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Structural-Level Stigma Within Emergency Food Assistance Programs:

Perspectives from Delaware and Pennsylvania

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Abstract

Objective*:* To characterize the ways in which structural stigma manifests within emergency food program settings. **Methods***:* We conducted 30-minute semi-structured interviews with 18 emergency food program clients in Pennsylvania and Delaware between August and December of 2024. The discussion guide included open-ended questions regarding client experiences of structural stigma, with an emphasis on issues of access and quality. Demographic data and household food insecurity (Hunger Vital Sign) were also captured. A hybrid inductive and deductive coding approach was used to analyze the data. **Results***:* Structural stigma is a persistent issue within emergency food program environments, impacting both participant access and quality. Access constraints included long wait times, limited agency over food choice, and accessibility challenges for individuals with physical disabilities, whereas quality constraints included receiving expired/spoiled foods or foods not aligned with participants' nutritional needs. These issues led to the erosion of autonomy and dignity and perpetuated clients' feelings of shame, frustration, and discomfort. **Conclusions***:* Intervention strategies such as routinely assessing structural stigma, implementing and monitoring quality standards, increasing infrastructure funding for pantries, creating direct distribution channels with local growers, and revising tax incentive policies show promise for reducing structural stigma within emergency food program settings. **Implications***:* Findings indicate the importance of addressing structural barriers related to accessibility and quality to reduce stigma and create more equitable and inclusive food assistance systems.

Introduction

Food insecurity continues to pose a significant challenge in the United States, affecting 13.5% of households in 2023.[1] This pervasive issue has far-reaching consequences for individuals,

families, and communities, contributing to detrimental physical and mental health outcomes, as well as impairing educational attainment for children and economic stability across generations.[2–5] While federal safety net programs such as the Supplemental Nutrition Assistance Program (SNAP) aim to reduce food insecurity, they often struggle to meet the needs of all households.[6] As a result, philanthropic and non-profit organizations step in to fill these gaps, providing emergency food assistance through food banks, pantries, and other charitable efforts. In 2022, approximately 49 million individuals relied on the emergency food system, with one in six Americans accessing resources provided by organizations such as Feeding America, the largest hunger-relief network in the country.[7,8] However, despite the critical role of these systems, stigma remains a persistent barrier, preventing many individuals from accessing the resources they need.[9–11]

Stigma, broadly defined as a social process involving labeling, stereotyping, discrimination, and status loss, operates across multiple levels, including individual/intrapersonal (i.e., self-stigma), interpersonal, and structural domains.[12–15] While much of the existing literature focuses on the individual and interpersonal dimensions of stigma, structural stigma, which refers to the societal-level conditions, cultural norms, and institutional or organizational policies that systematically limit access to resources and opportunities for specific groups,[14] has received comparatively little attention, particularly in the context of food insecurity.[11,14,16]

Literature on structural stigma within public health settings is burgeoning and has focused on two key issues: access and quality.[17] Inequitable access occurs when policies and practices lead to the systematic de-prioritization or mistreatment of those attempting to seek assistance, such as forcing individuals to endure long wait times or complete onerous administrative tasks.[17,18] These access inequities, which often stem from discriminatory laws, cultural norms, and institutional practices, have also been linked to health disparities in other fields, such as LGBTQ+ research.[16] In addition to inequitable access, structural stigma can also be manifested when individuals systematically receive lower quality care or services, which may result from underfunding or the devaluing of certain stigmatized statuses. Ultimately, inequitable access and low quality of care have both been shown to delay help seeking or deter assistance receipt amongst individuals in need.[17]

In the realm of food insecurity, structural stigma similarly manifests through implicit and explicit actions that impact food access and quality.[13] Prior research in this area is limited, but has shown that complex and time-consuming enrollment processes requiring extensive paperwork or administrative tasks discourage participation in food assistance programs.[9,13,19,20] For example, one study found that SNAP participation was 2.9 percent lower among individuals living in states with applicant fingerprinting requirements.[19] Involved administrative processes that require extensive personal information or police checkpoints have also been shown to reduce food assistance participation among immigrant populations as they perpetuate fear of legal consequences associated with the use of public resources.[21–23] Structural stigma is also manifested through the distribution of poor quality food within emergency food assistance settings.[11,24,25] By promoting veiled messages of worthlessness and dehumanization, these access and quality barriers reinforce inequality and shame amongst emergency food program clients, leading to internalized stigma and discouraging help-seeking behaviors.[11]

Guided by the Stigma and Food Inequity Framework,[13] this qualitative study explores the ways in which structural stigma manifests and shapes the experiences of individuals relying on emergency food assistance. By shedding light on these dynamics, this paper aims to contribute to

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a deeper understanding of structural stigma in the context of food insecurity and to inform the development of more equitable and effective food systems.

Methods

Participants and Procedure

Participants were 18 emergency food program clients recruited from emergency food program sites (i.e., food bank, food pantries) in Pennsylvania and Delaware between August and December of 2024. We used purposive and snowball sampling methods to recruit participants. Study eligibility criteria were as follows: be at least 18 years of age, have received emergency food assistance from a food bank, cupboard, or pantry in the last year, be a resident of Delaware or Pennsylvania, and be fluent in speaking English or Spanish.

Participants completed semi-structured phone or Zoom interviews lasting approximately 30- to 45-minutes. The semi-structured interview guide, which inquired about participants' experiences of structural stigma, was created in partnership with the stigma subgroup of the Health Equity Collective, a multi-sector effort with more than 200 organizations and 800 members in Greater Houston operated by the UTHealth Houston Center for Health equity. See Table 1 for representative interview questions. As compensation for their participation in the study, participants received a $50 ShopRite or GIANT grocery store gift card. The University of Delaware Institutional Review Board approved study procedures.

Table 1 Representative Interview Questions

Representative Interview Questions
1. I'd like you to start by imagining a scenario where you find yourself low on food and have decided to go to a food bank/pantry/cupboard. How would you decide which one to choose?
2. What is your typical experience like when you visit a food pantry to get food? Please describe the process from start to finish. Probes: 1. Do you need to make an appointment? 2. What paperwork do you need to fill out? 3. Do you need to bring any required documentation (e.g., driver's license)? 4. Are there any rules around how frequently you can obtain food? 5. How do you get to the food bank/pantry/cupboard? 6. Where do you wait to get your food (car, in line outside, inside)?
3. Please tell us about the types of food you typically receive from the pantry.
4. Do you have a choice in the items you get? Probes: 1. If there is food you don't want, do you have to take it? 2. Is there anything you have received that you haven't been able to use? If so, why?

5. Describe the overall quality of the food, including its nutritional value, taste, and freshness.
Probes:
    1. Have you ever been concerned about the quality of food items? If so, please explain.
    2. Does the food available fit your typical diet?
    3. Does the food available meet your health needs?
    4. If participant has a chronic health condition (e.g., diabetes) - "How does the food you receive from the food bank/pantry/cupboard fit with your needs for managing diabetes? Do you find that the food options support your dietary requirements, or are there challenges you face in maintaining your diet?"
6. How does the process of getting food, such as the layout of the space, paperwork, or interactions with staff, influence your experience at the food bank?
7. If you could change anything about your experience at the food bank, what would it be?

Measures

Demographics

Participants completed the following socio-demographic questions: age, gender, race, ethnicity, educational level, income level, employment status, relationship status, housing status, household size, SNAP participation over the last year, and WIC participation over the last year.

Hunger Vital Sign

Household food insecurity risk was assessed using the two-item Hunger Vital Sign screener.[26] The screener includes the following questions: (1) "Within the past 12 months, we worried whether our food would run out before we got money to buy more," and (2) "Within the past 12 months, the food we bought just didn't last, and we didn't have money to get more." Response options for both items are "often true," "sometimes true," and "never true." Participants were categorized as food insecure if they selected "often true" or "sometimes true" for either question. This measure has been shown to align closely with the 18-item U.S. Household Food Security Scale, exhibiting strong convergent validity and demonstrating high sensitivity (97%) and specificity (83%).[26]

Structural Stigma Interview Questions

Participants answered a series of open-ended interview questions (see Supplemental Material) to explore clients' experiences of structural stigma. The research team implemented measures to minimize participant discomfort and potential re-traumatization, such as including positive closing questions to conclude interviews and reassuring participants of their discretion for sensitive issues.

Data Analysis

Interviews were audio-recorded, and transcripts were generated using Zoom. Data were analyzed using Dedoose software, and participant demographic data were incorporated into the analyses to

provide interpretive context. In addition, a descriptive analysis of participant characteristics was completed. Interview data were examined using a hybrid deductive and inductive thematic approach.[27] The deductive phase included codes informed by the semi-structured interview guide to understand participants' experiences and perceptions of stigma. Subsequently, in the inductive phase, themes that emerged organically from the data were identified. The coding process was initially conducted by the lead author, who carefully analyzed the data to ensure consistency and depth in identifying patterns and themes. To further enhance the rigor of the analysis, all codes were independently reviewed by a second author. Coding discrepancies were resolved through consultation with the larger research team, and as necessary, external experts. All codes are described in table format with exemplar quotes, and themes are discussed in the context of the larger literature on this topic.

Results

The socio-demographic characteristics of the participants are detailed in Table 2. The sample was predominantly female (78%), White (56%), and single (78%). A significant proportion of participants were unable to work or on disability (33%), and half reported having a high school diploma as their highest level of education. The majority of participants (83%) reported annual incomes below $30,000.

Most participants relied on a single food pantry at the time of the interview (67%), while a smaller percentage reported attending two (28%) or four (6%) pantries. A majority of participants walked (40%) or drove (40%) to the pantry, whereas others took the bus (10%), and rode with a caretaker (10%).

Table 2 Sample Characteristics ($N = 18$)

	n	**Mean (SD)**
Age	18	57.2 (14.5)
Number of People in Household	18	2.5(1.6)
		%
Gender (Female)	18	77.8
Race		
White	10	55.6
Black or African American	6	33.3
Hispanic	2	11.1
Educational Level		
Less than a High School Degree	2	11.1
High School Degree	9	50.0
Some College	4	22.2
Bachelor’s Degree	1	5.6
Master’s Degree	2	11.1
Income Level		
Under $30,000	15	83.3
$30,000 - $60,000	2	11.1
$60,001 - $90,000	1	5.6
Relationship Status		

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Single	14	77.8
Live at Home with Partner or Spouse	4	22.2
Children Live at Home (Yes)	6	33.3
Employment Status		
Unable to Work/On Disability	6	33.3
Retired	5	27.8
Employed Full Time	3	16.7
Employed Part Time	2	11.1
Unemployed	2	11.1
Housing Status		
Rent	15	83.3
Own	3	16.7
Food Insecure	16	88.9
Enrolled in SNAP in the Last Year	12	66.7
Enrolled in WIC in the Last Year	1	5.6
Mode of Transportation to Pantry*		
Walk	8	40.0
Drive	8	40.0
Bus	2	10.0
Get a Ride with Caretaker/Others	2	10.0

Qualitative data analysis of participants' experiences with structural stigma in emergency food program environments identified three key themes (See Table 3): (1) accessibility constraints, (2) quality constraints, and (3) supportive pantry operations and structures.

Table 3 Qualitative Themes and Exemplar Quotes

Theme #1: Accessibility Constraints	
Long Wait Times	Honestly, I usually try to get there like two hours before because the line could go around the whole block. [...] I'll wait in my car. [...] It's a drive through. - Respondent 15 (54, Hispanic, Female, DE)
	Okay, so they start to give out the food at 10:30am, but if you want a chance at getting something you will get in line early. [...] Even when I get there at 10 o'clock, people are already in line. Probably by like a quarter of it's already four or five people in front of me. They're in line for at least 45 minutes to an hour. [...] I usually get in line 30 minutes early, so I'm in line by 10am [...] So I'm assuming the [people in front of me] got there, probably 45 minutes ahead of time. - Respondent 4 (46, Black, Female, PA)

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Agency Over Food Choices	I don't want to take stuff that I'm not going to eat, so I don't let nobody else shop for me [or go to drive through pantries]. Because they may get stuff that I don't like, and then I have to throw that away. So that's just really wasted food that somebody else could have got. - Respondent 5 (65, Black, Male, PA)
	I would say I would rather just go in there and get it myself, because when I got all that extra stuff it was extra work because they gave you things that you didn't really want. So I think that it's better just to go in yourself. - Respondent 3 (75, White, Female, PA)
Accessibility Challenges (Physical Disabilities)	So one [pantry] I went [to], I only went once. And the reason I only went once was because they don't really have the help to bring the food. I can't carry this stuff [due to my physical disability]. [...] It was all really great; however, I can't go back because I can't freaking carry this stuff. [...] Respondent 18 (46, White, Female, DE)
	My problem is, I can't stand in line [due to my physical disability]. So what happens is, when I get there, things are pretty well wiped out. The lines are pretty long in the morning when they open up, so by the time I'm able to get there in the afternoon it's very limited as to what I can get. Maybe some bread, and I might luck out and get another item that I want, but none of the main products. [...] It's all kind of gone. [...] - Respondent 17 (79, White, Male, PA)
Theme #2: Quality Constraints	
Expired/Spoiled Foods	The fruit sometimes is bad, and sometimes [...] they get mad at me that I'm looking at it because [they] think I'm holding the line up. But I don't want to bring home rotten freaking grapes, or rotted strawberries, or rotted blueberries. [...] I don't know why they even bring that stuff out. Like, don't they look at it? [...] [Sometimes] they're already mildewed or rotted. [...] I just throw them out [...] when I get home. That's the first thing I do is throw them out. So that's a little insulting. And I don't understand why they don't double check that stuff. They really ought to double check it, open up the little boxes, and make sure that everything is actually edible before they decide to serve it to poor people. [...] - Respondent 8 (63, White, Female, PA)

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	I would just say [if I could change anything about the pantry it would be] less expired food. - Respondent 4 (46, Black, Female, PA)
Differences in Food Quality/Sufficiency by Location	[At the other pantries] I've gotten bad stuff and I've had to throw it out. [...] I've had people say I went [to a different pantry], and I was really dissatisfied with their stuff. [...] When [my girlfriend] goes each week, she's had to throw so much stuff out because [the pantry is] giving her bad stuff. I wish she could come down here and go here, but she can't, because she's in [county name]. But I've seen some of the stuff that she's [gotten], and I'm glad I got this one down here. [...] She takes it home, but then she said, “Look at this, I go here, and I have to throw this out because it's no good.” I feel so bad. I don't know what to say because you can't come to the [county name] one [...]. So I try to help her out. [...] - Respondent 1 (58, White, Female, PA)
	The [pantry] gives out better meat [...], desserts, and vegetables [than the other pantry]. [Another pantry] gives out good everything, [...] more meat and vegetables [...]. - Respondent 12 (62, Black, Female, DE)
Food Options Not Aligned with Participants’ Nutritional Needs	They have a lot of canned goods, but I can't eat a lot of canned stuff because of my gallbladder. I can't take whatever they put in there, preservatives, or whatever it is, it bothers me. But the only thing that I can eat is the corn that they give you. The corn is salt free. They give you salt free corn and salt free peas, and I can mix it in with my ground meat and I make myself some kind of [meal]. - Respondent 3 (75, White, Female, PA)
Theme #3: Supportive Pantry Operations and Structures	
Simple Administrative Processes	We get a food pantry card and they stamp it each week you go. We keep it and just have to bring it with us when we come. If we forget it, they'll tell us to make sure we bring it next week. But they don't take your name down. [...] The paperwork was very easy. [...] I do [show] my ID to show that I lived in this county area because I guess they only serve so many areas. - Respondent 1 (58, White, Female, PA)

	No, [we don't have to sign anything]. We have a colored card. It has your information on it, members of your family. When you go there to get your bags they ask you what your number is, and that's how many members are in your family. You tell them that and they get the appropriate bag that's already preloaded with stuff. Pretty simple. [...] - Respondent 6 (57, White, Male, PA)
Helpful Accommodations Made by Pantry Staff	There are very helpful people there. Very, very nice and very helpful. [...] I feel good [when I visit the pantry] because they greet you sitting in the door there, and they always [...] call me by first name. [...] The [staff] greet you very nicely. If they see me with my cane they say "Would you like us to help you pick things out?" - Respondent 17 (79, White, Male, PA)

Theme #1: Accessibility Constraints

The first way structural stigma manifested in this study was through accessibility constraints including long wait times, agency over food choices, and accessibility challenges for individuals with physical disabilities. Sub-themes presented below are ordered from most to least frequently mentioned.

Long Wait Times

Participants reported experiencing long wait times in pantry lines, sometimes waiting multiple hours to receive their food. To get the best food selection and attempt to avoid these long lines, several participants reported arriving at the pantry early. For example, Respondent 8 (63, White, Female, PA) said,

> "The [pantry] at the church gets [...] a pretty long line. [...] The [pantry] starts at 10:30am, but I usually get there around 9:30am, [...] I [...] grab a chair, and I sit there. [...] I like getting there early, because I like getting the best selection, especially when it comes to the proteins and stuff. [..] By the time 10:30am rolls around, there's a lot of people behind me. [...] The only problem with it is that [...] I want to be one of the first ones there and that does require me to sit there for an hour. But, [...] I put my headphones on [and] I listen to something on Youtube or I call one of my daughters and I talk to them for an hour. [...] It's worth it to me in the long run for what it helps me with."

Another respondent reiterated the need to line up early for pantry services, despite pantry staffs' resistance. Specifically, Respondent 2 (64, Black, Female, PA) stated,

> "I try to get there as early as I can. I don't wanna be like 20th in line. I like to be in the top five. Some people get there really really early. I ain't gonna bother to try and beat them. They're like camping out for concert tickets for something. It's unbelievable

> how early they got there. [...] I try to get there a little after 9am, so [I wait for] an hour and a half. [...] They don't like everybody going there early. They really don't like that. They just can't stop us, because we all want to be first."

A couple of participants also noted that they were forced to endure poor weather conditions without appropriate accommodations while waiting in long pantry lines. For example, Respondent 2 (64, Black, Female, PA) stated,

> "There's always a line that you have to wait [in], and during the summer it was very hot. Now it's getting cold, and they don't have anything for you [to] stand underneath to get warm. But I just thank God that I'm able to get food so I'm blessed with that. [....] They give you seven minutes to shop, so it's a waiting game. [...] The line is just outrageous. I guess so many people in today's world need that help. [...] I guess the [other clients] just don't like the fact that they have to wait in this long line. [...] Where I live, I can look out my window, and the line is from here to [name of nearby town], I swear, and people are lined up at 6 o'clock in the morning, and they don't open until 10am. [...] Everybody's going through hard times, and people feel like that's the only way that they can live these days [is] if they go to the pantry." - Respondent 2 (64, Black, Female, PA)

Another participant shared that they became a pantry volunteer because they could not afford to waste gas by idling their car in long pantry lines. Respondent 18 (46, White, Female, DE) said,

> "Well, because I can't afford to waste gas, I go early, so I'm usually in the front of the line. I would say, usually within the first five-six cars. I tend to go at least an hour to an hour and a half before the start time and wait. [...] [At one pantry] I actually go and volunteer first. I sit at one of the tables and sort stuff into bags for the people to take once the event starts. That way, I don't have to idle my car. I just sit there with a blanket if it's winter, or in summer when windows are down, but the lines tend to be pretty long consistently at all of them."

Agency Over Food Choices

Participants often commented on pantries' distribution approaches, noting their preference for models that provided them with a choice in the foods they receive versus pre-packaged bags. Specifically, choice pantries allowed participants to avoid wasting unwanted food items, ensuring there is enough food for others. Respondent 18 (46, White, Female, DE) stated,

> "I definitely prefer choosing my own [items versus the pre-packaged drive through] because you're grateful for what you get, but there's always going to be stuff that you can't use. I don't like to waste anything or throw anything away, because I know it's hard enough for me to get food, other people can use this stuff. [...] So definitely picking and choosing is much more preferred"

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Similarly, Respondent 2 (64, Black, Female, PA) said,

> "I like to see what I'm getting [and shop for myself]. [...] In some pantries I've heard that you just go and drive by, and they just put it in your car so you don't know what you're getting until you get home. Whereas for [the pantry I go to], you know what you're getting. If you don't want it, you don't have to get it. [...]"

In another case, a participant provided an example of their experience at drive through pantries in which they received foods they do not want, despite specifying their preferences at the time of pickup. In particular, they drew attention to the fact that they felt bad throwing away the unused food items, many of which do not align with certain clients' cultural needs.

> "When you go to the [pantries] that you pull up to, you'll say, "[...] I don't want pork, and I don't want this." When you get home you open up the bag,[...] and it's pork and beans, but you don't know until you got home. So now you're home, and you could throw this stuff away if you don't got nobody to give it to. Then you feel bad to throw away food that can be used because they gave you specific stuff that your family don't eat. That's what happens. You pretty much just take what they give you. So imagine you [are], Muslim and they even gave you some pork and beans, or something like that. Or they'll throw stuff like [...] Vienna sausages in the bag. Like that's prison food. That's the type of stuff that they'll throw at them." - Respondent 4 (46, Black, Female, PA)

Several participants stated that they made efforts to ensure the food they received from the pantry was not going to waste, often offering the unwanted items to others. For example, Respondent 12 (62, Black, Female, PA) stated,

> "Yeah, sometimes I do [receive items I don't want]. But [I] just go to the side after I get my stuff and take out what I know I'm gonna use. Then I ask people in the line if they will want it, or I would just leave it right there for somebody else to get, because I don't want to take anything that I'm not going to use. [...] I would prefer to just go through and just get to pick out what I'm gonna use because somebody else can use that, and if I'm not going to use it, then why take it?" - Respondent 12 (62, Black, Female, PA)

Accessibility Challenges (Physical Disabilities)

Physical disabilities hindered many participants' ability to obtain food at pantries. For example, one participant stated that they were unable to stand for long periods of time, so they had to wait until the afternoon when the lines subsided to attend the pantry. However, by the time they arrived, most of the food was gone, leaving them with only a few items each week.

> "[I can't stand in line, so I go in the afternoon because it's not as busy]. I call them and they say "There's no line, but sir, there's a limited supply of what we have left. [...] I can't stand with my sciatic problem. I walk with a cane. I can stand for two or three minutes, and then I kind of lock up. [...] They're willing to help

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> [shop] if I'd like to, but by the time I get there, there isn't very much at all. I can get ground turkey, or something like that every once in a while. Other than that, things are really pretty well wiped out, so I'm very limited as to when I can go and what I can get." - Respondent 17 (79, White, Male, PA)

Another participant noted that they could not attend choice pantries in which they shopped for themselves unless they had assistance due to their inability to lift food items on their own.

> "So, all of the [pantries] that I go to, except for the [pantry name], are drive-up because I am disabled. [...] COVID did a number on me, and I got some immune diseases. So, I have no strength, and I cannot lift many things anymore, which is limiting. I've gone to [pantries] where they do have you [shop on] your own, and I don't go back, because it's already embarrassing to go, and then without help, it just makes it worse because I'm struggling in front of everybody. [...] [At the pantry without a drive-up], I go with somebody who helps me. [...] She helps me carry and put everything away for me." - Respondent 18 (46, White, Female, DE)

To address these accessibility barriers to pantry usage, participants made several recommendations regarding pantry operations including offering shopping assistance, online shopping options, and seats at the pantry so clients don't have to stand in line for extended periods of time. For example, Respondent 18 (46, White, Female, DE) said,

> "I guess, [I would recommend that the pantry] [...] offer [shopping] assistance ahead of time, in either writing or when you come up, letting people know, "If you need help, let us know." Because obviously I need the help, and I also don't like feeling singled out."

Respondent 7 (72, White, Female, PA) said that they preferred the online ordering system, which mitigated long wait times and allowed for food order pickups by clients' family or friends.

> "I would have to say [I preferred] the [pantry name] system, only because they had the online [ordering] system. They also had terminals in there, [so if] people didn't have a computer they could come in there [and] order right there on the computer. [...] Then [the staff] will put it all together for them. [...] I'm a mile or two away, [so] I order online, I set up a pickup time, [and] either I picked it up or my sister went in and picked up. There was no overcrowding. There's no waiting. [...] Here, it's okay, but [...] [I'm about to] have another foot surgery, [so] I'm not going to be able to get there, whereas [if] I had it be the other way where I could order online and have a family member pick it up, I would never be without it. [...] Unless I get a knee scooter or something, I'm not gonna be able to get up there, there's no way." - Respondent 7 (72, White, Female, PA)

A few participants noted that it would be helpful if pantries offered seating accommodations for clients while they were waiting in line for food.

> "Yeah, [if they offered seats at the pantry that would be helpful]. Since I walk with a cane, if there were benches on the outside of the community [center] where I could sit and work my way down the line that would be absolutely great." - Respondent 17 (79, White, Male, PA)

Respondent 7 (72, White, Female, PA) echoed this sentiment, and also suggested that pantries offer specific hours for individuals with physical disabilities.

> "Maybe for people with [disabilities], I know there's a lot of people standing in line with walkers. If they don't have a walker with a seat, it's hard for them. [...] Other than something like that [...], maybe let all those people in first or give them a certain time to come in [...]. At the pantry, if a person has to either take a caregiver [...] or can't stand, it is hard. I see people having a hard time. I can't stand, so I carry a little tripod seat with me. If I'm moving, I'm kind of all right, but anymore, I can't stand in place [with] my one foot the way it is. [...]" - Respondent 7 (72, White, Female, PA)

Theme #2: Quality Constraints

The second way structural stigma manifested in this study was through quality constraints including receipt of expired or spoiled foods, differences in food quality and sufficiency by location, and food options not aligned with participants' nutritional needs. Sub-themes are presented below from most to least frequently mentioned.

Expired/Spoiled Foods

Participants frequently reported receiving expired or spoiled or rotten foods from pantries. They expressed frustration with the poor food quality, which prevented some individuals from returning to certain pantries. For example, Respondent 18 (46, White, Female, DE) stated,

> "All of them are pretty much short-date or past-date foods. When you get stuff from the Food Bank, they tell you on the boxes with that little print-out from the USDA talking about past-date foods, and when they're still good and stuff. [...] I used to go to [pantry name], but I stopped going because their vegetables are all rotten. [...] I've gotten used to [the past-date items], so as long as they still taste good and smell good, I'm fine with it. But when they're just rotten, it's very disappointing. [It's] kind of insulting because sometimes I've gotten things that are completely moldy or just completely mush and really stink. And it's like, we can't eat this. Why did you even give it to us? That's one of the reasons why I love the [pantry name], because, like I said, when I go in, and I volunteer, I sit at the table [and] we actually sort out all the bad

> stuff. Where[as] most of the other [pantries], you just get what you get."

Another participant referred to the expired items as "trash" and stated that she had to become more vigilant when choosing food at the pantry after accidentally feeding her daughter an expired item.

> "[The expired items] were the ones that we got to pick, so basically we're picking the trash. It's like "Oh, well, we got this or we got that." And I'm like, okay, no wonder we can take what we want, because a lot of this stuff is expired. Last week I noticed that [the] boxes of pasta I had took [were expired]. I [also] got a bag of Veggie Straws, [...] [and] my daughter ate them. I didn't look at the date, so I just put them in [her] room [...]. And she texted me and was like, "Mommy, these veggie chips expired two years ago." I'm like "What?" [...] So now, I have to watch." - Respondent 4 (46, Black, Female, PA)

In one case, a participant noted that they wished pantry staff would ensure the food they are distributing is not expired. However, they had not raised this complaint to pantry staff as they felt they must be grateful to receive food, regardless of quality.

> "[Receiving expired items] happens a lot. [...] I think as many people as they have over there working, I think the [expired foods] should have been taken off the shelf. [...] They try to get [rid of] stuff that's dated, but sometimes it's so congested in there and maybe they forget to take it off [the shelf]. The stuff that I have gotten, many of the items were [expired], and I never brought it to their attention, because I was just blessed to have gone in there to get something for the day [...]" - Respondent 2 (64, Black, Female, PA)

A few participants expressed concerns about the safety of the food items they received from the pantry. For instance, Respondent 4 (46, Black, Female, PA) said,

> "[The expired foods] kinda freak me out. [...] Like [...] the cans of the chicken breasts in water. Those were expired, so when I saw that it made me say, "Oh, I got to go back home and check everything that I ever got there to make sure that I didn't pick up expired stuff before." And I didn't know, right? Because you can get botulism from the stuff that's in those cans. [...] So now I got to be careful. I didn't know they get down like that [with the expired food]. So now [that] I know that, I gotta watch [for] it. [...] I know some people don't mind, but [...] I don't like when you go, and they have a bunch of expired food. Last week I went, and it was some things that was from early March 2023. That freaks me out. That made me realize that I really had to start watching what I was picking up, [...] You know, we're going into 2025, and [this stuff] has a 2023 date on it. [...] It'd be one thing if it was a week old or the months just switched, but when it's almost two years old, that's

> a problem. [...] I'll be taking [the expired item] home to throw it in the trash."

Similarly, Respondent 2 (64, Black, Female, PA) stated,

> "I've gotten meat that was maybe a month expired, but I still use it because I was desperate. [...] Yeah, I do worry about [food safety] if it's expired and they're letting you have it. But it was frozen. Will I get sick? But I haven't gotten sick there."

Although several participants expressed frustration with their receipt of expired or spoiled foods at pantries, a few participants reported that the pantries they attended made concerted efforts to ensure the foods they were distributing were high-quality, brand name, and not expired. For example, Respondent 3 (75, White, Female, PA) said,

> "They monitor [the food]. [...] When you get meat there, it's usually really good. When I went through, I was looking at all the dates of everything, and the lady that ran it came, she said "we check the dates." [...] Like yesterday I went, and they always have spaghetti and they had the name brand San Giorgio spaghetti. It was thin spaghetti, and I just grabbed this [thing], and I didn't really look at it. I just went through and then when I came home, I said, "Oh, my God! I didn't check the dates." I checked them, and they were all like 2026. It was all good stuff, like it wasn't outdated."

Another participant expressed surprise at the high-quality of food they received from the pantry, stating they expected it to be low-quality foods that individuals or organizations wanted to write off.

> "I think everything's very good. It's never out of date.[...] The current dates on cans are good. [...] I was actually surprised, because I figured they want to get rid of that stuff, but they probably just write it off, anyway. [...] No [I have not been concerned about the quality of the food or spoilage]." - Respondent 6 (57, White, Male, PA)

Differences in Food Quality/Sufficiency by Location

Participants also highlighted differences in food quality and sufficiency by pantry location. One participant noted that wealthier neighborhoods tended to have higher-quality food items than lower-income neighborhoods. Respondent 4 (46, Black, Female, PA) expressed,

> "So I will say that because I'm in a township and the cost of living here is higher, that the donations that they get is better. [...] But my friend lives in [town name], and she said that she gets rotten stuff all the time. Especially if you grab meat, you need to hurry up and cook it. But they've never given me something rotten [here]. She said [...] in [town name], which is 20 minutes from me, they get rotten vegetables, rotten food, rotten turkeys, because she said they care less. [...] Out here, they will be more mindful of how long it's

> sitting out. It's not in the refrigerator there, it could have been out for hours, or something like that. So, like I said, it kind of depends, the better the area you live in, the better the food. No matter the donations."

Respondent 18 (46, White, Female, DE) also commented on the differences in food quality and sufficiency by pantry, noting that some pantries distributed mostly canned and pre-packaged items whereas others offered more fresh options.

> "Okay, so [the types of food] differ at different times [and by different pantries]. Sometimes all of them tend to be very meager, and then sometimes they have more than you can take. I want to say the [pantry name] has the biggest swing in stuff that you get from them. Sometimes, the majority of everything is canned stuff. They'll have maybe a can of salmon and a can of chicken instead of anything frozen or fresh. The other places, like the [pantry name], their stuff is all short date or post date foods, but there, [...] it's usually a bag of bacon and then a random array of all fresh or pantry items, not really any cans. And then the [pantry name] is basically all fresh stuff which I love. That's great, because a lot of that canned and prepackaged stuff is just not healthy for you." - Respondent 18 (46, White, Female, DE)

Food Options Not Aligned with Participants' Nutritional Needs

Participants reported that the foods distributed at pantries do not always meet their health needs. Specifically, participants expressed concerns about the high concentration of sodium in many of the canned options distributed by food pantries, stating they would prefer healthier options. For example, Respondent 18 (46, White, Female, DE) expressed,

> "They do give you a lot of stuff that's loaded in sodium. [...] Obviously they do have some low sodium cans, but most canned and prepackaged stuff is very high in sodium, preservatives, and things like that. I try to limit how many preservatives, colorings, and stuff because diabetes does run in my family, and I am overweight. So it's a concern that I try to stay away from. [...] But unfortunately, the low sodium stuff just tastes awful. [...] [...] I'm not the healthiest person in the world, and I don't eat the healthiest diet, but I think most people, in general, want to eat more fresh foods, and can't. I mean, canned foods are just when you don't feel like doing anything, and/or you don't have the energy to do anything, so you go pop open a can and heat it up. But in general, most people want something that looks like food."

Theme #3: Supportive Pantry Operations and Structures

Although several participants reported experiences of structural stigma at emergency food sites, many others mentioned supportive pantry operations and structures that made their experience more positive including simple administrative processes and helpful accommodations made by pantry staff.

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Simple Administrative Processes

Participants' perceptions of administrative processes were predominantly positive. Participants were particularly grateful for administrative processes that were simple and that minimized paperwork or ID requirements.

> "Fortunately, when I signed up for the Church [food pantry], I just had a very, very quick form to fill out that just said I would like to access this food [pantry] and sign my name. I didn't have to provide any income which is really really good, because that's very embarrassing and [...] I didn't have to do any of that. You just had to self report that you were under whatever the income was and that's all you did. And just signed it and then they give you a little [card]." - Respondent 8 (63, White, Female, PA)

Similarly, Respondent 5 (65, Black, Male, PA) stated,

> "You sign your name on a paper/tablet. No [we don't have to show an ID or any other documentation, so I am satisfied with the model]."

Respondent 16 (22, Black, Female, DE) echoed,

> "I think the simplicity behind the order form and the process that our [pantry] has is really important [for making it a positive experience]."

Although most participants reported positive perceptions of pantry administrative processes, one participant expressed that the collection of personal information made them uncomfortable, as they feared it would be used against them in the future. Respondent 18 (46, White, Female, DE) stated,

> "I wasn't happy about the [pantry name] doing the whole registration thing because you feel like it's going to be used against you. [...] At that time, it was literally just your information, your name, your address, whatever. I don't typically like that, but I was just like, okay, whatever because you feel like maybe they're going to use this against you at some point. It just feels some type of way. [...] For example, say that somehow my health gets better and I am able to participate again in society to the point that I did before or more, and things change. You just feel like you might be singled out or that information is going to get out and people are gonna talk about you. Or [it may] limit your chances for things. Like if I were to go with a company and they just show discrimination basically. [...] What I really liked about [the other pantry] was that they told you upfront before you went that no ID, no identifying information was needed other than just asking your first name. That's it, so that was really great."

Helpful Accommodations Made by Pantry Staff

A few participants noted that pantry staff made helpful accommodations to ensure a more positive experience such as offering shopping assistance if they had a physical disability or making accommodations so participants could avoid harsh weather conditions. Respondent 1 (58, White, Female, PA) said,

> "I'm very satisfied with the staff. [...] I really like a lot of things [...]. Now it's been cold out, and there's a gentleman that helps at the food entry. He always lets us go in and sit like in the hall in a chair to keep us out of the cold. It's very helpful. [...] Tonight, he was telling us when it starts getting colder they're going to start opening up the churches at 3:30pm for the food pantry, and then you have to wait until 5pm. But at least they'll let you in to sit where it's warm so that you're not out in the cold. And they said when it's poor weather they're gonna try to accommodate people who walk and don't have transportation. They'll tell you what they have, and you can get it delivered. Like me, because I don't drive, and in really bad weather, they don't want us walking."

Discussion

This qualitative study found that structural stigma is a persistent issue within emergency food program environments impacting both participant access and quality. Regarding inequitable access, participants reported common issues such as long wait times, limited agency over food choices, and accessibility challenges for individuals with physical disabilities. Further, participants described situations where long wait times, which could occur in harsh weather conditions, and a lack of accommodations for individuals with physical disabilities, implicitly communicated that their time and needs were not valued, and contributed to frustration and discomfort. The data presented provides important insight into how these logistical challenges, sometimes unintentionally, contribute to unwelcoming and difficult to navigate environments, which in turn deter participants from returning to pantries. Findings also suggest important opportunities for helping to guide pantries and support policy efforts to address limitations.

Findings also align with broader research on the role of structural stigma in public health, which demonstrates the ways in which systemic access barriers lead to the de-prioritization of those seeking assistance, amplifying feelings of exclusion and perpetuating health inequities.[16,17] As the field begins to advance its awareness of the significance of structural stigma and the factors driving participant experiences within emergency food environments, specific approaches to intervention and measurement are needed. Recent studies show that within healthcare settings, for example, there is a recognition of the importance of routinely monitoring structural stigma with audit tools, scales, or checklists to gauge progress and advance equity.[17] Adapting these tools or developing aligned measures for use in emergency food assistance settings would improve program administrators' ability to understand and modify infrastructure and operations (i.e., wait times, accessibility of facilities, need for assistive technology) to better support the needs of all clients, while also advancing the field through measurement alignment.

The erosion of autonomy is another mechanism of structural stigma often described in this study. Choice-based food pantry models, which allow for agency in selecting foods aligned with dietary

needs and preferences and counteract the disempowerment associated with rigid, pre-packaged distributions, are articulated here, and have been established in the literature, as a preferred strategy for clients.[28,29] Despite the use of one common term (i.e., choice), the actual approach to providing choice in food selection varies considerably across pantries. For example, the Akron-Canton Regional Foodbank highlights four primary types of choice pantry models: 1) supermarket model, 2) table model, 3) window model, and 4) inventory list model.[30] On the surface, supermarket and table models offer the most agency of the choice models as they allow clients to walk through the pantry and choose their own food items off of shelving units or tables. Window models allow participants to select the items they would like by pointing to items for staff to package from outside of the pantry. Inventory list models, in which clients select items off of a list of available food options and pantry staff assemble the order, potentially offer the least agency of the choice models. These variations give rise to additional considerations regarding the ways in which choice pantries are applied, and if some approaches may do a better job than others at addressing structural stigma.

A majority of participants in this study described a preference for full choice models (i.e., supermarket and table models) as they allowed clients to choose foods that best aligned with their cultural and religious preferences, food allergies, and nutritional needs. However, a few participants noted that other choice models (e.g., inventory list) or traditional pantry models (e.g., pre-packaged drive through pantries) are better suited to meet the needs of clients with physical mobility limitations. It is also worth noting that "choice" pantries became recognized as a best practice over the past 20 years, and today are widely adopted.[28,29] Studies which help to describe the process by which choice pantry methods were communicated nationally, and ultimately adopted as a best practice, may also help to inform similar next steps in the area of structural stigma.

In addition to inequitable access, structural stigma was also manifested through quality constraints. For example, many participants reported receiving expired or spoiled foods, which they described as frustrating, insulting, and dismissive of their dignity. Food safety concerns were also raised by participants. These results are buttressed by similar research demonstrating that receiving poor-quality or undesirable food from pantries reinforces feelings of shame and unworthiness among recipients.[11,24,25,31,32]

Efforts to address quality constraints have been undertaken nationally through a variety of methods, including through the implementation of quality standards, such as nutrition policies and food safety plans, which can be disseminated to donors to emphasize the dedication to food quality for clients.[33,34] It is unclear, however, how such standards are monitored, and whether emergency food boards, for example, have adequate knowledge or resources to measure progress toward standards, or identify areas of critical need. Another way in which states have addressed food quality is through efforts to prioritize policies and funding streams that create direct distribution channels between local growers and pantries, thereby improving the freshness of pantry foods by decreasing transportation and storage time.[34] State-level funding has also been allocated toward grants for pantries, ensuring they have access to appropriate infrastructure (e.g., cold storage) to ensure limited spoilage of non-shelf-stable foods. Tax incentive policies for food processors, retailers and distributors are another potentially important approach to ensuring a steady flow of healthier foods; however, many do not currently consider food freshness or quality, and may need to be re-evaluated with this lens.[34,35]

Finally, administrative processes are a long-standing issue within many social service areas, including emergency food. Simple sign-up and sign-in processes, along with welcoming, supportive, and accommodating staff, are critical to reduce usage barriers. Prior research demonstrates that extensive verification requirements (e.g., ID requirement, proof of employment, residence, or poverty) dissuade many individuals from seeking needed food assistance, particularly among the most vulnerable populations, such as immigrants.[9,11] To mitigate these burdens, efforts to reduce or eliminate verification requirements have been recommended.[9]

Limitations and Future Directions

Despite the potential utility of findings regarding structural stigma within emergency food assistance settings, our study is not without limitations. The study sample was small and included predominantly English-speaking women in Pennsylvania and Delaware who actively participated in emergency food assistance at the time of the interview, thus limiting the generalizability of study findings. It is likely that newer immigrant families, and those who speak languages other than English or Spanish have different experiences which are not fully captured here. In addition, our study is limited to emergency food pantries in community settings, where participant experiences are likely very different from pantries in other settings such as hospitals or schools. Additionally, although this study captures important qualitative data, further research is needed to quantify the impact of structural stigma on food insecurity outcomes, perhaps with the development and testing of a measurement tool enabling the assessment of scores for specific criteria. Longitudinal studies could also evaluate the impact of changes to pantry systems and policies on diet, mental health and food insecurity as well as other social determinants of health which may be closely related to issues of food security or dietary quality.

Public Health Implications

The findings from this study underscore the urgent need to address structural stigma within emergency food systems. Interventions such as adopting full-choice pantry models that maximize client agency, developing and routinely using structural stigma measurement tools, implementing accessible, participant-centered infrastructure, and enforcing food quality standards are imperative for reducing structural stigma. Additionally, policy initiatives that prioritize infrastructure improvements (e.g., cold storage grants), direct partnerships with local growers, and revisions to tax incentives to emphasize food freshness and quality could further strengthen emergency food programs.

Simplifying administrative enrollment processes and eliminating unnecessary verification requirements are also essential for reducing access barriers, particularly among marginalized populations. Beyond research and policy action, these findings highlight opportunities for community engagement. Local stakeholders, including volunteers, donors, and community organizations, play a vital role in advancing equity within emergency food systems. Partnering with or contributing to local food banks—through donations of time, funds, or fresh produce—can help strengthen infrastructure, improve food quality, and support client-centered practices that uphold dignity and reduce stigma. Beyond research and policy action, these findings highlight opportunities for community engagement. Local stakeholders, including volunteers, donors, and community organizations, play a vital role in advancing equity within emergency food systems. Partnering with or contributing to local food banks, through donations of time,

funds, or fresh produce, can help strengthen infrastructure, improve food quality, and support client-centered practices that uphold dignity and reduce stigma. By addressing structural barriers related to accessibility and quality, emergency food assistance programs can improve participant dignity, support health equity, and ultimately advance the public health impact of food assistance programs.

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