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Barriers to Health: Understanding the Barriers Faced by Community Intervention Projects

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BARRIERS TO HEALTH: UNDERSTANDING THE

BARRIERS FACED BY COMMUNITY INTERVENTION PROJECTS

by

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ABSTRACT

Health disparities affect significant portions of the population and are most often experienced by marginalized communities (Wilkin, 2013). Health disparities are also impacted by geographical location, and hunger often affects rural areas (Dutta, Anaele, & Jones, 2013; Rural Health Information Hub, 2017). This study aims to understand how nonprofit organizations focused on addressing food insecurity disseminate information to members of the local community and how the input of community members impacted the overall food insecurity campaign. This study was conducted by interviewing five nonprofit directors and conducting three focus groups with clients of the. aforementioned organizations. The author found that while organizations attempted to take culture and clients' lived experiences into account when crafting their messages, they were forced to balance multiple perspectives and attempted to predict the behavior of an entire community using one representative. Further, structural concerns such as physical walls and limited resources – such as time – also served as barriers to communication. This paper is a response to calls to focus on communication ecology and the perspective of both the organization and the client. This paper has, thus, added to the scholarship by providing a look at the lived experiences of both those seeking to ameliorate food insecurity and those experiencing food insecurity in the south.

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DEDICATION

I dedicate this thesis to my mother who has always been my biggest supporter.

Whenever I was discouraged or overwhelmed, she made sure to remind me just how

much faith she had in my ability to carry on. I am thankful for the ice cream, phone calls,

and unwavering support. Even when I was unsure and overwhelmed, she was there to

cheer me on.

I also want to thank my cohort, Abbey and Lauren, for being constant sources of

encouragement and support. I don't know how I would have survived graduate school

without them.

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CHAPTER I – INTRODUCTION

A health disparity, as defined in *Healthy People 2020*, is "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (Office of Disease Prevention and Health Promotion [ODPHP], 2010a, para 6). Health disparities affect populations facing significant obstacles to health based on their racial or ethnic group, age, socioeconomic status, gender, religion, or sexual orientation (ODPHP, 2010a; Wilkin, 2013). Individual behavior and access to health care are two of the most commonly cited determinants of health; however, social determinants of health (SDH) – social status, level of education, social support, environmental constraints, and geographic location, including neighborhood and housing quality – all play an influential role in the creation and perpetuation of health disparities (Knight, Benjamin, & Yanich, 2016; Lundell, Niedereppe, & Clarke, 2013).

To better understand social determinants of health and the ways they can be ameliorated to improve health outcomes and reduce health disparities, the World Health Organization (WHO) assembled the Commission on Social Determinants of Health (Marmot, 2005). The WHO's Commission identified several themes that contribute to the creation and perpetuation of health disparities, including employment conditions, social exclusion, priority public health conditions, women and gender equity, early child development, globalization, health systems, measurement and evidence of policy interventions, and urbanization (World Health Organization [WHO], 2019). These determinants are but a myriad of social and structural barriers that have long been identified in research seeking to understand what lies between individuals and good health (Teitelbaum, Theiss, & Boufides, 2019). However, there is sometimes a disconnect

between health communication scholarship and the dominant approach of health care providers who treat individual symptoms (Knight et al., 2016; Gollust & Cappella, 2014).

Scholars are beginning to note that the oft-emphasized individualized model of health – the assumption that a change in an individual's behavior rather than a challenge to the prevailing ideologies of health will solve health disparities (Dutta & de Souza, 2008; Lupton, 1994) – is lacking as it places blame on the individual and ignores the broader societal context that contributes to health decisions (Hinnant et al., 2019). These models do not explain the wide range of inequalities experienced by underserved communities, nor do they account for the importance of the collective voice that is so often a part of the health decision-making process (Dutta et al., 2019; Schiavo, 2016). Further, these models of health perpetuate a "myth of control" – the idea that preventing illness, disability, and death are possible by human action alone – while implying that poor health is a personal failure (Reid & Tom, 2006, p. 416).

As mentioned previously, health disparities most commonly affect populations facing systemic obstacles based on ethnicity/race, gender, sexual orientation, disability status, or socioeconomic status (Dutta et al., 2018; Dutta et al., 2019; Hinnant et al., 2019). Burgess et al. (2019) point out that racial and ethnic disparities are widespread and well-documented in the area of healthcare. While many healthcare providers are aware of such disparities, few are willing to admit that they are part of the problem. As such, healthcare disparities are often attributed to patient-level factors – such as attitude and unwillingness to cooperate – rather than provider-level or systemic factors (Burgess et al., 2019). However, in a study regarding the effects of tobacco marketing on usage, Moran and colleagues (2019) posited that African American youth and individuals of lower

socioeconomic status were more likely to report exposure to tobacco marketing and, thus, were more likely to use tobacco products. Matsaganis and Wilkin (2015) suggested that among racial/ethnic minority groups, Hispanic and African American populations are most likely to experience disparities. This has largely been explained through lacking material resources, including access to care or the adequate funds (Manuel, 2018); however, even when access to care and sociodemographic factors are similar to their white counterparts, Sealy-Jefferson, Vickers, Elam, and Wilson (2015) revealed that racial/ethnic minority groups still experience lower rates of health service use. This leads to the suggestion that factors such as culture, language, and discrimination are heavily involved (Sealy-Jefferson, Vickers, Elam, & Wilson, 2015).

Evidence regarding health disparities among sexual minority groups is similarly well-documented. As Eliason, Robinson, and Balsam (2018) suggest LGBT individuals who can find trusted medical sources use them at a rate that is equal to or higher than the general population. However, LGBTQ+ individuals often face discrimination and prejudice that impact their decisions regarding health (Eliason, Robinson, & Balsam, 2018). Fiddian-Green, Gubrium, and Peterson (2017) reported that sexual health promotions focus on heteronormatively defined initiatives and often fail to include LGBTQ+ youth, thus resulting in adverse health outcomes and increased social stigma. Further, Sexton, Flores, and Bauermeister (2018) found that LGBTQ+ women are less likely to have insurance, less likely to participate in cervical cancer screenings, and experience lower rates of overall good health when compared to heterosexual women. While this is not an exhaustive list of the health disparities experienced by certain

populations, it provides insight into the effect the experience has on overall health outcomes.

Although health outcomes have improved significantly for all sectors of the population, health disparities persist in even the most "developed" countries (Joyce & Bambra, 2010, p. 21). As evidenced above, an individualized model of health currently exists in many areas around the world and continues to contribute to the widening of health disparities. In the United States, for example, Native Americans and Alaskan Natives have shorter life expectancies than all other races combined (Hinnant et al., 2019). Women of color experience higher rates of diabetes, obesity, and HIV/AIDS, among other public health problems, compared to non-Hispanic white women (Vardeman-Winter, 2017). Obesity is significantly more prevalent in African American adults (48%) than in non-Hispanic white adults (33%; Skurka, 2019). Further, while the mortality rate in the United States has increased for most, there is as much as a 15-year gap in life expectancy between the most advantaged populations – or those who have access to resources including higher educational levels and socioeconomic statuses – and the least advantaged (Spencer, Wheeler, Rotter, & Holmes, 2018). Massey (2016) also highlights the digital divide and points out that, while health care in the United States is increasingly digital, older, minority individuals with less education are relying on outdated print material and their health is suffering because of it.

Within the United States alone, certain populations experience greater health disparities based on geographical location (Rural Health Information Hub [RHI], 2017). Vanderpool and colleagues (2013) acknowledge that women who reside in Appalachian Kentucky experienced a higher rate of cervical cancer than the rest of the country,

including a 45% higher mortality rate. Skurka (2019) posited that children in rural areas are 26% more likely to experience obesity than their urban counterparts. However, not all rural populations experience the same disparities at equal levels (RHI, 2017). Rural populations in the Western and Southern United States have historically experienced some of the highest rates of food insecurity (Ramadurai, Sharf, & Sharkey, 2012). The rural South consistently experiences higher levels of health disparities across multiple areas including lower average life expectancy at birth (RHI, 2017), the highest level of potentially excess deaths related to cancer, chronic lower respiratory disease, heart disease, and stroke (Moy et al., 2017), and the highest prevalence of diabetes at a rate of more than 10.6% of adults 20 years or older (Bolin & Bellamy, 2015).

Another health disparity that often impacts rural areas, one that serves as a daily reminder of the inequalities faced by so many, is hunger (Dutta, Anaele, & Jones, 2013). Hunger is often a direct result of experience with broader inequalities that constrain access to resources (Dutta, Anaele, & Jones, 2013). *Access* to food, not availability, is believed to be the main cause of hunger (Peracchio, Bublitz, Hansen, & Tussler, 2019). However, as Dutta and colleagues (2016) note, the widespread hunger issue emerged largely from policy decisions – both past and present – and is a systemic problem. Long term hunger has a deleterious effect on the health of those who experience it and, despite the overwhelming amount of food in the United States, one in eight American households experienced hunger in 2016 (Peracchio, Bublitz, Hansen, & Tussler, 2019). Scholars have long sought a stable definition for the more encompassing concept of food insecurity (Anderson & Cook, 1999). The multitude of definitions is an interesting phenomenon that alludes to the greater problem overall (Maxwell, 1996).

Food Insecurity

The concept of "food security" emerged in the 1960s and 70s in the field of international development as organizations worked to consistently meet the food needs of their constituents (von Braun, Kumar, & Pandya-Lorch, 1992). Following the World Food Conference in 1974, the concept of food security expanded exponentially. In fact, Maxwell (1996) stated, "At last count, there were close to two hundred different definitions of the term" (p. 155). The 1974 World Food Conference emphasized ensuring access to food for all while making sure that the supply of food remained reliable and prices remained stable. In response, organizations such as the International Fund for Agricultural Development (IFAD) – each with their own definition of food security – formed to ensure that these goals were being met. There was no standard definition of food security or a set way to measure it, and this contributed to the staggering array of definitions. However, the 1990s brought an era of refinement in the definition of food security and, as a result, food insecurity (Anderson & Cook, 1999).

In 1990, the Life Sciences Research Office (LSRO) published this conceptual definition of food security:

Access by all people at all times to enough food for an active, healthy life and includes at a minimum: a) the ready availability of nutritionally adequate and safe foods, and b) the assured ability to acquire acceptable foods in socially acceptable ways (e.g., without resorting to emergency food supplies, scavenging, stealing, and other coping strategies; Anderson, 1990, p. 1560).

Following this definition of food security, food insecurity exists when access to nutritionally adequate food is not available or when the ability to acquire nutritionally

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adequate food in socially acceptable ways is limited. Further, hunger and malnutrition are listed as potential companions of food insecurity but are not viewed as mutually exclusive (Anderson, 1990). A more recent definition of food insecurity from Healthy People 2020 and is stated to be "the disruption of food intake or eating patterns because of lack of money and other resources" (ODPHP, 2010b, para. 1). Based on these definitions, the current paper conceptualizes food insecurity as the disruption of food intake, eating patterns, or access to nutritionally adequate food because of lack of money and other resources which limit the ability to acquire said food in socially acceptable ways.

Understanding food insecurity requires the acknowledgment that individuals who are food insecure may view all view themselves differently (Maxwell, 1996). An attempt to include a comprehensive list of the social and environmental determinants that are associated with food insecurity emerged in the early 2000s when Hamm and Bellows' (2003) proposed definition of "community food security," derived from the concept of traditional food security. Community food security (CFS) is defined as "a situation in which all community residents obtain a safe, culturally acceptable, nutritionally adequate diet through a sustainable food system that maximizes community self-reliance and social justice" (Hamm & Bellows, 2003, p. 37). Previous definitions of food security had largely focused on hunger and food production (Sattanno, Swisher, & Moore, 2007). This shift in the understanding of food security encouraged a view that encompassed all aspects of the food system, including social determinants, to address food insecurity more holistically (Kaiser, 2017).

Community food security interventions vary by location as they correspond to community definitions of health and consider local definitions of food security (Hamm & Bellows, 2003). However, Anderson and Cook (1999) found that there are effectively three overarching types of CFS interventions. The first includes nutritionists and educators who provide nutrition education and stress community involvement in promoting food access. The second includes individuals who advocate for more environmentally sound food production including community agriculture, subsidized shares for lower-income individuals, and selling fresh produce in poor, urban areas. The third focuses on food interventions providing immediate relief of hunger and includes food banks, soup kitchens, and pantries (Anderson & Cook, 1999). The current paper is most interested in the third group of food insecurity interventions.

Community-Based Food Security Organizations

The first food bank in the United States opened in 1967 in Phoenix, Arizona. St. Mary's Food Bank provided 275,000 pounds of food to people in need in their first year. Currently, there are over 200 individual food banks associated with the Feeding America network and more that are not associated with the network located around the United States (Feeding America, 2019). Since their inception, food banks have played a significant role in low-income household diets as the food that is available is eaten by families in need (Kaiser & Hermsen, 2015). These entities provide perishable and/or packaged food and often collect donations from external sources to provide for their clients (Lindenbaum, 2016). However, some critics argue that food banks create the illusion of action but only serve to distract from structural inequalities that perpetuate

systemic poverty (Vlaholias-West, Thompson, Chiveralls, & Dawson, 2018;

Lindenbaum, 2016).

Other food interventions include soup kitchens, cooperative grocery stores,

farmer's markets, and community gardens. These interventions, like food banks, have

also received stark criticism (Moak, McAteer, Rossi, & Schmidt, 2018). McIntyre,

Patterson, Anderson, and Mah (2017) posit that such food interventions pose no real

challenge to economic or political systems. Lindenbaum (2016) suggests that while many

emergency food sources voice concern for food policies, few actively advocate for the

systemic alleviations of poverty as activism could damage their relationships with

potential benefactors. Further, many of these interventions present other material barriers

to clientele including limited transportation options to visit food banks, grocery stores, or

farmer's markets (Moak et al., 2018), a lack of access to fresh food (Ramadurai, Sharf, &

Sharkey, 2012), cultural barriers such as a lack of ingredients that meet dietary

restrictions or needs (Vlaholias-West et al., 2018), and discrimination based on

race/ethnicity have all been listed as further systemic barriers to utilizing these food

interventions (Moak et al., 2018). To date, the most effective and sustainable food

interventions are those that require extensive community input and adapt to specific

community contexts (Guthman, 2008).

Community-Based Research

Community-based research is becoming an increasingly important area of focus in

the field of health communication (Aldoory, 2017). Wilkin (2013) suggests that health

disparities are often further magnified by geographical influences including the built

environment, local neighborhoods, and the local storytelling network (STN). As such,

scholars have begun exploring ecological approaches to health behavior, including

examining "the multiple contexts that influence behavior" (Moran et al., 2016, p. 135).

As community-based interventions consider local concerns, scholars have begun focusing

on the challenges these organizations face in designing and implementing health

interventions (Matsaganis, Golden, & Scott, 2014; Matsaganis & Golden, 2015; Wilkin,

2013). As health communication does not occur in a vacuum, those who seek to reduce

health disparities must consider the whole picture (Wilkin, 2013). Community

involvement allows scholars an opportunity to target individuals based on pre-existing

networks of social capital (Clarke, Evans, Shook, & Johanson, 2005). Further, this line of

research allows members of the community to identify their health concerns and needs

(Ginossar & Nelson, 2010a). By defining health in the context of a local neighborhood,

scholars are able to identify communication hot spots – locations that are trusted by

members of the community and serve as hubs of information (Wilkin, 2013) – and

relevant storytellers – individuals whose opinions carry weight and whose endorsements

would greatly enhance participation interventions (Clarke et al., 2005) – that are

necessary to influencing health outcomes (Wilkin, 2013).

In recognizing the important role community plays in health, this paper will be

guided by the communication infrastructure theory (CIT; Ball-Rokeach, Kim, & Matei,

2001) and the culture-centered approach (CCA; Dutta, 2007). These theories will help

understand the impact that community, culture, and extended social networks have on the

resolution of health disparities. CIT is a culturally sensitive approach that focuses on

understanding connections (Ball-Rokeach et al., 2001) while the CCA framework

challenges structures that enable or constrain access to health resources (Dutta, 2007).

Together, the two provide a more well-rounded view of a community-based notion of health. This view can explain the barriers faced by community-based organizations when designing and implementing interventions (Aldoory, 2017). Further, by better understanding how a community assigns meaning to health (Dutta, 2007) and how a community interacts with one another and their surroundings (Wilkin, 2013), suggestions could be made as to how individuals can better target health interventions and effect meaningful, lasting change in the communities that they wish to serve.

In the following sections, an overview of the theoretical frameworks, the relevant literature on community-based health communication interventions, and the proposed study methodology will be discussed

CHAPTER II – LITERATURE REVIEW

Communication has been noted to have a complex relationship with health disparities (Vardeman-Winter, 2017). Health disparities are posited as being "closely related to breakdowns in communication processes and limited access to relevant health information" (Dutta & Kreps, 2013, p. 1). Individuals that experience health disparities often have inequitable access to health communication interventions (Cameron, 2013) and face difficulties in communicating health concerns (Dutta & Kreps, 2013). These communicative disparities all have the potential to exacerbate health disparities (Harrington, 2013). In a recent study, Zhao Martin and colleagues (2019) explored the creation of perceived norms surrounding Latinas' connection to their neighborhood information sources. In doing so, they discovered that cultural norms and a lack of communication, such as having no interaction with healthcare professionals, created norms suggesting that it is common for Latina women not to get Pap smears (Zhao Martin, Murphy, Ball-Rokeach, Frank, & Moran, 2019). Vardeman-Winter (2017) studied the negative effect that white framing, or language that perpetuates racial inequality in the health care system, has on women. In doing so, she posited that power differentials emerge when individuals who are in positions of power create and disseminate health messages, and such behavior can deter women from seeking the care they so desperately need (Vardeman-Winter, 2017).

Ndiaye, Krieger, Warren, and Hecht (2011) suggest that "inadequate communication patterns, poor message choices, lack of intercultural competence, and unequal access to information" are all factors that contribute to health disparities (p. 470). Zhao Martin and colleagues (2019) suggested that as Latina women experienced

incredibly high rates of cervical cancer, one contributing factor was the lack of access to information and the lack of open discussion in social networks. Burton (2012) found that health care providers in Guam who neglected to verse themselves in the communicative traditions of the indigenous patients offered corrective messages that deeply offended patients who believed the provider was insulting them (Burton, 2012). Further, Vardeman-Winter (2017) posited that a physical and social distance exists between researchers, policymakers, communicators, and communities targeted for health communication interventions.

However, communication is also useful in narrowing some disparities (Ndiaye, Krieger, Warren, & Hecht, 2011). Communication scholars can affect positive change through interpersonal interventions, message design, and communication skills training (Harrington, 2013). Additionally, providing adequate access to patient education and cultural education for health care providers may also aid in narrowing health disparities (Len-Ríos, 2012).

For communication professionals, recognizing that cultural differences exist among individuals' experiences of health and taking the necessary steps to address individuals rather than collective stereotypes may provide more cultural competency and allow for the narrowing of health disparities (Dutta, 2007). For example, Rouner and colleagues (2015) noted that Native American youth experience sexual health differently than white youth. Although a younger generation is more likely to use the internet as an information source, Native American youth were more likely to seek out pamphlets or engage in interpersonal discussions about sexual health (Rouner, Long, Bubar, Vernon, & Aungie, 2015). Fiddian-Green, Gubrium, and Peterson (2017) focused specifically on

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Puerto Rican Latinas as combining all Latinas ignored cultural variety and in doing so, it was posited that Puerto Rican Latinas were more likely to identify as lesbian or bisexual than the general population. Further, this specific population did not consider certain health messages as relevant as other groups of Latinas (Fiddian-Green, Gubrium, & Peterson, 2017). By recognizing these differences, future health communication interventions could be better tailored to the specific needs of these individuals.

Understanding and adapting to cultural differences also aids in the understanding of interpersonal communication. Recognizing the role of interpersonal communication in both formal and informal contexts is an important step in reducing health disparities (Ndiaye, Krieger, Warren, & Hecht, 2011). Dillon and Basu (2014) found that African American and Latino men living with HIV/AIDS were more likely to seek information from members of their own community, or those persons who also qualified as minorities within the minority. They were also more likely to trust information given to them by those who also suffered from HIV/AIDS (Dillon & Basu, 2014). Another trusted source for many individuals is the health care provider. As such, interpersonal level interventions such as patient-provider communication training could potentially aid in reducing disparities (Len-Ríos, 2012).

Community Based Participatory Research

Beyond interpersonal interventions, scholars have recently begun focusing on community-level interventions designed to address health disparities. Community participation provides a way for researchers to incorporate the perspectives of community members into their research (Ginnosar & Nelson, 2010a). Further, community based participatory research (CBPR) allows the community to define its needs, identifies the

resources already available to community members, and provides a way for intervention designers to create sustainable health outcomes through mobilizing the community (Basu & Dutta, 2008; Ginnosar & Nelson, 2010b). Incorporating community participation into health interventions generates systematic changes as and fosters a sense of social commitment, or the feeling that leads community members to engage in health-promoting behaviors (Basu & Dutta, 2008). CBPR allows members of the community to feel empowered and provides the local community with indispensable information and communicative skills including information seeking, better patient-provider interaction, and a better understanding of health messages (Mammen, Sano, Braun, & Fost Maring, 2019).

CBPR has been used in a variety of situations. Garney and colleagues (2015) studied the effects of a public screening of an obesity documentary on a rural community in the Brazos Valley. Community-based organizations worked with scholars, health professionals, and community members to develop a plan to screen the film, recruit participants, personalize data collection, and interpret the results of data. In doing so, scholars were able to provide information directly to relevant stakeholders and encourage meaningful change (Garney et al., 2015). Similarly, Bachman and colleagues (2018) worked with local healthcare providers in rural Kentucky to better understand the best way to disseminate information about colorectal cancer screenings in Appalachian Kentucky. Cohen, Wilson, Vanderpool, and Collins (2016) worked with a local advisory board consisting of many community organizations and posited that mammography technicians and health care providers in this particular region should listen to women and

treat their fears as valid. Further, they should work with community organizations to understand this populations' experiences and fears (Cohen et al., 2016).

Basu and Dutta (2008) found a positive link between community participation and health information orientation as well as health information efficacy. Garney et al. (2015) discovered the use of CBPR enhanced the dissemination of a mass media campaign designed to address obesity. By incorporating members of the community, those involved in the implementation of the community intervention were able to reach the appropriate community stakeholders and address the targeted audiences (Garney et al., 2015). Further, Matsaganis, Golden, and Scott (2014) found that the use of CBPR lead to the increased utilization of reproductive healthcare by African American women while Rouner et al. (2015) found that this approach improved sexual health literacy among Native American youth. Additionally, Hamilton and colleagues (2017) used CBPR to implement a health fair for children in the state of Alabama. In partnering with the University of Alabama and several community partners, the scholars realized that adhering to the resources a community already has to offer, regardless of convenience to the individuals conducting the research, strengthens community ties (Hamilton et al., 2017). Farmer, Edgar, Gage, and Kirk (2018) employed a CBPR approach to the creation of a documentary for at-risk Māori. After working with community groups, the scholars found that the best approach was to focus on families as the Māori society is a collectivist one. They even suggested that using this approach could allow for the creation of more holistic health communication interventions as they relate to indigenous communities (Farmer, Edgar, Gage, & Kirk, 2018).

Nonprofit Organizations

Nonprofit organizations (NPOs) are those that are "dedicated to the common good" (Sanders, 2015, p. 206) and "offer an alternative to share-holder backed corporations" (Gill & Wells, 2014, p. 28). Despite this stated alternative, much of our thinking about how NPOs operate comes from the same economic theorizing that is used to explain for-profit corporations (Koschmann, 2011). However, scholars have argued that NPOs face different and more difficult challenges than for-profit organizations (Gill & Wells, 2014). NPOs must communicate within the organization and with external stakeholders but economic theories do not account for the complexities of social interaction experienced by NPOs as they reduce human behavior to the acquisition of goods and services. Further, these theories fail to provide an insight into the lived experiences of NPOs and often ignore the role of communication (Koschmann, 2011). NPOs work to affect change in several different areas that influence health including social, environmental, political, and economic. Health communication research suggests that this focus on broader-level issues may be more impactful than focusing on an individualized notion of health. Thus, by using communication campaigns that target broader factors, NPOs are able to effect lasting change (McKeever, 2013).

Lewis (2005) argued that it is imperative for communication scholars to understand that NPOs are unique in several ways. These organizations often face legal constraints, personnel challenges, and challenges in locating/acquiring resources that other organizations do not (Lewis, 2005). While these differences are important, the most important difference is that NPOs are often experienced in a "social, interactive, relational, meaningful – in short, communicative" way (Koschmann, 2011, p. 141). NPOs

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must balance the interests of clients, donors, volunteers, policymakers, employees, and others as they work to create and disseminate messages (Gill & Wells, 2014). Each group experiences NPOs in a vastly different way and, as such, it is important to take into account the lived experiences of each as messages are created (Koschmann, 2011).

As many NPOs work to distribute goods and services to members of a given community, they are tasked with explaining the problem they are attempting to ameliorate (Dempsey, 2009). As a result, NPOs often have the responsibility of speaking on behalf of their clients (Gill & Wells, 2014). In doing so, organizational leaders must be mindful of their privilege (Dempsey, 2009) as they may unintentionally "reinforce racist, imperialist conceptions and … further silence the lesser-privileged group's own ability to speak and be heard" (Alcoff, 1991, p. 23).

Gill and Wells (2014) examined Mothers without Borders (MWB) in an effort to understand how such an organization is able to rhetorically construct itself as a legitimate entity to stakeholders such as donors and volunteers. In conducting this analysis, the scholars found that this NPO placed the voices of donors and volunteers above client voices – the voices of the people they claimed to be speaking for (Gill & Wells, 2014). Focusing too much on outside voices places NPOs at a disadvantage and may foster negative feelings from clients (Alcoff, 1991). However, as Dempsey (2009) posits, grassroots organizations – or those firmly situated in a local context – have the ability to positively connect with their community and provide proper communication and assistance.

NPOs provide a form of social capital – "the networks of cooperation and collaboration that exists in a community or region" (Smith, 2003, p. 37) – whose

presence can bring about changes in the quality of relationships among a community.

Increased trust, satisfaction, understanding, and group values are all benefits associated

with social capital (Lewis, 2005). Social capital is communicative (Koschmann, 2011)

and, as evidenced by past research, breakdowns in the communicative networks that lead

to social capital can exacerbate problems such as homelessness (Tompkins, 2009). NPOs

that foster social capital – most often by providing links between the community and

resources – are, therefore, an invaluable resource (Koschmann, 2011).

   Nonprofit organizational rhetoric. As mentioned previously, there is an emphasis

placed on the individual in western communication. However, it is often the case that

more credibility and legitimacy is afforded to those who are affiliated with some sort of

entity, whether that be a community group or a larger organization (Cheney & McMillan,

1990). As Cheney and McMillan (1990) posited, "the power of individuals acting within

their organizational roles tends to overshadow their efforts as non-affiliated persons" (p.

97). Organizations are incredibly persuasive entities and it is for this reason that they

should be considered when discussing communication (Young, 2001).

   In order to survive, organizations must adapt to their surroundings; particularly

they must work to tailor their messaging. The organization communicates its values and

identity to its audience, and it is up to said audience to interpret these messages (Miller,

2019). It is for this reason that scholars of organizational rhetoric consider multiple forms

of rhetoric within an organization so that they may get a better look at the overall

organizational identity (Ewalt, 2018). Nonprofit organizations are, then, a particularly

interesting space for examination as these organizations must appeal to a wide range of

audiences. Their messages must appeal to both clients and staff as well as external

stakeholders, such as donors (Gill & Wells, 2014; Koschmann, 2011; Miller, 2019; Young, 2001). Nonprofit organizations must also possess a solid organizational identity as this is necessary to make successful choices (Young, 2001). Further, they must be consistent across the board in order for the organization to present an authentic, coherent sense of identity that is necessary for credibility (Miller, 2019).

In his examination four types of nonprofit organizations, Young (2001) examined identity issues faced by nonprofit organizations. In doing so, he posited that those who faced identity crises and could not present a consistent sense of self to their audiences struggled to meet their goals. Those who resolved these issues had a better chance of meeting said goals (Young, 2001). Miller (2019) examined how the YMCA constructed and maintained its organizational identity through the use of ideographs. It was argued that the YMCA used strategic ambiguity as an organizational rhetoric strategy in an effort to appeal to as wide an audience as possible. Further, this strategy allowed the YMCA to adapt to changes in their environment as well as internal and external pressures as they appeared (Miller, 2019).

While nonprofit organizational rhetoric is the most pertinent for this paper, other work in the field of organizational rhetoric has been conducted to consider ideas of space (Ewalt, 2018), discourse surrounding maternity leave (Meisenbach, Remke, Buzzanell, & Liu, 2008), and the National Animal Identification System (Veil, 2010). Organizational rhetoric allows for identification and provides individuals with a way of relating their identity to that of an organization (Ewalt, 2018). For the current study, the organizational rhetoric of nonprofit organizations concerned with mitigating hunger in their communities will be of interest. As such, understanding how organizations – specifically

nonprofit organizations that represent marginalized groups – invite identification is an important area of research (Gill & Wells, 2014).

Rationale

As evidenced by the previous sections, a common theme found in both CBPR and NPO communication is the necessity of understanding both culture and neighborhood-level influences as they relate to health outcomes. One theory that addresses the necessity of culture in addressing health disparities is Mohan Dutta's (2007) culture-centered approach. A theory that addresses the neighborhood level influences on an individual but has only recently begun focusing on health is the communication infrastructure theory (Ball-Rokeach, Kim, & Matei, 2001). Both theories will be explained in further detail, however, as CIT does not take culture into account when explaining community influence, the researcher believes a combination of the two is necessary. What follows is a rationale for why the current study is being done and what this adds to the literature before the explanation of the differences between cultural sensitivity and cultural centeredness is provided.

Food insecurity in the United States is decreasing. From 2017 to 2018, the prevalence of food insecurity decreased from 11.8% to 11.1%. However, the prevalence of food insecurity in the south remains higher than the national average (Coleman-Jensen, Gregory, & Rabbitt, 2019). Several studies of food insecurity have been conducted in the United States (Dutta, et al., 2016; Okamoto, 2017; Ramadurai, Sharf, & Sharkey, 2012), however, few have focused on rural areas and fewer have focused on the rural south (Ramadurai, Sharf, & Sharkey, 2012). Although community-based participatory research is a growing area within health communication, little research has taken this approach to

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food insecurity. Further, few studies have focused community organizations as a whole –

most break down organizations to the individual level, meaning that research is focused

specifically on how individual participants utilize these resources. When studies have

focused on organizations, they have often been health care organizations, such as

hospitals, clinics, or healthcare nonprofits (Bachman, et al., 2018; Cohen, Wilson,

Vanderpool, & Collins, 2016; Dutta, et al., 2019). Nonprofit organizations aimed at

reducing food insecurity provide an interesting vantage point for studying the

communication inherent in food insecurity interventions. This study aims to understand

how these small, privately run nonprofit organizations disseminate information to local

members of the community and how the messages are constructed. Further, the scholar

would like to assess the impact and input of community members on the overall food

insecurity campaign.

<center>Cultural Sensitivity versus Cultural Centeredness</center>

Cultural Sensitivity

Cultural sensitivity involves the tailoring of health messages to incorporate

cultural characteristics such as norms, values, beliefs, and lived experiences of a target

population (Friedman & Hoffman-Goetz, 2006). This shift was a response to the critique

of the dominant health communication paradigm which emphasized a Western,

individualistic approach to health. Culturally sensitive approaches offer communication

solutions that are considered most relevant by the health communicator rather than those

who are situated within the culture (Dutta, 2007). Although this is a step forward from

the individualized notion of health, Dutta, among others, argues for the implementation

of a culture-centered approach that allows for the participation of community members in

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creating messages about health (Littlejohn et al., 2017). The following section will provide a more in-depth explanation of the communication infrastructure theory as it most closely aligns with the idea of cultural sensitivity.

Communication Infrastructure Theory (CIT)

  Multilevel storytelling network. At the heart of communication infrastructure theory (CIT) is the idea of neighborhood storytelling or the communication process through which people move from simply being occupants of space to being residents of a neighborhood. This social-ecological theory was informed by storytelling models of public opinion, community integration, collective identity, and rhetorical action, and argues that neighborhoods and identities are actively constructed through discourse (Kim & Ball-Rokeach, 2006a). The storytelling neighborhood is privileged not only because this process is necessary for the formation of a sense of belonging, but it is also "the most agentic process in the construction of those precious bonds that gestate coorientation in the form of imagined community or a sense of 'we'" (Ball-Rokeach et al., 2001, p. 394). This process is enabled by a communication infrastructure, which is a multilevel storytelling network (STN) set within a communication action context (CAC). This infrastructure serves as the basic communication system in a community and is relied upon by residents to provide them with information necessary to their daily lives (Wilkin et al., 2011).

  The multilevel STN is comprised of micro-, meso-, and macro-level actors who create and share information about the local community (Wilkin et al., 2011). At the most macro-level are the storytellers that have production and dissemination capabilities including media, political, religious, health, and governmental institutions (Ball-Rokeach

et al., 2001). These institutions have the capacity to tell stories about whole cities, nations, or the world at large for a vast audience (Wilkin et al., 2011). At the meso-level are the intermediate storytellers such as local media, community-based organizations, schools, and churches whose primary goal is to tell stories about the neighborhood and connect certain residential areas (Ball-Rokeach et al., 2001; Wilkin, 2013). Finally, at the most micro-level are the interpersonal networks of individual residents (Ball-Rokeach et al., 2001). These networks include family, friends, neighbors, religious leaders, health practitioners, and others with whom residents regularly interact (Wilkin, 2013). Within these networks, individuals may share details about their daily lives or tell stories about their neighborhoods. Each of the storytellers in this network can offer tailored, local resources that aid individuals in navigating obstacles in their environment and achieving their goals. However, the influence of these resources on goal achievement – the ability of communicative resources such as community groups to aid in eating more vegetables, for example (Wilkin, 2013) –, as well as the integration of the STN – the ability of the community to come together and form a cohesive group, such as a nonprofit to alleviate hunger –, may be constrained or enhanced by the CAC (Literat & Chen, 2014).

  Communication action context. All of the elements of an individual's built and social environment that affect the availability or accessibility of communication resources form the CAC (Wilkin et al., 2011). The CAC varies on a scale of openness and closedness. In the case of a neighborhood, boundaries are based on shared agreements including geographic labels, incorporated areas, and real estate developments, among others. The open context encourages communication and integration among residents. The closed context, on the other hand, discourages integration. It is important to note that

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any given CAC will have elements of both openness and closedness (Ball-Rokeach et al., 2001).

The most frequently identified features of the CAC are physical, economic, sociocultural, and technological (Ball-Rokeach et al., 2001; Matsaganis & Golden, 2015). Physical features include the physical presence or absence of resources, such as health care facilities or transportation services, which have the potential to enable or constrain neighborhood storytelling (Broad et al., 2013). Physical structures of a geographic area (streets or roadways) and the presence or absence of gathering places including parks, libraries, and movie theaters should also be considered (Ball-Rokeach et al., 2001). Economic features include work conditions (if there is time available to interact with other neighborhood residents) while sociocultural features include the diversity of residents (both ethnic and linguistic), class similarity, and cultural similarity (Wilkin et al., 2011). Additionally, technological features such as access to communication technologies (internet, for example) must be considered as they are becoming an increasingly important facet of the CAC (Ball-Rokeach et al., 2001).

An integrated network. While the CAC has the power to constrain or enhance the influence of local resources on the achievement of goals, it also has the potential to enable or constrain integration of the STN. Ideally, the neighborhood STN would be broad, deep, and integrated. However, much emphasis has been placed on the idea of integration (Ball-Rokeach et al., 2001). CIT research focused on health has suggested that residents who are more integrated into their neighborhood STN are more likely to actively seek health information and be more knowledgeable about certain health issues (Matsaganis & Golden, 2015). This belief has been widely held due to the documented

relationship between increased connectivity and increased civic engagement (Literat & Chen, 2014). However, research has found that the level of integration is not equally related to all health outcomes (Wilkin, 2013). The most effective instances seem to be in cases of information seeking and sensemaking (Kim & Ball-Rokeach, 2006b; Matsaganis & Golden, 2015). Further, community organizations have been noted as playing a crucial role in the linkage between micro and macro-level storytellers (Ball-Rokeach et al., 2001). The more integrated a community organization is, the better they can imagine their community and tell meaningful stories, thus effecting meaningful change. Research has found that community organizations that are integrated and engaged in collaborative storytelling with residents, large organizations, and at-risk populations can enact successful structural change to health care services which affords residents greater access to resources (Kim & Ball-Rokeach, 2006a).

In sum, at the most basic level, CIT places resources (both communicative and material) at the center of community. Without resources to construct and share stories, there is no community (Kim & Ball-Rokeach, 2006a). However, this theory also offers scholars a way to better understand how individuals not only interact with one another but also how they interact with their lived environment and the organizations that create and disseminate information (Wilkin et al., 2015). While CIT offers a unique perspective on the formation of an integrated communication infrastructure, it focuses on identification that requires a shared location (Ball-Rokeach et al., 2001). However, cultural associations within those shared locations are also important to consider. Mohan Dutta's culture-centered approach considers the cultural identification more so than shared physical space and integrated neighborhoods.

Culture-Centered Approach

 A critical approach to health communication. With his culture-centered approach (CCA), Mohan Dutta advocates for an approach to health communication that seeks to understand the ways voices are silenced and how this silence is reiterated and maintained by health intervention (Dutta, 2007). CCA emphasizes listening to subaltern voices – those who have been erased, are absent, or are not noticed –to afford them a place in dominant discursive spaces. Further, the CCA places a particular emphasis on local knowledge and culture as the base for understanding health problems and identifying their solutions. As such, there are three central tenets that guide the CCA: culture, structure, and agency (Ramadurai, Sharf, & Sharkey, 2012).

 Culture. Culture encompasses lived experiences and is a critical element in the creation of knowledge, shared meanings, and behavior changes (Dutta & Basu, 2008). It is conceptualized as "a complex and dynamic web of meanings that is continuously in flux, as it interacts with the structural processes that surround the culture" (Dutta, 2007, p. 310-311) and provides a framework of meaning that is concentrated within the contexts in which meanings are negotiated, experienced, and located (Dutta, 2014). As mentioned above, culture is also intrinsically linked to social structures culture shapes structures while structures shape culture (Dutta, 2007).

 Structure. Structure here refers to "patterns of social organizing that enable or constrain the ability of cultural members to secure resources and engage in healthy practices" (Basu, Dillon, & Romero-Daza, 2016, p. 1368). Structures are embedded within a social system and are instrumental in creating marginalized life experiences (Dutta, 2007). Included in this conceptualization are both communicative and material

resources. Communicative resources include the processes which constitute participation and representation while material resources include institutions, organizations, and systems that distribute, allocate, or control material resources (Dutta, 2014). These structures determine how society is organized and how individuals within that society interact and behave with respect to one another (Ramadurai et al., 2012). Further, these structures enable or constrain communication as they are linked to power. This means that resources are often distributed in a manner that either creates or reinforces existing power balances, thus silencing subaltern voices (Dutta, Anaele, & Jones, 2013).

Agency. The final concept, agency, "refers to the capacity of cultural members to enact their choices and to participate actively in negotiating the structures that constrain their access to resources" (Dutta, 2014, p. 72). Cultural members enact agency as they navigate existing social structures in an attempt to solve health problems and also change the structures that constrain life experiences (Dutta, 2007). Agency is expressed in the voices of cultural members; by speaking about their experiences with health and defining the problem, subaltern populations are making their voices heard (Dutta, 2015).

Together, culture, structure, and agency interact to form a "dynamic web, with communication being situated at their intersections" (Dutta, 2014, p. 72). Interpretive frames are positioned in the places where cultural values and the structures that organize them contrast with one another; alternatively, agency is enacted through the mobilization of cultural resources working with structures to provide subaltern populations with a voice. As subaltern populations participate in discursive practices, the meanings and interpretations of everyday lived experiences emerge. As populations use cultural

resources to navigate the structures that surround them, meanings emerge and allow them to begin to question the values that guide them (Dutta, 2014).

CCA in use. The CCA approach has been particularly meaningful and useful in the realm of health (Borron et al., 2017), and several scholars have applied the CCA to better understand food insecurity; food insecurity as is commonly regarded as a health disparity linked to structural inequalities in the distribution of resources (Dutta et al., 2013; Dutta et al., 2016; Ramadurai et al., 2012). Other scholars have examined the cultural components that contribute to disparities in the number of Latino and African American MSM HIV infections through the lens of CCA. In doing so, many have found that communication interventions often fail to address cultural factors such as unwillingness to identify as homosexual, distrust of medical facilities and health care providers, and cultural ideas of masculinity (specifically in the Latino community) that contribute to these disparities (Dillon & Basu, 2014; Basu et al., 2016). Further research has examined end of life care in African American populations (Dillon & Basu, 2016) and rural Chinese populations (Sun & Dutta, 2016), depression in U.S. born Mexican-Americans (Martinez, 2017), the global response to infectious disease (Sastry & Dutta, 2017), and the improvement of patient-provider interactions for transgender individuals (Ross & Bell, 2017).

While the culture-centered approach focuses heavily on cultural sensitivity, this approach allows for a better understanding of the cultural context and structural elements that enable and constrain participation in the conversation about health. This approach, which is grounded in the critical tradition, emphasizes the role of culture in the creation of shared definitions of health problems and solutions. Further, it emphasizes the

interconnectivity of culture, structure, and agency, all necessary components to the implementation of meaningful and lasting change (Dutta, 2007). Although the communication infrastructure theory is not based in critical theory, it emphasizes the local voice and the interconnectivity of the individual with the structures that constrain or enable their voices to effect meaningful change.

<div align="center">Culture Centered Network Approach</div>

While there are similarities between the culture-centered approach and communication infrastructure theory, notably the focus on communally constructed definitions of health problems and solutions, the two theories differ in significant ways. Dutta's (2007) CCA is built on the notion of a ground-up approach to health communication that employs culture as a lens to examine the dominant paradigm for absences and silences. The hope is that this approach will allow for new frameworks of health that allow subaltern populations to not only participate in creating an understanding of health but to also challenge the structures that perpetuate these absences and silences (Dutta, 2007). CIT, on the other hand, aims to understand how "differences in connections to communication resources influence civic outcomes – for example, gaining voice, efficacy, and active belonging" (Kim & Ball-Rokeach, 2006a, p. 176). As several scholars have mentioned, variance may exist within the communities themselves thus limiting the effectiveness of CIT (Kim & Ball-Rokeach, 2006a; Liu et al., 2018; Wilkin, 2013). Wilkin (2013), among others, has called for a greater focus to be placed on communication ecology – the interconnection of all communicative resources within a neighborhood – as research has suggested that a single communication approach does not work for all people in a community. As the culture-centered approach calls for extensive

participation and provides an understanding of these ecologies – such as interpersonal networks and community groups – I argue that expanding the communication infrastructure theory to include tenets of the culture-centered approach would afford researchers a greater understanding of these ecologies. As the focus of this study is on the level of community organizations, the following section provides an explanation of the way that the expanded theory could perform at the meso-level of the storytelling network.

Meso-Level Opportunities

Meso-level storytellers play a pivotal role in the linkage of micro-level storytellers with macro-level storytellers (Wilkin et al., 2015). In examining Korean immigrants' integration into a church community, Son (2018) notes that churches are exceptionally well-suited to this type of linkage as they build trust-based relationships with other community organizations and leaders. However, a noted limitation of this study is the need for a look at the sociocultural factors that contribute to church participation. The author calls for a better understanding of the factors that enable or constrain participation in church activities and leadership roles (Son, 2018) which could be provided by integration of the CCA. The CCA offers structure as a way of understanding how society is organized and how we interact with one another (Ramadurai et al., 2012).

In examining reproductive health disparities in a small urban community, Matsaganis and Golden (2015) found that privacy concerns were of much greater importance than initially believed. Addressing structural concerns such as lack of transportation was not enough in the case of this intervention program. Residents were afraid of seeking preventative reproductive care as they feared being stereotyped or

having rumors spread about their reasoning for seeking health care. The researchers

suggest providing an alternative interpretation for community-based organizations to

disseminate into the community (Matsaganis & Golden, 2015). By incorporating the

CCA, researchers could better understand the cultural reasoning that leads to stereotyping

or rumors based on mere presence at clinics and provide those creating communication

interventions with a stronger narrative that addresses these concerns to encourage less

shaming.

As Dutta, Anaele, and Jones (2013) mention when dealing with food insecurity,

coalition building provides a way for community members to participate in the creation

of solutions to health problems while enacting agency. By coming together to create

shared definitions of health, individuals are not only becoming more integrated into their

community, but they are also challenging the structures that organize resources (Dutta,

2014). As Dutta (2010) argues, it is imperative that individuals challenge these structures

as communities that are involved in the act of defining health problems and creating

solutions are more likely to benefit. From the integrated perspective, having community-

based coalitions that allow all community members to participate in the construction of

health definitions and solutions would not only provide a stronger link between citizens

themselves, but it would afford them a chance to challenge local structures that constrain

access to communicative resources while enacting new structures that enable that access.

Integration at this level would also afford researchers the opportunity to examine how a

community-based organization that has been created through community participation

links micro and macro-level storytellers. Also, important to note at this level is that

stressing a community culture rather than focusing on shared ethnic or racial backgrounds tends to provide a much greater capacity for integration (Liu et al., 2018).

Research Questions

As mentioned previously, the main goal of this project is to understand the barriers that community-based organizations face when implementing health communication interventions. Further, the current study aims to understand how community-based organizations work with members of the community to define health, understand the issues that they face, and avoid reinforcing negative stereotypes as they attempt to ameliorate hunger. As such, two guiding questions have emerged:

RQ 1: What challenges do hunger-related nonprofit community organizations face in connecting with community members?
RQ 2: How do hunger-related community organizations work with community members to facilitate integration and overcome barriers?

CHAPTER III - METHODOLOGY

The Research Setting

This study was conducted with selected non-profit organizations whose missions focus on fighting hunger in Hattiesburg, Mississippi. 15.9% of households in Mississippi experienced food insecurity from 2016-2018 while 6.3% of households experienced very low food security – the repeated disruptions in eating patterns (Coleman-Jensen, Rabbitt, Gregory, & Singh, 2018). Mississippi is repeatedly included in lists of the most food insecure states. In a 2018 study – based on 2016 data – Mississippi had the highest rates of county and district food insecurity in the country (Gunderson, Dewey, Crumbaugh, Kato, & Engelhard, 2018).

The Community-Based Organizations

The organizations chosen for this project included food banks, food pantries, and soup kitchens. Three of the five organizations chosen for this study were explicitly faith-based. Although this was not a criterion for selection, it was to be expected as the study takes place in the south. The criteria for selection were as follows: the organization must be nonprofit, meaning that it does not charge for services such as food distribution; it must work in the area of food insecurity, though it does not have to focus exclusively on food insecurity; the organization must be located in and operate out of Hattiesburg.

Participants

This study included two groups of participants to fully understand the communication between nonprofit organizations and the individuals they serve. Participants included the directors of five community-based organizations responsible for hunger assistance programs. These organizations were selected and contacted because of

their prominent role in the community, and several directors pointed the researcher to other community directors. No incentives were offered for participation in this study. Participants also included the clients of the nonprofit organizations. As the researcher aimed to understand how community-based organizations include clients in the development of their assistance programs, it was imperative that their voices be included.

Data-Collection Methods

Data for this study was collected through in-depth interviews conducted with directors of these organizations. Further data was collected through focus groups conducted with clients of these organizations. The researcher conducted focus groups with two to four clients recruited on a volunteer basis.

Participants for this study were contacted to schedule interviews after completing the IRB process and receiving approval. These interviews lasted from 30-75 minutes and took place at the organization's base of operation. Following the completion of the interviews, clients of the organization were contacted and invited to participate in a focus group session. The focus groups lasted from 30-45 minutes and took place at the organization's headquarters. In sitting down with these individuals, it was the researcher's hope that a well-rounded, holistic view of the organizations' communication interventions and the barriers that all parties involved face could be explored.

Written informed consent was obtained prior to the start of the interviews and focus groups. Interviews were conducted by the primary researcher using a semi-structured interview guide. The interview guide included the following questions: In your time, what has the face of hunger looked like? How do you include members of the community in organizational decisions? What messages are you sharing about

food/nutrition with members of the community (including clients and non-clients)? Do you think that there are times clients might be reluctant to share feedback with you? The interviews were audio-recorded and transcribed in their entirety. Throughout the interview process, the researcher kept a field journal to document thoughts, feelings, and immediate observations.

The focus group sessions were also audio-recorded and transcribed in their entirety. These sessions were semi-structured with a few guiding questions to lead the conversation including: What are the ways this organization has been helpful to you? What have your interactions with this organization been like? Do you feel like you have a connection with the people here? Have you had any opportunities to give feedback on some of the services they provide? Do you feel that you're respected when people talk to you? These sessions were moderated by the primary researcher with a secondary researcher providing assistance. A field journal was kept to document thoughts, feelings, and immediate observations throughout the process.

Data Analysis

To begin, the interview and focus group data was transcribed in its entirety. The analysis was conducted iteratively, alternating between the existing theoretical framework and emerging data (Tracy, 2013), using two coders for reliability. This was done to reach theoretical saturation (Lindlof & Taylor, 2002). Multiple rounds of coding were conducted to reach saturation before categories were constructed using the discovered tenants of the theoretical framework and the emerging experiences of the sample population.

The primary cycle of coding was conducted using open coding (Lindlof & Taylor, 2002) and In Vivo Coding to "honor the participants' voice" (Saldaña, 2009, p. 74) simultaneously. In this stage, the researcher and coding partner examined the transcriptions and began creating codes. The data was coded using QualCoder. Open coding allows for an unrestricted, initial coding of data. In this stage of coding, categories were not yet built or defined. This stage of coding opened the data for interpretation (Lindlof & Taylor, 2002). In Vivo coding occurred simultaneously. In Vivo coding uses the participants' words as category names and leads to the creation of a codebook (Lindlof & Taylor, 2002; Saldaña, 2009). In this stage, the researcher and second coder coded one transcript before meeting and discussing the selected codes to ensure both coders understood the direction of the project.

Following the creation of the codebook, the researcher and second coder sat down to discuss the codes before they began secondary-cycle coding. In this stage of coding, the codes that were identified in the primary cycle were critically analyzed and organized into "interpretive concepts" (Tracy, 2013, p. 194). Here, the codes included interpretation as well as identification of patterns and helped to explain the information gleaned from the transcripts (Tracy, 2013). In this stage, the researcher used pattern coding to systematically group codes under certain categories. This type of coding was appropriate for developing themes from the data and searching for explanations in the data (Saldaña, 2009). The secondary cycle was completed individually before the coders met and resolved any disagreements through discussion. Following the initial discussion, changes were made to the overarching themes and the primary researcher began work on the manuscript.

As aspects relating to the built environment, including lack of access to resources, were apparent in the theoretical framework used to guide this study, the researcher expected to identify themes such as a lack of resources, a lack of access to resources, or a perceived lack of access to resources. Cultural barriers, such as a lack of adequate communicative practices were also expected to appear. In addition, as the area these programs serve includes tertiary locations such as surrounding Mississippi counties, a theme of lacking integration into the STN and a fragmented community culture was expected to emerge. By identifying these themes, the researcher aimed to provide a better understanding of the barriers, both real and perceived, to designing and implementing health communication programs in the rural south. As this geographic area has not been examined in depth, these themes are important to identify and explore. By identifying and analyzing these items, suggestions could be made to overcome the barriers to implementing a successful health communication program in rural Mississippi.

Once the coding cycles were complete, the researchers resolved any disagreement through discussion. For example, the researcher and second coder found multiple ideas that could be better categorized under one subtheme rather than as a group of subthemes. The researcher and second coder compared notes and categories on several occasions before the final set of themes was chosen. The primary researcher selected quotations that were most explanative of the themes reported by the researchers. The primary researcher also managed the organization of the manuscript. The researcher chose not to seek to establish intercoder reliability as a statistical agreement was not the primary goal. In conducting this researcher, the goal was to lend a voice to the participants and to seek understanding. By meeting several times to discuss the codes and themes, the researcher

and second coder discovered emergent themes and shared different interpretations of the

data which allowed for a richer understanding of the data (McDonald, Schoenebeck, &

Forte, 2019).

CHAPTER IV – RESULTS

The following sections will detail the findings of the in-depth interviews and focus group interviews with the executive directors and the clients of the nonprofit organizations.

Theme One: Everybody Has a Story

One of the most predominant themes found across the board, in both interviews with executive directors and focus groups with clients, was the idea that everyone has a story and one cannot make judgments based on appearance. Executive Director 1 noted that there had been moments where a client arrived in "a Cadillac" or a "super fine pickup truck," prompting volunteers – those assisting with clients or those performing pro bono services – to comment on their appearance. However, there is often a deeper story lingering beneath the surface. They stated:

> There's an instance that I can think of where a guy drove a super fine pickup truck. And he came in dressed very nice and he told me his story. He had been pretty high up in the oil industry – and this was several years ago when the oil industry tanked – and he'd lost his job. So, yeah, he lived in a nice neighborhood and the clothes in his closet were nice and the car that was probably paid for or close to it or he was upside down in it was nice. But he was unemployed and desperately trying to find something at that same income level. There wasn't food in the house right then. We don't know people's stories and it's not my place to judge.

James reiterated this idea by stating, "I used to own my own business," before "I lost everything." This was not the life that James had known, and, to him, this story was important. He did not necessarily look like he belonged in this space, there were few physical markers of his poverty, but his circumstances had changed and brought him to that organization for assistance. It became apparent throughout the data collection process that no two stories are the same and that, according to Executive Director 2 getting to know these stories is important as this forms a relationship. As they stated, "For sustenance, you can find that just about anywhere. But find a relationship and finding that you have worth and meaning with someone else, that goes well beyond." Acknowledging the importance of these stories also provided an understanding that the face of hunger is not what one may think.

Face of hunger. Poverty is often portrayed in a certain light, as being obvious to the naked eye, however, one theme found throughout the data collection was that this was often not the case. When discussing their client base, Executive Director 3 stated, "You can't just look at somebody and tell whether they're hungry." Although poverty is often posited as having physical markers, the directors and clients both agreed that it is difficult to look at someone and guess that they are going without. For some, it was difficult to tell if an individual was visiting an organization for services or to volunteer. For example, Executive Director 1 stated:

> We really can't tell when somebody walks in the door, 'Are they here to volunteer? Are they here to make a financial donation or a canned food donation? Are they lost? Are they look for the thrift store?' Or are they here because they need services? There are people who walk in and you would think, oh, they're

probably here for food. Might be homeless, living in their car, that kind of thing. But many, many people come in and they're wearing a shirt with the name of their business, whether it's a convenience store or a restaurant or a home health agency. So, the face of hunger just looks like everybody you see sitting around you.

Luke, who participated in multiple services from a given organization, mentioned that unless he disclosed his status as a client of the organization, he was often mistaken for a volunteer. He believed his demeanor and background made it easier for him to be viewed in that light as he was, "I won't say sheltered but I lived a completely different life," before "life just hit."

Many people expect individuals using services such as food banks, pantries, and soup kitchens to appear a certain way. Two executive directors stated that they do see individuals who fit the stereotypical mold. For example, Executive Director 5 stated, "Some of them are a lot needier than others." However, they are often the exception to the rule. As Executive Director 2 stated,

> They [our clients] look just like you and me. They're not the stereotypical dirty and beat up, wounded – well, some are, but as a general. There are those that are living under the bridge but there's really – sometimes, I don't think you'd be able to tell just at a moment's glance from one to another. Seeing where they are and beginning to know who they are, then you so see the difference, but it does range.

Dignity, humanity, and the experience of seeking assistance. The lack of obvious markers was, for most, a relief. For example, Luke stated that "there's a persona" that comes with "being in here." Being able to exist without visible markers of his poverty

made it easier for him to talk to other people. However, many clients expressed that they – like most people – desired to be treated with dignity regardless of how they looked. Even if they were not given the utmost respect, most agreed that dignity is a basic element of humanity that should be present in these spaces. For example, Alice stated,

> See, everybody has a history. You know, I have too big of a history. But the thing is, you don't treat somebody that way. Whether it's the welfare office, the food stamp office… I mean, people just get this mindset because you went there and asked for help here or there or you ever came in here. It's bull. It's not nice. You don't go to those organizations or whatever and ask if they're treating you ugly.

For many, dignity and humanity translated to wanting to form a human connection. For example, James stated, "Sometimes, at the end of the day, somebody just needs somebody to sit down and talk with." Executive Director 1 recognized this and agreed, "A lot of times, it's just having somebody listen to you." Emma stated, "I mean, most humans, we would want to" build a connection and form a relationship with employees they repeatedly encountered. Abe reiterated this idea by acknowledging, "A lot of people just need somebody to talk to. They just need somebody to act like they care." As multiple clients and directors stated throughout the interviews and focus groups, "Treat others as you want to be treated."

Many clients stated that the experience of seeking assistance was an arduous one. Abe stated, "You're not gonna to these places unless you need help." Alice agreed and added, "If you don't get it, you usually don't go back there because, like you said, you only got so much gas." They articulated that, no matter how kindly they were treated, they were visiting these organizations for assistance and knowing which organizations

will help and which ones will not was crucial. Crystal reiterated this by asking, "What's the point" in going if you don't get the help you're seeking? Although clients expressed concern that not much food is included in their bags, Alice stated,

But my income, especially when I lost my home – and then I got back in the home and I had to buy everything new – it was so stretched that literally if I didn't get the few items I get here in the bag, I may not have anything to eat.

The executive directors seemed to realize this as they spoke about ways they tried to lift some of the burden such as assisting with paperwork – one director stated that instead of asking clients to fill out applications themselves, "We fill it out with you." Other directors gave examples of going to their clients' homes and reaching out to the client if they have not visited for a length of time. As Executive Director 1 stated, "We just want to help people get to a better place. So, wherever I am, I'm going to try to reach people where they are."

"I'm not a nasty person." Regardless of what kind of assistance is offered, for many clients, one of the challenges that they faced when seeking assistance was the lack of respect that they were given, regardless of their looks. As Alice stated, "You go places and people treat you so… just because you're there. It doesn't matter whether you're dressed nice or falling apart." The act of seeking assistance was enough to mark her as different and, in some cases, not worthy of respect. Many of the clients felt the need to clarify that they were not the typical assistance seeker. As James stated, "I don't do drugs, I don't smoke, I don't do crack or anything like that… I wasn't born in this lifestyle. I find myself in this situation right now, trying to get out of it."

Many of the directors acknowledged that, for many of their clients, this was a temporary challenge. Executive Director 3, who works primarily with college students, stated, "Our clientele is constantly changing. Ours come and go. They graduate or the situation gets better and we don't see them again." However, regardless of the limited time they may spend in this situation, many find it difficult to earn respect and felt the need to constantly remind others that they were actively trying to find their way out of this situation. For example, James stated,

I'm not your conventional homeless person that is stuck in this lifestyle, has been in this lifestyle for a while and doesn't really see a way out. I'm more that – me, personally speaking – I'm more that person that's going through. I came in, I see my exit, and I'm going through it. I'm not camping out in it. I'm not setting up shop in it. I'm going through this.

As there is a stigma that surrounds seeking assistance, many clients felt the need to remind others that they are not less than because of their situation. Luke, who had been shunned by peers because of needing to utilize an organization's services, stated,

I'm not a bad person. There's a persona and it was hard for me to accept this because people come in here, they're court ordered. They have this persona that they're bad people and I had that same persona. It took me a long time to take that reputation and not really make it my own but adapt to it. I'm gonna stay me no matter what. It just blew my mind. You're talking to me like that because you have no idea.

In Luke's experience, people used the fact that he was receiving services as a basis for judgement. For Alice, there was a physical marker of an injury received on the

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job. She experienced people looking down on her because of this disability and felt the need to clarify that, "I am not a nasty person. I got hurt on the job. I'm crippled for the rest of my life; I've been this way for over ten years."

For some, this lack of respect was more detrimental to their well-being than hunger. For example, Crystal stated,

So many agencies, it doesn't matter what it is – it doesn't matter if it's that one or another one, even where you go to get food or something. They treat you to the point, where, I need to eat today but I'll never be back again. It's not worth what they put me through. It's not worth it.

Regardless of how steadfast these clients adhered to the rules or how invisible their poverty seemed to be, they felt that they were unwelcome in the spaces designated as helpful. They did not feel respected and felt the need to justify the help that they were seeking.

Theme Two: The Complexities of Nonprofit Organizations

The second most common theme was that of organizational complexities. This theme encompassed several subthemes including constraints and frustrations, partnerships, maintaining the mission of the organization versus the need to compromise, making givers out of takers, communication with clients, and privacy concerns.

Constraints and frustrations. For many of the executive directors, one of the most common constraints they faced was the need to adapt messages to a wide variety of audiences. Regardless of their feelings about a situation, it is their job to be as diplomatic as possible when speaking to different audiences so that they avoid alienating either clients or potential donors. For example, Executive Director 3 stated that they had to

remain mindful of their setting when they crafted messages. When talking about staff, they said,

> I know the university doesn't pay them enough and that's causing some food insecurity, so I do have to be careful in the messaging. I'm not going to be able to change the salary rate. So, there's this weird balance. Same with working with Aramark, who does the dining. They have caused some problems with students being able to afford meals. Students are forced to purchase a meal plan, that's the contract. They live in a dorm; they have to have a meal plan. But those meal plans are really expensive and then they can default on them. But Aramark also matches swipes for Our Swipe Out Hunger program. So, there's a weird balance and we do have to pay attention to the messaging. You don't want to bite the hand of your provider, even when your provider might be doing something you don't agree with.

Another constraint is that most organizations are bound by guidelines that can prohibit them from sharing information that they would like. Executive Director 5, who runs a church-based food pantry, stated that, "They're [local organization] allowed to have testimony and preach and stuff. I think MFN kind of turns an eye to that. But I won't do it. We don't want to break any rules." Although others had broken the rules, they remained wary of taking that same step and thus found their messages constrained by donor guidelines.

For many, when seeking donations, they felt the need to consider how the partnership would benefit the other organization. As Executive Director 1 stated,

Whenever I'm talking with somebody, I try to think, 'What benefit can they gain out of whatever this situation is?' So, if I'm talking to a company and maybe we need a financial sponsorship or we need them to donate some food or to donate a service, what benefit is that gonna give them? Are they gonna be able to put it on some kind of report that they helped the community, are they gonna get a tax write off? What can we do to help you? And, as a great side benefit, you're gonna be helping the community.

As they navigated how to posit partnership as beneficial to all and how to best communicate with their respective audiences, organizations also faced the question of whether they should stick to their stated mission, regardless of who they offend, or if they should compromise and attempt to appease the greater public.

Maintaining the organizational mission. Many of the organizations in this particular region are faith-based. Three of the five organizations chosen for this study are explicitly faith-based and mention God in their mission. Executive Directors 2 and 5 stated that their missions included "helping the lost and hurting" and they do that "through the Word of Christ." Executive Director 1 stated that their mission is to "shine the light of God's love" as they work "to help those who are struggling, those who are poor, and those who are underserved." However, Executive Director 1 also recognized, "The needs that we're meeting are not necessarily spiritual. They're the basic necessities of life." In recognizing this, they acknowledged that they adapted their message to different audiences and pulled away from faith-based messages as leaning so heavily into faith could alienate potential clients. The mission of the organization, to help people, was more important than explicitly preaching to clients.

Executive Director 2, however, maintained that the ability to preach and openly share the Word of God with people was more important than funding or potentially alienating clients. They stated,

> It's unapologetic and unjudgmental. There's not many places that you can openly say, we'll pray here and no one's going to say anything. We can speak the name of the Lord and no one's going to go, 'Oh, I'm offended.' And at the same time, we're not saying that if you don't, you're going to Hell. That's not it at all. It's hard. Sometimes it's difficult that we live in a society – and even those who are in need want to come in with the expectation and stipulations that 'I want help, however, don't go religious on me.' And we're going, you know, we're not religious. We just want to give you hope. And give you the same hope we have.

For some clients, this was something that they appreciated. Luke stated, "I wasn't a Christian before I came here. I felt like there was a void and I was looking for something, you know, and I didn't know what it was. I came here and I realized it was Jesus Christ." Others, however, felt that the lack of respect they received when visiting an explicitly faith-based organization was hypocritical. For example, Crystal said, "It's just, you can't even go into any church anymore because they're not what they say they are." Many individuals believed that God played a large role in their lives but appreciated the opportunity to choose whether they received the Word or not.

Make givers, not takers. Another subtheme that appeared throughout the conversations with both executive directors and clients was the idea of clients shifting from the role of "taker" to that of a "giver." For one organization, giving clients the tools to empower themselves, such as knowledge from money management classes, promised

to lead to them helping others who had been in similar situations. As Executive Director 2 stated,

They come in and they live with us and they go through classes and their meetings, but they also give back to the community. There are a lot of times with our volunteers, they're our workforce, also. Now they're learning that instead of being takers, they're givers. They're beginning to give out and help others – many others that were in the same lifestyle and situation they were once in. It's – they see their life having meaning and it helps their recovery.

Executive Director 4 mentioned that their mission was based "on what we believe a community should really be like. You give what you can and take what need." There was no shame in either giving or taking but, as a community, one should ideally be involved in both. Executive Director 1 stated that this is the "pretty side" of their job as they get to see people help one another. They stated,

People just care for each other in times of need and we get to see that all the time. We get to see the pretty side. We also hear that really rotten side of what happened but then we see how people rally around those in need. And, interestingly, people who are impoverished, my gut tells me, they're giving a way bigger percentage than those who are financially well-off. They will give the shirt off their back to somebody because they know what it feels like.

Clients reiterated this idea themselves as many volunteered at the organizations they utilized. Alice, an older woman, stated,

Because I've been where there is nothing but those places that people don't know about, I can't express how much that – and I've donated things to them because

they helped me. I don't just go to [organization] because I live right next door. I

go for the people that have helped me. I will donate to them. Because they gave

me something and helped me, even if it was a rug for $5.

James, a client for a different organization and an older man, stated that as a way of

"giving back to [organization], I do self-volunteer work." Executive Director 3 stated,

"We have clients that want to give back. They want to volunteer. Sometimes we put out a

change jar and they want to put change n so they can help the pantry."

For both clients and directors, the idea of giving as much as you get was

prevalent. And as evidenced above, for clients, it often came down to how they were

treated and how organizational staff communicated with them. The more of a connection

one felt with an organization, the more likely they seemed to want to help that

organization in return. Further, the more of a connection individuals felt, the easier it was

for organizations to communicate with clients.

Theme Three: Communication with Clients

The third most common theme was that of communication with clients. This

theme encompassed several subthemes including listening, transactional interactions,

literacy concerns, the impact of physical space on client communication, and

communication resource guides.

"We just listen." Many clients expressed their desire to be heard. Lydia stated,

"There's only so many people in here that you can talk to. Having someone to just talk to

would be a real blessing." James stated, "I just want to sit down and talk." Both clients

were referring to a general desire to experience a human connection, however, others

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referred explicitly to the act of giving feedback to an organization. When discussing how she would like to give organizational feedback, Amy stated,

Either email or in person. Just because I'm a communication person, obviously, so I feel like it's almost more genuine or you could get your point across better if you could sit down – not just with a worker or, whatever – but with someone who's in charge of running the – so you can sit down with them and say, this is my situation, this is what I've experienced, this is what I think could help.

Other clients agreed that it was on the organization to put forth an effort to listen to their clients. For example, Emma stated, "You don't know your clientele if you don't care or if you don't – if you haven't put forth any effort to get to know what your clients need."

Several directors stated that they do attempt to listen to their clients. Executive Director 1, for example, stated that in addition to formal surveys, "We just listen." They continued,

For example, we are thankful that [community group], they are starting a feminine hygiene product bank for us. That isn't a survey, that's because our receptionist will have women whisper to her, "Do y'all have any tampons? Any pads?' Something like that. So, we quietly have kept them in a drawer, but it's only been if someone asked because we didn't have a source to get that. A lot of it is just, people ask us enough, then we realize that this is something they need.

Executive Director 3 stated something similar and added, "We will go in there and ask them questions and ask for feedback," but having multiple clients approach them to ask for items is the way that they perceive a need. This is interesting as several clients

noted that the relationship between clients and organization staff is "missing the human aspect" and seems "transactional."

Transactional interactions. For many clients, the relationship between them and the organization is transactional. James stated,

> It's a business. The human aspect isn't here. While during that business, people are gonna stop and speak with someone, it's only gonna be for a few seconds. A quick interchange. Those are okay because it's quick and they can go on about their business. You're here to eat, go ahead and eat. You're here to ask for a different kind of service, go ahead and ask for that. But there's no communication, a personal sharing of information or socializing or anything like that.

Luke, who also worked as a volunteer in the dining area, stated that this was a rule. He said,

> I'm really not supposed to be talking to – I'm really not supposed to be having full conversations with diners and volunteers for protection because I don't know what you're about. You don't know what I'm about.

This rule was in place to protect him and executive directors reiterated this idea. Executive Director 4 posited that it was hard for them to say no, regardless of their inability to help everyone, and maintaining that boundary made it easier for them to do their job. They stated,

> You can't do it for everybody. We're doing something good here that would be jeopardized. You can't set that precedent. You can do more good for more people by having to say no sometimes.

However, many clients felt that this distance between them and the organization was uncomfortable and felt like too much work for not enough pay off. Crystal questioned, "What's the point if you can't get it?" While another lamented the lengthy process necessary just to get assistance. For example, Alice stated, "They're only going to help you this one time and you have to go to the financial class." For her, this class was unnecessary as she explained, "He [the instructor] said, you sure do got a handle on your budget. I said, yeah, you can't do something if you don't have money." It was not an issue of not understanding how to handle a budget but, rather, having to navigate a system that would not give them the adequate assistance.

For many, the transactional nature of these organizations left them feeling uncomfortable. However, one organization, where Alice stated that a staff member "loves me," seemed to garner positive reviews from clients and other directors. Knowing that, if they "feel like they need to address" one of the organization's staff members or the director, "they can call anytime," was something that garnered positivity and good feelings.

Literacy concerns. One of the challenges that appeared consistently during director interviews was the idea of using language that people understand. For many, simply sharing a message – regardless of how well intentioned – was not enough to reach the intended audience. For example, when speaking about health, Executive Director 1 stated, "We don't talk about hypertension; we talk about high blood pressure. We don't talk about hyperlipidemia; we talk about high cholesterol. You just have to use language people understand." This concept extended to ideas that most people take for granted such as the understanding that what you eat effects how your body works. However,

tailoring messages was not limited to director-to-client communication. When crafting

messages for potential donors, directors stated that they must be mindful of the stigma

that surrounds their clients and craft their messages in a way that does not shame them for

seeking help but also does not alienate donors. For example, Executive Director 4 – who

works with children – stated, "I have to frame it as, 'I'm not here to talk about these

parents, I'm here to talk about the kids who for whatever reason, aren't getting the

nutrition that they need."

One organization that required clients to sit through a lecture to receive a meal

attempted to tailor their lectures to their clients' interests. Instead of choosing speakers at

random, Executive Director 2 stated,

> Some of them were, like I said, train safety, fire safety, weatherization for your
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> home, the census. Next week, we have adult education. We've had [mental health
>
> agency]. We have Bible studies. We have – I don't want to call it self-help –
>
> motivational speakers. It's one of those people who are probably religious but
>
> also motivational speaking about where you are going and those kinds of things.
>
> Any topic we hear of that we think kind of resonates with our diners…

In addition to guest speakers, directors stated that they must be wary of the

medium of their message. For some, "they can't read," and for others, "they don't have

access to a computer. So, giving somebody a website doesn't do them any good."

Connecting with individuals on their level, adapting to the place that they are at, was

articulated as one of the most important steps many organizations could take. Ensuring

that clients could understand the message they were given was important because, as

Executive Director 4 stated, "When you can connect it to something that they understand, then it's, like, 'Oh.'"

The impact of facilities and physical space on client communication. Another constraint that many clients pointed out is that of physical space and separation. James posited that it wouldn't matter how long he had been utilizing a particular service. There was no desire on behalf of the staff to interact with the clients and there were physical barriers in place to prevent nonessential interactions. He stated,

> There's that separation. Just like that window when you walk in. When you come in here, they're behind that window and you're out here in the lobby. Unless you go to that window that's there to conduct business, you don't have a verbal interaction.

Amy pointed out the steel door of a different organization and posited that having "a glass door" that made it easier to see inside would lessen the boundary between staff and clients.

Also in relation to space, Emma articulated the idea that she had been raised to take up as little space as possible. In doing so, it was instilled in her to not offer feedback, even if given the chance. She said,

> Growing up in a poor environment has made me hyperaware of those things and it makes me feel like, if I'm not the most meek and nice person possible, if I take up the least amount of space in one of these spaces, they're not going to take it away from me and I'm not allowed to complain about it.

Regardless of how unwelcoming they found the environment, many people hesitated to complain because, as James pointed out,

'Well, it's free. What are you worried about it for? It's free, you don't like it, what are you coming for? If you don't like it, don't come.' Well, some people, this is their only opportunity. Their only chance to eat a meal a day. If you see something wrong about it, well, guess what? It's either eat or starve. If I've got a choice between eating and starving, I'm going to eat. So, you don't say anything. You just go on ahead with your day.

The directors, however, positioned space as a provider of privacy for clients. Executive Director 1 pointed out, "There are some things you may not want to, you may not want to go over your health history with your child sitting next to you or, whoever gave you a ride if you're not close to them. You don't want everybody to know." Amy agreed that privacy was nice as "you don't feel pressured," however, having other people around and being in an open environment can make clients aware that "I'm not the only one having this problem, I'm not the only one using this."

Communicating resource guides. One subtheme that continued to appear throughout conversations with both directors and clients was a lack of awareness regarding services each organization offered as well as a lack of awareness regarding services offered by other local organizations. As Alice stated,

This is the thing, though, when you're in this situation, you don't know where to go. Like, I said, there's so much more that [organization] can and will do. Plus, they have social workers here. People don't even know that!

In an effort to alleviate this uncertainty, several organizations provide general resource guides for clients. However, due to logistical concerns on behalf of the

organizations, Executive Director 1 explained that these resource guides are available only to those who ask. They stated

That is something that, if you ask for it, we'll give you. Our numbers are consistently serving over 1,500 families per month. So, in reality, for us, that is three reams of paper plus the copying costs. And even though it's the same resource guide that was out there last July, they may pick it up every time they come and so that's an expense for us. And it's not that we don't want people to have access to things, we have to control all of our expenses. So, if someone asks us, we go over it with them but we try not to put just generic paper out there because some people just pick up everything they see.

However, many clients reiterated that they didn't know where to even begin asking for help. Abe stated, "Unless people know that, they don't realize that there's other agencies out there that give." Executive Director 2 acknowledged this in saying that they often get clients "who just got laid off from work, sitting in our lobby going, what now? What do we do now?" Alice stated, "You're in this situation. You have all kinds of needs, but you really don't know how to navigate it, in a way."

One director stated that they felt some of the lack of awareness stemmed from the inability to succinctly summarize all of the services offered by their organization. As Executive Director 2 stated,

Now, because we have so many different irons in the fire, sometimes it's hard to get the full message out there. How do you say, in an elevator speech… [Gesturing to a several page pamphlet detailing their services.] There are people who have known us for many years who are, like, "Oh, y'all give out food boxes?

We didn't even know you did that." How many different ways can we say what we do for people to get it? I think the bigger challenge is to make sure what we have to offer to meet the needs is getting relayed to where it needs to get relayed.

Some clients agreed that relaying information to the correct audiences was an area that many of the organizations could improve in. For example, one organization recently changed locations. Some clients of this organization were not aware and, as Amy stated, "See, that's one of those things. If I was in a situation where I was hungry and went there, I'd think it didn't exist anymore."

Both logistical concerns on behalf of the organization – Executive Director 1 pointed out that many of their clients, "can't read" – and a missing sense of connection on behalf of clients contribute to the overall problem of a lack of awareness regarding resources. Although organizations attempt to ameliorate this by providing resource guides, ensuring that these guides get into the correct hands, are accessible to all, and are providing the necessary assistance are all obstacles that both clients and directors have faced.

Theme Four: Community and Sense of Place

Another overarching theme that appeared in both the client and director discussions was that of community and the idea of a found family or a sense of belonging. For example, when talking about the help he have received from an organization, Luke said, "We're brothers. We're supposed to look at each other as brothers." Any time Luke referenced the individuals he most often interacted with, he referred to them as "brother [name]." Alice referenced the affection she felt for an employee of an organization when discussing their mutual love for plants. She also

stated, "She loves me," in reference to that employee, displaying the bond that the pair shared.

Executive Director 1 recognized that the bond ran deeper than they imagined it would among clients. They stated that the staff "really are family" and continued to acknowledge that the clients are, too. They stated,

And, sometimes you pick up on it and sometimes you don't but because they pretty much come the same week of the month every time and they're gonna come, usually around the same time of day – like after they've dropped their grandkids off at school or whatever the deal is – but they kind of all know each other and I didn't realize how much that was the case until one day somebody came and got me out of my office and said, "A lady just fell on the sidewalk." And I went out front and she actually was having a seizure and she had driven herself here so we couldn't connect who she was and we didn't want to dig immediately through her billfold to try to get a name or anything. You would have thought nobody in there knew her but they all immediately were able to tell us where she lived, who she was living with, where he was at the moment, why she drove herself – they knew a whole lot about her. One of them went and got the man that she lived with, got him down here, and we were, like… She was leaving. Nobody had spoken to her. She sat alone. And that's why our volunteer and our front desk person didn't think she knew anybody in the lobby. But immediately, they all really did know her. This is a close community even though we serve seven counties, within it there are pockets.

Another director acknowledged the bond that they feel when connecting with clients. They take the time to learn their situation and adapt their services based on needs, much as a family member would. Executive Director 5, for example, said,

There was this man, very frail man. When he came in, he could hardly walk and when we pushed his buggy into the parking lot, the man fell. We helped him up and he fell again right by the truck and insisted on pulling himself up. He fell twice. It was, like, we need to see about putting him on Meals on Wheels. And we did. But when we saw that need, that he couldn't get around well at all no matter how hard he was trying…

Executive Director 3 acknowledged that their client base has different needs than the traditional client base. To be more accommodating, they have started adding items that "were never on our shopping list" to said list and requests for donations in an effort to better accommodate their clients.

There is a sense of connection for some individuals. They feel that they belong and that they are connected to the organization. Executive Director 2 pointed out that this connection has the capacity to serve as a "well check" for some of their clients. They stated

When they're not here, we're concerned for them because something has happened. It actually puts a little safety measure in their life because we start learning where they live, what their situations are. They have one more pair of eyes to care for them – sometimes the only pair of eyes watching out for them.

And for other directors, this connection is crucial to their mission. As Executive Director 4 stated, "Really there are people in our community that have so much to give

but they need help from us before they can contribute." By forging these connections and uplifting community as a source of power, they are attempting to determine "the type of world that we live in" and "what [city] is going to be."

Barriers. Something that contributed to the difficulty many people felt in connecting was the systemic barriers in place. It came up in multiple director interviews that many of their clients could not read (Executive Director 1, 2, 4, and 5) and that many clients did not have access to the internet (Executive Director 1, 2, 4, and 5). When discussing challenges in reaching clients, Executive Director 1 stated, "Well, they can't read. They don't understand and they don't have access to a computer." Further, they continued by positing race and gender as barriers to connecting with clients. They stated,

I have no doubt that there are also barriers if the client is black because I'm white, if the client is male because I'm female… whatever the deal is, there are going to be barriers that I'm incapable of overcoming because I can't change the color of my skin or my gender to be more in line with them.

Executive Director 4 also posited this as a problem and acknowledged the "systemic failures and a lot of the racial history" that contributed to the struggle many of their clients faced but posited that others "don't want to acknowledge" them. Instead, they would rather encourage people to "pull yourself up by the bootstraps" and work to achieve more. Because of this, they felt that representation was necessary to understand the struggles faced by many of their clients.

Representation. One thing that several individuals articulated as a way to form a connection was the idea of representation. Executive Director 4 acknowledged that they came from a vastly different background than most of their clients and stated, "Even if I

don't make them [clients] uncomfortable, it's not going to make them comfortable."
Executive Director 1 also believed that being "very intentional that our staff and our
volunteers are representative" was important as it allowed them to "hear the voices of the
people we're serving" so that they wouldn't be "out of touch."

Clients agreed that this representation was important and agreed that those who
were not seeking representative voices seemed like they "don't care" and "haven't put
forth any effort." For some, representation made them feel more comfortable sharing
their opinion. Luke, who utilized an organization's services and also volunteered as a
way to give back, stated that he had seen other volunteers be asked for feedback "because
they have more of a specialization" and because of this, the staff "kind of operates around
whatever he does because he's been in the kitchen so long."

Others, however, did not feel this same sense of community and felt that their
feedback would be ignored if they shared it. Some clients expressed their concern that
any negative feedback would result in termination of services. For example, Emma
stated,

> And I feel like, if we offer feedback, like, 'hey, this could be better.' The
> university – because the university isn't very good at being nice to poor students –
> they'd just be, like, 'Okay. We'll just take it away if you don't like it. Oh, here.
> We were offering this great service – doing this great service for you because we
> care about you. Since you don't like it anymore, we're just going to take it away
> and use that money toward football.'

James, after discussing his thoughts about the organization, stated, "But I keep it to myself because, again, at the end of the day, it's free food." He didn't want to risk losing his meal for the day by opposing the status quo at the organization.

Working and seeking assistance. Many of the clients reiterated that they were not the typical assistance seeker and were either employed, actively seeking employment, or were not unemployed by choice. For example, Crystal stated, "I don't work because – not that I don't want to – I'm always on the road with my kids that's got the disabilities or I'm either at the schoolhouse." Alice stated that even though "I was working full time for a government, in a government job, but I have a son with disabilities, and I had two children awarded to me through the court with disabilities." Because of this, she needed all of the assistance she could get. James acknowledged that he had owned his own business and a divorce "had my home life disrupted," which placed him in a bad mental state. However, he maintained that he was "trying to get out of it."

Executive Director 1 acknowledged that some clients come into the pantry "wearing a shirt with the name of their business" while Executive Director 2 stated that sometimes clients will leave before they may be ready because "they barely made it on time and they have to get back to work." For some, this need to get in and out before they head to work can diminish the capacity to form a relationship. As Emma stated, her interactions were never more than surface level "because I usually have work directly after and I have to go." So, for some, the experience of working while seeking assistance was an added stressor.

God's love. One way that both clients and staff worked to build relationships and find a sense of community was through God's love. Three of five organizations, two of

them being the most prominent in the community, explicitly state that spreading God's love is part of their mission. Clients acknowledged that this message is shared widely and that they appreciate it. For example, Lydia stated, "They're always smiling and telling me Jesus loves me. It's nice." Alice acknowledged that, "God built the house and God gave me that – you know, I'm blessed." God's love served as a kind of glue that built community for many of these individuals and strengthened the message that many of these organizations were trying to send.

Summary

In sum, the four main themes found throughout the interviews and focus groups included everybody has a story, the complexities of nonprofit organizations, communication with clients, and community and a sense of place. These themes encompassed the broader ideas of organizational communication, culture, and structural barriers to communication. Directors emphasized that although the face of hunger is often presented as being obvious, it is difficult to tell who among us is going without. However, clients posited that their presence at these organizations is enough to mark them as assistance seekers and as a result, they are sometimes treated with less dignity and respect than they feel that they deserve. Further, clients felt the need to justify their presence by reiterating that they were not the typical assistance seeker but had simply fallen on hard times. Although directors acknowledged this fact, many stated that they had to be mindful of their audiences and be diplomatic when attempting to garner support for their organization as they did not want to alienate clients or potential donors.

Directors stated that they "just listened" to their clients, however, many clients stated that the organizational culture was more transactional. Interactions did not last

longer than the time it took to request a service or complete an action, and this was

something that made them feel unwelcome. Others presented physical space as a concern

and pointed out that unless they were invited to begin a conversation, there was no way

for them to interact with organizational staff. Despite these concerns, some participants

felt that they had found a community among those they sought assistance alongside.

Overall, the findings are an interesting blend of client and director concerns and

compliments as well as an in-depth look at the barriers to communication faced by these

organizations.

CHAPTER V – DISCUSSION AND IMPLICATIONS

Although food insecurity in the United States is decreasing, the southeastern region continues to experience high levels of food insecurity (Coleman-Jensen, Gregory, & Rabbitt, 2019). The present study, grounded in the culture-centered approach (CCA) and the communication infrastructure theory (CIT), responds to calls for research that includes focus group discussions (Matsaganis & Golden, 2015) surrounding community-based organizations and work "in exploring communication processes that bring about opportunities for challenging and transforming the unhealthy structures" (Dutta & Basu, 2008, p. 570). The current study draws on information gathered from three focus groups and five in-depth interviews with clients of these organizations. The following analysis highlights how the storytelling network (STN), structural factors, culture, and agency influence how organizations communicate with clients and how clients impact organizational decision making.

The present study found that the relationship between clients and organizational staff was marked by the desire to avoid generalization and stereotyping to avoid placing blame or causing a rift in the community. The connection formed when directors took the time to seek out client stories was viewed as a part of the integration of multiple different networks. Further, this forced individuals to acknowledge that those who were experiencing hunger came from a multitude of backgrounds and included those who were working as well as those who were obviously impoverished. Participants emphasized the importance of organizational communication and how this could make or break the connections formed between organizations, partners, and clients. Participants also emphasized how a lack of proactive communication and a personal touch, including

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physical and emotional distance between clients and organizational staff, impacted the

decision to seek assistance. Finally, participants discussed finding a community and a

family among the other clients and organizational staff who utilized these services. These

findings build upon existing research and contribute to the knowledge surrounding how

organizations build health interventions and how clients influence the messages created

by said organizations.

The findings of the present study support previous work that has been done in the

area of participatory communication and the CCA. One of the most prominent themes in

the current study was the idea that everyone has a story. The story that one tells about the

experience of hunger and seeking assistance is co-constructed between clients and those

in positions of power, such as organizational staff (Dutta et al., 2016). Clients, for the

most part, did not fit the stereotypical mold of poverty. By articulating their stories and

reiterating that they were not the traditional assistance seeker, they were navigating the

elements of their environment that affected their ability to access communication

resources (Ball-Rokeach et al., 2001).

As many participants articulated, hunger can happen to anyone. Food insecurity is

a problem that many Americans face and can be experienced as the result of a job loss, a

natural disaster, a traumatic personal experience, or a myriad of other reasons. As was

repeated by multiple participants, everyone has a story. This wide array of experiences is

indicative of "structural violence, the inability to meet the basic necessities of life" (Dutta

et al., 2016, p. 656). The inability to meet the basic necessity of providing food despite

being a once productive member of society was in direct opposition in a local cultural

understanding that the individual is responsible and through hard work, anything was

possible (Dutta et al., 2016; Ramadurai, Sharf, & Sharkey, 2012). These narratives also emphasize the importance of understanding the idea that everyone experiences food insecurity differently. For some, hunger is a recurring theme of their lives and is part of a larger cycle of poverty. For others, they are currently experiencing a rough patch and hope to be on their feet again soon. These narratives provide a localized understanding of the broader experience of food insecurity. They also shed light on the experiences that participants had with various organizations providing assistance. Many of the narratives showcased that hunger was often beyond individual control and tended to exist in a tangled web of other networks such as medical services, family dynamics, places of worship, employment, and the neighborhood they resided in, much in line with previous research (Ball-Rokeach et al., 2001; Dutta et al., 2016; Matsaganis & Golden, 2015; Ramadurai, Sharf, & Sharkey, 2012; Wilkin, 2013).

These narratives are also an act of expressing agency as they disrupt the traditional idea of what an assistance seeker may look like (Dillon & Basu, 2016; Dutta et al., 2016; Ramadurai, Sharf, & Sharkey, 2012). Poverty is often posited as having a "particular look," and while it was acknowledged that these individuals do experience hunger, many expressed that the "face of hunger" is often unrecognizable at first glance. Unless a neighborhood is particularly integrated, it is difficult to know a relative stranger's story (Wilkin et al., 2011). However, as seen in Matsaganis and Golden's (2015) work, many people make assumptions based on ones' presence at an emergency food distributor. As mentioned previously, everyone has a story. Clients who had recently lost their job or had undergone a traumatic life event were not markedly impoverished and in a culture that is mistrustful of anyone seeking assistance (Dutta et al., 2016), those

who did not look like they belonged were questioned more severely and risked emotional damage. Their presence was an act of expressing agency. They disrupted the dominant narrative that assistance seekers are "dirty and beat up" by showing that the face of hunger looks just like you and me.

In line with Dutta and Basu (2008), clients also enacted agency by making decisions on how to interact with organizations. Although clients acknowledged that they often tolerated treatment that they would not if they had a choice, they placed an emphasis on dignity and respect as a determining factor when deciding which organizations to visit. Many expressed their appreciation for being treated with professionalism and articulated their desire to continue a relationship with organizations that made them feel welcome. Further, the dignity that they received encouraged them to actively participate in the organization by making donations themselves. Although clients acknowledged their understanding that the organization was not capable of providing every item they needed, they expressed their gratitude for being treated with respect and articulated that a lack of respect and dignity was indicative of an organization that is out of touch with its community.

As Wilkin (2013) posited, a stronger connection to the overall storytelling network (STN) had the potential to result in increased positive health outcomes. For many individuals, they expressed the desire to change for the better if they were treated with dignity and respect. Given that support by an organization had the potential to change a client for the better. As Wilkin (2013) also posited, it is often the case that clients will listen to others in similar situations and place their opinions above that of a distant organizational leader. While organizational staff can provide food and recommend

additional services, other clients provide one another with honest feedback and help their

peers determine if a location is worth their limited resources. If an organization does not

treat its clients with dignity and respect, clients are not likely to encourage others to visit

this organization. Instead, they will encourage them to search for assistance elsewhere.

The experience of seeking assistance was described as an arduous one.

Participants described having to navigate the numerous structures in place that

constrained access to resources (Basu, Dillon, & Romero-Daza, 2016). Although many

clients expressed their agency by choosing to visit organizations that treated them kindly,

thus and challenging the dominant discourse of transaction-based interactions, others

acknowledged that because of structures that reinforce power balances (Dutta, Anaele, &

Jones, 2013), they were forced to do what they could to survive. For many, it did not

matter how they were treated personally. If an organization provided them with resources

and did not constrain access, they were willing to deal with that experience so long as

they could eat. Organizations that treated them kindly but did not provide much in the

way of food were seen as not worthy of the time and resources it took to visit that

organization. Other CAC factors such as work and family life (Ball-Rokeach et al., 2001;

Wilkin, 2013) also played a role in the experience of seeking assistance as they

constrained the amount of time and energy clients could expend visiting different

organizations.

Although the organizations themselves had the ability to constrain communication

and create or reinforce power balances (Dutta, Anaele, & Jones, 2013), they were often

constrained by other elements of the CAC (Wilkin, 2013). Organizations worried about

offending donors if they spoke out against low wages or policies that restricted clients'

access to resources. Much of the criticism surrounding nonprofits stems from the idea

that they do not actively challenge the structures in place that contribute to systemic

poverty (Lindenbaum, 2016). Several directors expressed their reluctance to "bite the

hand of" their providers. Although several expressed that their messages were not

entirely changed based on donor desire, the power balance was reinforced as donors had

the ability to constrain or enable access to resources such as funds, labor, and food. This

power balance was further reinforced as organizations were made to consider how it

would benefit the donor as they asked for assistance. A structure was in place that

determined how this section of society was organized and how organizations interacted

with one another which also contributed to how the organization interacted with its

clients (Duta, 2014; Dutta et al., 2016; Ramadurai, Sharf, & Sharkey, 2012).

Organizations expressed their desire to help their clients, however, they were not

able to challenge the structural barriers that limited them for fear of losing funding or

access to other material goods (Dutta, 2014; Dutta et al., 2016). Organizational directors

understood that to help their clients, they had to integrate into the system themselves thus

eliminating their ability to challenge power imbalances (Dutta et al., 2016; Wilkin, 2013).

They were essentially silenced themselves and found themselves so constrained by power

imbalances such as existing laws and financial concerns that they could not challenge the

barriers to access they acknowledged. For them, the most appropriate way to help clients

was to accept the status quo so they could provide at least some assistance rather than

none at all.

Another concern for several organizations was whether they should maintain their

mission of openly spreading the Word of God or if they should compromise their

message to serve more people. As several scholars have pointed out (Ball-Rokeach et al., 2001; Matsaganis & Golden, 2015; Ramadurai, Sharf, & Sharkey, 2012; Wilkin, 2013; Wilkin et al., 2011), churches serve as a locus of community building and the Word of God can reinforce the dominant culture. This can allow for a more integrated network and provide a community with a common ground. However, refusing to acknowledge voices expressing their discomfort with religion or their desire not to be preached to as they receive assistance is an act of silencing. Not allowing those who are seeking assistance the opportunity to have a say in the messaging that they receive alienates marginalized voices. Allowing a compromise where clients who wish to pray with staff or have staff pray for them explicitly ask for this service, however, allows clients to enact agency. By choosing how they engage with the organization, whether they pray or receive the Word of God or not, clients have the capacity to challenge the dominant structure while also working to meet their health needs (Basu et al., 2016; Dillon & Basu, 2016; Dutta et al., 2016).

For many participants, listening was a particularly important skill to possess. As Dutta (2015) articulated, listening is a way to resist the dominant narrative and allows those involved in the conversation to challenge the status quo. It also brings the voices of the marginalized to the foreground. Listening on behalf of the directors provided them a way to understand the needs of their clients. Many acknowledged that they did not know what their clients experienced so taking the opportunity to listen was, for them, crucial to understand the population that they served. Listening served as a way for participants to understand that dominant conversations around hunger, such as stigma and blame, might not be representative of everyone's individual experience. Further, as Dutta (2015)

pointed out, listening provided a way for marginalized voices to share their experiences with mainstream structures such as economics and society.

Listening provided a way for participants to co-construct how hunger could be alleviated and the best ways to challenge the dominant system (Dutta, 2007; Dutta, 2014; Dutta, 2015; Dutta et al., 2016). Although the directors remained in a position of power, by listening, they expressed their desire to ensure that they were not making decisions unilaterally. Several directors expressed that they did not want to assume they knew what was best for their clients as they knew that they often did not. This emphasizes the local understanding of health and is a way of seeking feedback without delving into surveys or other formal methodologies. However, it is important to note that for this co-construction to be effective, the axis of knowledge must be situated in the marginalized communities (Dutta, 2015). In doing so, directors and organizational staff are given access to discursive spaces they are not usually invited into.

However, some participants expressed concern that access to these spaces was restricted. Though these organizations provide services to clients, they are also structures that have the potential to enable or constrain engagement in health or access to resources (Basu, Dillon, & Romero-Daza, 2016). As other scholars (Dutta, Anaele, & Jones, 2013; Ramadurai, Sharf, & Sharkey, 2012) have noted, these structures have a. hand in determining how individuals interact. Material resources can be distributed in ways that reinforce existing power balances which have the potential to silence marginalized voices (Dutta, Anaele, & Jones, 2013). Clients described the transactional and sometimes impersonal nature of these organizations. The perception existed that these organizations were there to provide one specific resource and if the client was not seeking that

particular resource or if they could not be provided that resource, the interaction was terminated. Physical space, such as a window through which clients spoke or a steel door, reinforced boundaries between clients and organization staff. This reinforced the idea that those in charge of the organization were in power while those who were seeking assistance were virtually powerless to do more than accept the assistance they were given. As noted elsewhere, some directors acknowledged that because they did not have the same life experience, they could not speak on behalf of their clients. Limiting interaction to only include transactions restricted clients' agency and the overall ability of marginalized voices to speak (Dutta, Anaele, & Jones, 2013; Ramadurai, Sharf, & Sharkey, 2012).

The language individuals use has the potential to vary from neighborhood to neighborhood. It also has the potential to vary based on cultural background (Wilkin et al., 2011). As these organizations control access to resources, recognizing that the language many of them use contributes to constraining access to messages is an important step (Dutta, 2014). Many of the organizations included in the present study worked with populations that used different language than they ordinarily would. Many clients lacked education and had difficulty understanding the dominant discourse surrounding health such as a discussion of diabetes, hypertension, or other medical terms. By adapting to their vocabulary, by including terminology that all clients could understand, these organizations were creating an open context in which integration could be achieved (Ball-Rokeach et al., 2001). Further, providing clients information in a language that they could understand challenged the dominant discussion of health and

allowed them to participate in the conversation – and express agency – as they were given the necessary information to make informed decisions.

One finding that was not expected was the significant role that space – both physical and social – played in many participants' experiences at these organizations. Although the researcher expected space to play a role in seeking help and connecting with local resources, space played a much larger role than anticipated. Ball-Rokeach and colleagues (2001) pointed out that elements of the built and social environment – the communication action context (CAC) – have the ability to constrain access to communication resources. Dutta (2007) further elaborated that structures are entrenched in power and contribute to creating marginalized life experiences. For some clients, physical structures such as a window or steel door providing a literal barrier between them and organizational staff served to constrain their ability to communicate their needs and concerns. This physical barrier served as a sign to clients that the organization did not care to hear their feedback and could make clients feel unwelcome. Other participants expressed their fear that taking up too much space – both literally, simply by being present, and metaphorically, by voicing their concerns and criticism – would result in the termination of their services. The physical barrier that existed between staff and clients, therefore, reinforced traditional power structures (Dutta et al., 2016).

In support of previous research done by Matsaganis and Golden (2015), the theme of privacy was also articulated as it related to space. Some participants felt that the structural barriers such as separate rooms or restricted interaction among clients afforded them privacy and dignity. It was posited that clients were potentially discussing information that they might not want broadcasted so these barriers prevented any

unwanted disclosure. However, these barriers contributed to the stigma surrounding the issue of hunger. Clients wanted to know that they were not alone in needing to seek resources so limiting the barriers between them and normalizing the search for assistance could provide much-needed comfort to many.

Elements of the CAC that were mentioned extended beyond those of physical space. One element that Ball-Rokeach and colleagues (2001) put forth was the experience of working. In support of Wilkin and colleagues' (2011) findings, those who worked mentioned that, though they may like to give feedback or form relationships, their work conditions often limited their ability to seek connections beyond the initial greeting as they sought assistance. They were there to get help, not to form a connection. The experience of working while still needing to seek assistance also served as a way for clients to express agency. Building on findings from Ramadurai, Sharf, and Sharkey (2012), some clients positioned themselves as different from the stereotype of the unemployed assistance seeker. In doing so, they were challenging the stereotypes and stigma that surrounded assistance seekers. This was not an act of widespread resistance to an unfair stereotype; however, it served as a marker of self-efficacy and was meant to prove that assistance seekers were not wrong for wanting to survive.

Ball-Rokeach and colleagues (2001) positioned access to technology as a potential barrier to integration and participants acknowledged this. As many clients were living with the most basic of necessities, they did not have access to the internet. Because of this, websites and social medial profiles were not the way to connect with this particular population. However, the cost of printing materials and the inability to adequately summarize an organization's function in a brochure were both put forth as

reasons much information is moved online. Further, in support of previous research (Basu et al., 2016; Liu et al., 2018; Wilkin et al., 2011), race, gender, and socioeconomics also appeared as barriers to integration. Directors acknowledged that they were not in the position of knowing how their clients lived. Several acknowledged that they did not have the same experience as they were white, women, or came from an affluent background while many of their clients were people of color and in need of assistance.

To ameliorate some of the potential barriers that existed between clients and directors, directors attempted to engage in intentional representation. However, in support of Basu and colleagues' (2016) findings, this had the potential to be harmful as it saw culture as static and one staff member as representative of an entire community. By hiring a person who was experiencing food insecurity to speak for an entire community, community culture was posited to be something that could be predicted based on one person's experience. Despite intentionally seeking to hire a staff member that was supposed to be representative of a community so that participants felt more comfortable speaking out about their experiences, this seemed to be a double-edged sword. Those who did not seek representation were accused of not caring while those who did were still met with clients that felt as if they did not have the power to speak.

Although many individuals felt that they did not have the power to speak, others felt that they did not know enough to contribute to the conversation. Many expressed a lack of awareness regarding services and posited that when they were met with an unexpected change in lifestyle, they did not know how to proceed. As other researchers have noted, this is one way that participants are structurally silenced (Dutta, 2007; Dutta, 2014; Dutta et al., 2016; Literat & Chen, 2014; Ramadurai, Sharf, & Sharkey, 2012;

Wilkin, 2013). Although organizations provided resource guides for clients, they were only available by request. Many participants did not know where to even begin, let alone how to ask for a resource guide – or that they were available. Participants were also made to sit through classes that reiterated information they had been inundated with – particularly blaming them for their poverty – or were expected to spend large portions of their time devoted to seeking assistance regardless of their other responsibilities. A lack of access to communication was posited as a problem by many as participants did not know what they needed unless they had access to information about services offered.

One of the ways that participants seemed to address lack of access to information or other resources was by forming a sort of community. As several scholars have posited, an integrated STN has the potential to positively impact health outcomes (Matsaganis & Golden, 2015; Wilkin, 2013; Wilkin et al., 2011). Participants expressed feeling as if the organizational staff and clients of the organization had become like family to them. Although some health outcomes have not been proven to be positively related to an integrated STN (Wilkin, 2013), the relationship that these participants possessed provided several avenues of exploration. For example, clients shared information with one another regarding where to go for resources while organizational staff actively helped one another outside of work. Structural barriers such as a lack of access to material goods still existed for many of them, however, the connection they had and the community that they found provided a place for them to belong and served as a sort of social capital. As expressed in a study conducted by Ramadurai, Sharf, and Sharkey (2012), participants felt responsible for one another. They shared access to resources, resource guides, and made an effort to adapt services to their needs. By coming together, becoming an integrated network, and

establishing social capital, participants had the opportunity to better their health outcomes.

Religion plays a significant role in southern life. Churches serve as a base of community building while Christian values often constitute the culture of many communities (Ball-Rokeach et al., 2001; Ramadurai, Sharf, & Sharkey, 2012; Wilkin, 2013). Several of the organizations included in the population for the present study were explicitly faith-based. Both clients and directors expressed their desire to worship and placed God's love at the forefront of their experiences. For the directors, they attempted to show God's love by providing for those who could not provide for themselves. In turn, clients expressed their belief that they had been blessed when they were treated with respect and dignity. Active participation in Bible studies, worship services, prayer sessions, and other religious events created shared values and practices of Christianity in these spaces.

Many participants reiterated that sharing God's love with others was why they were either involved as a staff member or actively gave to organizations that respected them. By treating others with kindness and helping them when they were down on their luck, participants were embodying a value that is deeply rooted in religion. In difficult times, participants called upon the knowledge that God loved them and that He would see them through. Further, communities were built based on God's love. Organizations themselves drew upon the teachings of larger religious groups or were supported by these groups thus connecting them to the community at large. As a result, many groups formed a network based on the idea of God's love (Ball-Rokeach et al., 2001; Matsaganis & Golden, 2015; Ramadurai, Sharf, & Sharkey, 2012).

Limitations and Implications

As the researcher concludes, a few limitations must be taken into account. First, the sample for this study is relatively small and focused specifically on organizations located in one geographic area. As such, the findings are not generalizable to all nonprofit community-based food organizations. Second, as all of the focus groups were conducted in the organization's headquarters – to alleviate the transportation concern – some clients may have felt unable to provide their true thoughts or feelings. Finally, the findings and conclusions presented in this paper are based in the researcher's interpretation of the data. Despite the author's best efforts, participants' narratives may not be categorized in the way that they intended.

In the future, as space played such a large role in the experience of seeking assistance, researchers could consider what would happen if physical barriers were different. If an organization did not include service windows or steel doors, how would the experience of seeking assistance change? Further, in concurrence with a call made by Dutta and colleagues (2016), researchers should look at narratives of hunger around the United States. Hunger is such an encompassing part of so many lives and the lived experience is important to understand. Gaining more information about how we talk about hunger, how we communicate with those seeking assistance, and how we interact in structures such as nonprofit organizations around the world is vital to understanding the broader concepts of hunger and poverty.

As previously mentioned, Dutta and colleagues (2016) called for more localized narratives of hunger and expressed the need for studies that span the globe. Although work has been done in the rural south (Ramadurai, Sharf, & Sharkey, 2012), this study

has added to the scholarship by providing a look at the lived experiences of both those seeking to ameliorate food insecurity and those experiencing food insecurity in the south. Wilkin (2013) called for a greater focus to be placed on communication ecology and by taking into account both perspectives, this paper has done just that. By taking a broader look at how both executive directors and clients view the organization, the researcher was able to gain a better understanding of how the STN is integrated and the roles that organizational culture, local culture, agency, and structure play in said integration. This study served to reinforce previous findings in the areas of both CIT and CCA research. The data gleaned mirrored data gathered by other scholars such as Wilkin (2013), Dutta and colleagues (2016), and Ramadurai, Sharf, and Sharkey (2012). However, it provided a look at a new geographical location and answered calls for a better understanding of how integration occurs.

Conclusion

Although this study was limited to one geographic area, several suggestions can be gleaned from the findings. As many participants reiterated, the "face of hunger" is often indistinguishable upon first glance. By treating anyone who enters the door of a hunger fighting nonprofit with dignity and respect, a culture of understanding could be fostered. Many people have no idea where to even begin searching for help in times of crisis so explicitly stating the services offered, where to find community partners who could provide other services, and communicating understanding that the experience of seeking assistance can be overwhelming can serve to make clients feel less alone as they attempt to adjust. The need for human connection was reiterated throughout the data collection process and though it may seem daunting, a simple smile and an ear willing to

listen can go a long way in creating a bond that is beneficial to both client and organization. Further, by understanding that structural elements such as limited knowledge and physical barriers are detrimental to forming relationships, organizations can work to ameliorate these issues. One organization took the time to fill out forms with clients, giving them both access to information they otherwise might not have and a chance to interact with organizational staff. This also eliminated the barrier of space as clients had to sit down, away from the barrier of the window or steel door and speak with another human being.

This study provides an insight into the lived experiences of both directors and clients of hunger fighting nonprofits, more research must be done in this area. Food insecurity is a problem that continues to affect many rural Americans and while many organizations say that they would love to no longer be needed, that doesn't seem likely to happen any time soon. Communication scholarship provides a way to understand how best to ameliorate physical and emotional distance between clients and organizations. It also provides a way to better integrate our communities and challenge inequalities that limit access to full integration. As Executive Director 2 stated, "For substance, you can find that just about anywhere. But find a relationship and finding that you have worth and meaning with someone else, that goes well beyond." Feeding the body is a critical mission that must continue, however, so is feeding the relationships that connect communities and provide us all with strengths to break down the barriers to health.

APPENDIX A – Scripted Questions for In-Depth Interviews

Q1: Can you tell me a little bit about the organization and about your mission?
Q2: Can you share a little bit about your experience working here? In your time, what has the face of hunger looked like?
Q3: How do you include members of the community in organizational decisions?
Q4: How are the opinions and preferences of community members collected?
Q5: What messages are you sharing about food/nutrition with members of the community (including clients and non-clients)?
Q6: How are you sharing these messages with members of the community?
Q7: What are some of the challenges you see to disseminating your message in this community?
Q8: Is there a gap in what you want to convey with what your clients want to hear?
Q9: Is there a gap in what you want to convey with what your donors/other stakeholders want you to share?
Q10: Do you think that there are times clients might be reluctant to share feedback with you?
Q11: Do you feel like volunteers or employees sometimes have trouble empathizing/sympathizing with clients?

APPENDIX B – Scripted Questions for Focus Group Sessions

Q1: What are the ways this organization has been helpful to you?
Q2: What have your interactions with this organization been like?
Q3: Do you feel like you have a connection with the people here?
      A) Can you describe that relationship?
Q4: Do you feel like your opinions are valued by the organization?
Q5: Have you had any opportunities to give feedback on some of the services they provide?
      A) Can you tell me about a time you were asked to give feedback?
Did you see any type of change based on your feedback?
Q6: When people talk to you, how do they talk to you?
      A) If you could change anything about the way that they talk to you, what would you change?
      B) Do you feel that you're respected when people talk to you?
Q7: How have you been consulted in the past for providing feedback for the organization?
Q8: How was your opinion solicited concerning programming offered by the organization?
      A) Is that the way you would like to give feedback?
Q9: In the past, if you have had ideas in wanting to contribute to the workings of the organization, how were those ideas received?
Q10: Have you ever had an issue with the organization that you didn't know how to fix?
      A) Can you tell me about it?
Q11: Do you have any recommendations for the services they offer?
Q12: Do you have any recommendations for how the organization communicates with you?

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NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION

The project below has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure:

- The risks to subjects are minimized and reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered involving risks to subjects must be reported immediately. Problems should be reported to ORI via the Incident template on Cayuse IRB.
- The period of approval is twelve months. An application for renewal must be submitted for projects exceeding twelve months.

PROTOCOL NUMBER: IRB-19-565
PROJECT TITLE: Barriers to Health: Understanding the Barriers Faced by Community Intervention Projects
SCHOOL/PROGRAM: School of COMM
RESEARCHER(S): Vera Landrum, Kathryn Anthony

IRB COMMITTEE ACTION: Approved
CATEGORY: Expedited
       7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

PERIOD OF APPROVAL: December 11, 2019

Donald Sacco

Donald Sacco, Ph.D.
Institutional Review Board Chairperson

Office *of* **Research Integrity**

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Modification Institutional Review Board Approval

The University of Southern Mississippi's Office of Research Integrity has received the notice of your modification for your submission Barriers to Health: Understanding the Barriers Faced by Community Intervention Projects (IRB #: IRB-19-565).

Your modification has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure:

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RESEARCHER(S): Vera Landrum ,Kathryn Anthony

IRB COMMITTEE ACTION: Approved

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

PERIOD OF APPROVAL: February 18, 2020

Donald Sacco

Donald Sacco, Ph.D.
Institutional Review Board Chairperson

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