, N. (2013). "Fish, chicken, lean meat and eggs can be eaten daily": a food-based dietary guideline for South Africa. *Food-Based Guidelines for South Africa*, 66-76.

Steyn, N. P., Bradshaw, D., Norman, R., Joubert, J. D., Schneider, M., & Steyn, K. (2006). Dietary changes and the health transition in South Africa: implications for health policy. *The double burden of malnutrition*, 259-303.

Suggested servings from each food group. (2016). Retrieved from American Heart Association: www.heart.org/HEARTORG/HealthyLiving/HealthyEating/HealthyDietGoals/Suggested-Servings-from-Each-Food-Group_UCM_318186_Article.jsp#mainContent

Swart, M., & Swart, J. (n.d.). *Putu pap*. Retrieved from Rainbow Cooking: www.rainbowcooking.co.nz/recipes/putu-pap-krummelpap-crumbly-porridge

Taking stock of food prices. (2016, April 20). Retrieved from Statistics South Africa: http://www.statssa.gov.za/?p=6421

Vorster, H. H., Badham, J. B., & Venter, C. S. (2013). An introduction to the revised food-based dietary guidelines for South Africa. *South African Journal of Clinical Nutrition*, 5-12.

Wakefield, S., Yeudall, F., Taron, C., Reynolds, J., & Skinner, A. (2007). Growing urban health: Community gardening in South-East Toronto. *Health Promotion International*, 92-101.

Wills, J., Chinemana, F., & Rudolph, M. (2009). Growing or connecting? And urban food garden in Johannesburg. *Health Promotion International*, 33-41.

List of Primary Sources

Anonymous 1, personal communication, April 13, 2016

Anonymous 2, personal communication, April 13, 2016

Anonymous 3, personal communication, April 13, 2016

Anonymous 4, personal communication, April 13, 2016

Anonymous 5, personal communication, April 15, 2016

Anonymous 6, personal communication, April 16, 2016

Anonymous 7, personal communication, April 18, 2016

Anonymous 8, personal communication, April 22, 2016

Anonymous 9, personal communication, April 22, 2016

Anonymous 10, personal communication, April 26, 2016

Appendix 1: Interview Questions

1. What is your favorite meal?
2. Do you eat this?
    a. If so, how often?
    b. If not, why not?
3. Do you think this is a healthy meal?
4. What would make it healthier?
5. Is it a meal you could eat every day?
6. What did you eat yesterday?
7. Where do you buy food?
8. How long does it take you to get to where you buy food?
9. How often do you buy food?
    a. Do you buy in bulk or small quantities?
10. Approximately how much do you spend on food per month?
11. When you think about the cost of food do you add the cost of transportation?
12. Do you think that it is difficult to access food around you?
    a. If so, why?
13. Do people in the community ever worry about not having enough food?
    a. If so, why?
    b. If so, is it a small amount of people or a lot of people?
14. How has access to food changed?
15. What was your diet like when you were a child?
16. Is there anything that would help you get food more easily?
17. People often think about gardens as improving food access, what do you think about gardens? Do you have experience with gardens?
18. Do you ever eat traditional foods?

Appendix 2: Informed Consent Form

I can read English.

I understand that this project is asking me to talk about my ideas and thoughts about healthy food and where and how I get food.

I understand that my words will be used in a small book that talks about what Zulu people eat and that the book will be put on computers for anyone to see.

If I want to know what words of mine will be put in this book I understand that I can ask the student to tell me by phoning me if I give my cell number.

I understand that my name will not be put in this book and nobody will know it is me who said these things.

I understand that I can choose not to answer any question and that will be OK. I can ask for my words to be taken out of the book, but I need to tell the writer before Friday, 29 April, 2016.

I understand that my voice will be recorded but the recording will be thrown away after 1 month. Only the writer will be allowed to listen to the recording and to write down what I said.

I understand that I will receive no gift for talking with this person.

I have the writer's cellphone number it is 081 350 9489.

I understand that if I am worried about this I can call the teacher Zed McGladdery 084 683 4982.

Signature (participant)_____Date:_____

Appendix 3: Local Review Board Approval

IRB Action Form

Circle Action Level:
AD / Local RB / Full SIT IRB

Cover Sheet for Review of Research with Human Subjects
World Learning, Brattleboro, VT 05301

ACTION TAKEN: Form below for AD/LRB/IRB use only

Name of Student Hannah Richason
Title of ISP Proposed Research Food Access Issues as Perceived by Maskha community members and food experts
Study Abroad Program -SFH 442 SPRING 16
Name of academic director John McGladdery
Names of LRB Members Clive Bruzas (PhD), Frances O'Brien (PhD)

Identifying project number SP16/16

Research exempt from federal regulations. Action taken:
_ approved as submitted _ approved pending revisions
_ requires expedited review _ requires full IRB review _ not approved

Research Expedited Review. Action taken:
✓ approved as submitted _ approved pending revisions
_ requires full IRB review _ not approved

Research requiring Full IRB review. Action taken:
_ approved as submitted _ approved pending submission or revisions _ not approved

6 April 2015
LRB/IRB Chairperson's Signature — Date

6 April 2015
LRB/IRB Member's Signature — Date

Student Name: Hannah Richason

Appendix 4: SIT Study Abroad Statement on Ethics

(Adapted from the American Anthropological Association)
This document must be read, signed, and submitted to the AD prior to ethics review meeting.

In the course of field study, complex relationships, misunderstandings, conflicts, and the need to make choices among apparently incompatible values are constantly generated. The fundamental responsibility of students is to anticipate such difficulties to the best of their ability and to resolve them in ways that are compatible with the principles stated here. If a student feels such resolution is impossible, or is unsure how to proceed, s/he should consult as immediately as possible with the Project Advisor and/or AD and discontinue the field study until some resolution has been achieved. Failure to consult in cases which, in the opinion of the AD and Project Advisor, could clearly have been anticipated, can result in disciplinary action as delineated in the "failure to comply" section of this document. Students must respect, protect, and promote the rights and the welfare of all those affected by their work. The following general principles and guidelines are fundamental to ethical field study:

I. Responsibility to people whose lives and cultures are studied
Students' first responsibility is to those whose lives and cultures they study. Should conflicts of interest arise, the interests of these people take precedence over other considerations, including the success of the Independent Study Project (ISP) itself, for if the ISP has negative repercussions for any members of the target culture, the project can hardly be called a success. Students must do everything in their power to protect the dignity and privacy of the people with whom they conduct field study.
The rights, interests, safety, and sensitivities of those who entrust information to students must be safeguarded. The right of those providing information to students either to remain anonymous or to receive recognition is to be respected and defended. It is the responsibility of students to make every effort to determine the preferences of those providing information and to comply with their wishes. It should be made clear to anyone providing information that despite the students' best intentions and efforts anonymity may be compromised or recognition fail to materialize. Students should not reveal the identity of groups or persons whose anonymity is protected through the use of pseudonyms.
Students must be candid from the outset in the communities where they work that they are students. The aims of their Independent Study Projects should be clearly communicated to those among whom they work.
Students must acknowledge the help and services they receive. They must recognize their obligation to reciprocate in appropriate ways.
To the best of their ability, students have an obligation to assess both the positive and negative consequences of their field study. They should inform individuals and groups likely to be affected of any possible consequences relevant to them that they anticipate.
Students must take into account and, where relevant and to the best of their ability, make explicit the extent to which their own personal and cultural values affect their field study.
Students must not represent as their own work, either in speaking or writing, materials or ideas directly taken from other sources. They must give full credit in speaking or writing to all those who have contributed to their work.

II. Responsibilities to Hosts
Students should be honest and candid in all dealings with their own institutions and with host institutions. They should ascertain that they will not be required to compromise either their responsibilities or ethics as a condition of permission to engage in field study. They will return a copy of their study to the institution sponsoring them and to the community that hosted them at the discretion of the institution(s) and/or community involved.

III. Failure to comply
When the AD(s) feel that the student has violated this statement of ethics, the student will be placed on probation. In the case of egregious violations, students can be subject to immediate dismissal under the conditions of the SIT STUDY ABROAD dismissal guidelines.

I, _____, have read the above Statement of Ethics and agree to make every effort to comply with its provisions.

Date: _31/3/16_____

SIT Study Abroad
School for International Training

Access, Use, and Publication of ISP/FSP

Student Name: Hannah Richason

Email Address: hrichaso@indiana.edu

Title of ISP/FSP: Food for Thought: Perceptions of Food Access and Healthful Eating in the Masxha Community

Program and Term/Year: South Africa: Community Health and Social Policy Spring 2016

Student research (Independent Study Project, Field Study Project) is a product of field work and as such students have an obligation to assess both the positive and negative consequences of their field study. Ethical field work, as stipulated in the SIT Policy on Ethics, results in products that are shared with local and academic communities; therefore copies of ISP/FSPs are returned to the sponsoring institutions and the host communities, at the discretion of the institution(s) and/or community involved.
By signing this form, I certify my understanding that:

1. I retain ALL ownership rights of my ISP/FSP project and that I retain the right to use all, or part, of my project in future works.

2. World Learning/SIT Study Abroad may publish the ISP/FSP in the SIT Digital Collections, housed on World Learning's public website.

3. World Learning/SIT Study Abroad may archive, copy, or convert the ISP/FSP for non-commercial use, for preservation purposes, and to ensure future accessibility.
   - World Learning/SIT Study Abroad archives my ISP/FSP in the permanent collection at the SIT Study Abroad local country program office and/or at any World Learning office.
   - In some cases, partner institutions, organizations, or libraries in the host country house a copy of the ISP/FSP in their own national, regional, or local collections for enrichment and use of host country nationals.

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5. World Learning/SIT Study Abroad websites and SIT Digital Collections are publicly available via the Internet.

6. World Learning/SIT Study Abroad is not responsible for any unauthorized use of the ISP/FSP by any third party who might access it on the Internet or otherwise.

7. I have sought copyright permission for previously copyrighted content that is included in this ISP/FSP allowing distribution as specified above.

May 5, 2016

Student Signature Date