A SCHOOL-BASED COMMUNITY KITCHENS PROGRAM AS A STRATEGY FOR PROVIDING FOOD AND NUTRITION-RELATED AND PSYCHOSOCIAL BENEFITS TO INNER CITY FAMILIES

by

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Abstract

Problem: Inner city school families are vulnerable to poor nutrition. This study was conducted in inner city schools to address the following research questions: What perceived benefits, in the areas of food, nutrition and psychosocial well-being, can small, school/community-based health promotion programs provide? How do such programs operate – what are their goals, strategies and challenges? How can their perceived benefits be interpreted in terms of health promotion theory?

Methods: A qualitative, responsive evaluation approach was used to examine a community kitchens program, "Cooking Fun for Families," in eight elementary schools in Vancouver, Canada, over a two-year period (2001-2003). All programs served adults; some also included children. Data consisted of program observations (n=75); interviews with adult participants (n=27), staff (n=13) and administrators (n=13); document review (staff sessional evaluation forms, n=29); and an adult participant questionnaire (n=88). The study examined how the program model was implemented and the perceived benefits of the programs. Findings were interpreted within a health promotion framework.

Findings: The clientele were ethnically diverse and the majority suffered from food insecurity. Program implementation: From 4-15 adults cooked together weekly or bi-weekly, under the guidance of a facilitator. Some programs also provided instruction and activities for children. Several programs culminated with a shared meal. The programs addressed numerous issues, such as healthy eating on a budget, safe food handling, encouraging children to eat more fruit and vegetables, involving children in food preparation, and social and cultural isolation/integration. The small, intimate, inclusive, engaging, sensitive and non-threatening nature of the programs supported the development of perceived benefits in food-related and psychosocial areas. Main perceived benefits: Food-related skills and competencies, social integration and positive health/psychosocial well-being increased for adults. Healthy eating attitudes and behaviours and food preparation skills increased for children.

Conclusions: The programs applied current strategic health promotion strategies of enhancing (healthy-eating) health literacy, strengthening social networks and providing a supportive environment. The food/nutrition and psychosocial perceived benefits of the programs occurred in conjunction with each other. This type of program holds promise for increasing healthy eating skills, attitudes and behaviours and psychosocial well-being among inner city children and their families.

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Chapter 1: Introduction

There is a scarcity of evaluations in the academic literature that discuss the perceived food and nutrition-related and psychosocial benefits of small, local, school/community-based health promotion programs for vulnerable[1] populations. The theoretical bases of these small programs are often not well articulated and program goals and objectives may be unclear or may shift over time in response to program clientele and staffs' understanding of the clientele's changing needs. What can health promotion researchers learn from these types of "on the ground" programs about how they operate and what they are perceived as accomplishing? To answer these questions in regards to one such program, this study examines a school/community-based health promotion program called "Cooking Fun for Families" (CFF).[2] CFF aims to support vulnerable families whose children attend inner city schools in Vancouver, Canada, with a focus on encouraging healthy eating as well as providing opportunities for psychological and social support. It takes place within an inner city context of poverty, and serves a clientele that consists of multi-ethnic/language-group families. With this heterogeneous group that likely encompasses a wide range of needs, the program implements the new public health/health promotion approach of shifting the focus from disease prevention to building capacity for health (Kickbusch, 2003). That is, it does not focus on particular health problems or disease prevention *per se*, but rather has a broader focus on supporting "positive health" – health as a resource for living – as it has recently been defined by the World Health Organization and articulated within the fields of health promotion and public health (Locker & Gibson, 2006; Raeburn & Rootman, 2007). The study uses a responsive evaluation approach (Stake, 2004; 2008) to examine the implementation of the CFF program and its perceived benefits, as articulated by program participants, staff and

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[1] "Vulnerable" refers to the fact that these individuals are particularly at risk of poor health outcomes due to a variety of social, economic and/or cultural factors (Czeresnia & Soares, 2008).

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administrators. More broadly, the study aims to address questions about how health education and health promotion actions that are developed and instituted at the local community level can be understood in relation to health and nutrition education aims and principles, and health and social outcomes in health promotion theory.

Small, community-based programs are often developed and endorsed by local communities in response to perceived needs within the community. One frequently perceived need within poor inner city communities relates to residents' insecure relationship with food and healthy eating. Good nutrition is a prerequisite for good health. However, many children and their families who live in poverty in Vancouver's inner city areas and elsewhere may not be consuming healthy diets, as numerous studies show that it is difficult to consume a healthy diet while living in poverty (Ezzati et al., 2005; Vozoris, Davis & Tarasuk, 2002; Vozoris & Tarasuk, 2004; Williams et al., 2006; Young, 2004). Children growing up in poverty may, therefore, be at risk for developing nutrition-related short-term and longer-term health problems (e.g., obesity, heart disease, diabetes, high blood pressure, hypertension, osteoporosis, food allergies and some cancers) (McKinley et al., 2005; Robinson & Booth, 2004; Seligman, Laraia & Kushel, 2009; Vozoris & Tarasuk, 2003). Children's ability to concentrate on learning at school may also be affected by poor nutrition and/or their feelings of lack of control over being able to have their basic food-related needs met (Connell, Lofton, Yadrick & Rehner, 2005; Kleinman et al., 1998; McKinley et al., 2005; Murphy et al., 1998; Robinson & Booth, 2004). Furthermore, lack of concentration at school is likely to negatively affect children's future life chances. For some children living in poverty in Vancouver, compounding the risks related to growing up in poverty is their status of recent immigrancy, with the social exclusion and lack of access to health-related information that often accompanies a move to a different cultural and language milieu. Although

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[2] The name "Cooking Fun for Families" refers to the generic program model, which is considered to have been implemented by each of the eight programs studied in this research.

many new immigrants are in good health when they first arrive in Canada, their health tends to deteriorate over time as they adopt dietary practices of the mainstream culture (Hyman & Guruge, 2002), either out of choice or necessity.

Many players have come to the table to try to ameliorate the nutrition-related effects for children of growing up in poverty. In Vancouver, the school district has been a major contributor and partner with the provincial government and others in providing extra food to children who attend inner city schools (e.g., with breakfast, lunch and snack programs). The Cooking Fun for Families program was conceived in the mid 1990s as an educational adjunct for families to these types of feeding programs. CFF is an extra-curricular program that takes place outside of the classroom and involves parents, either with or without their children. It operates in the format of a "community kitchens program," a type of community-based nutrition program in which participants cook together, learn from each other, and often eat together, on a regular basis. The CFF program modifies the traditional community kitchens format somewhat to include a facilitator whose role is educational and supportive. CFF aims to provide hands-on knowledge, experience, motivation and social support related to healthy eating, and to take place within a comfortable, enjoyable, supportive social situation (known as an "environment" in health promotion terminology). Parents are also encouraged, as part of the program, to engage with their children in food-related activities at home, in order to build children's food-related knowledge and skills and to strengthen family cohesion.

Schools are an important setting for the new public health/health promotion, which seeks to engage other players besides health agencies in producing and supporting health (Kickbusch, 2003) and to provide opportunities for citizens to take action and produce social change affecting the social determinants of their health (Coburn et al., 2003). Schools provide an environment that can be targeted for change related to social processes. They are one logical choice of setting for health promotion programs since they are perceived as supporting positive values relating to

health and education, are accessible to a broad population base, and provide the opportunity to positively influence children's health-related habits, which are known to persist into adulthood (Poland, Green & Rootman, 2000).

Although CFF had been implemented in a number of Vancouver schools over several years prior to the conception of this research, it had not been subject to systematic evaluation. I had been involved in the development of the program and therefore knew of it, and was interested in understanding the potential of this type of small-scale school/community-based health promotion program for contributing to the well-being of inner city school families. I therefore chose to conduct an in-depth examination of the program for my doctoral research.

To more fully introduce the rationale, context and purpose of the research, in the remaining sections of this chapter I discuss core principles of health promotion theory as they relate to community-based programs, give a description of the setting in which the CFF program was developed and operates, and describe the development and structure of the program. I then specify the research purpose, approach and significance; discuss my dual role as initially, program developer and later, program evaluator; and finally, briefly outline the contents of the remaining chapters.

1.1 Health promotion theory and small community-based programs

The overarching goal of health promotion is that of health and social equity within populations, with the reduction of health inequities among population groups as the ultimate force directing public health programs, policies and activities. This translates into a pursuit of means to support and facilitate the achievement of similar or equitable levels of health and social outcomes (at the highest levels possible) by population subgroups with dissimilar (and often truncated) life opportunities (Commission on Social Determinants of Health, 2008; Eakin, Robertson, Poland, Coburn, and Edwards, 1996; Labonte, 2004; Potvin, Mantoura, and Riddle, 2007; World Health Organization, 1986).

Health promotion actions with the ultimate goal of increasing health equity or reducing health disparities[3] within the population are thus often targeted to "vulnerable" groups – those who are less healthy, or at risk of poorer health, than others, due to circumstances (e.g., economic, social, daily living) which are less than ideally supportive of health. According to the distributive justice philosophy supported by the original health promotion document, the Ottawa Charter (Potvin, Mantoura, & Ridde, 2007), "priority should be given to improving the situation of the most socially disadvantaged in a society" (Rawls, 1971, 1981, as cited in Starfield, 2006, p. 3). Health inequities result from a lack of resources and opportunities to participate equally in society (Raphael, 2004a, p. xi). Equity therefore must be supported by an unequal distribution of resources to try to equalize the levels of resources between disparate groups: "Equality in outcome demands inequalities in opportunity" (Labonte, 2004, p. 261). However, fully achieving the goal of health equity in most countries or jurisdictions would require complicated and extensive restructuring of economies and social conditions. Nonetheless, small programs developed within communities can contribute toward attaining this broad goal by acting from a "bottom up" perspective and targeting programs to the most vulnerable population groups. Small locally-developed and implemented programs are in an advantageous position in this respect for a number of reasons: they are able to be responsive to the communities' changing and varied needs and circumstances with tailored personal attention for supporting education, skill development and motivation; they can provide for the time needed for the give-and-take that is necessary for encouraging clients' development of a sense of agency, ownership, control and empowerment; they operate within clients' local sphere of familiarity and comfort; and they function from a position of connectedness with local networks and services that they can integrate into their service delivery to clients.

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[3] Health inequities and disparities refer to differences in health that are considered preventable and are therefore seen as unfair (Braveman, 2008).

The CFF program model was developed using a combination of theories, including Social Cognitive Theory (Bandura, 2000; Baranowski, Perry & Parcel, 1997), the Precede-Proceed Program Planning and Evaluation Framework (Green & Kreuter, 1991), and health promotion theoretical constructs such as community development, empowerment and participation (Labonte & Laverack, 2001; Laverack, 2004; Raeburn & Rootman, 2007; Raphael, 2001; Wallerstein, 1992). The programs are structured to apply the intensive and personalized health education methods needed to support the involvement of vulnerable, disadvantaged families. These types of educational resources are needed to level the playing field in terms of achieving equitable outcomes. The program's intent is to put health promotion theory into practice by contributing to community building, community development and individual capacity building (key strategies of health promotion [Raeburn & Rootman, 2007]), based on the directive of the Ottawa Charter for Health Promotion to "develop personal skills, create supportive environments, and strengthen community action" (World Health Organization, 1986, pp. 2-3).

Health promotion aims to support and facilitate health, and health equity between population groups, by addressing what have been labeled "determinants of health." Four broad elements of the determinants of health – human biology, lifestyle, environment and health care organization – were first articulated in the "Health Field Concept" of the Lalonde Report in 1974 (Raeburn & Rootman, 1998, p. 4). Lifestyle referred to determinants that people could individually and personally affect, such as eating and exercise habits, while environment referred to the physical, social, cultural and economic milieux in which people live and work (Nutbeam, 1997; World Health Organization, 1986). More recently, conceptions of lifestyle and environment have become more enmeshed, since it has been recognized that lifestyle factors are complexly determined and are not always under the control of individuals independently of

environmental factors (Kickbusch, 2003). These concepts will be discussed in more detail in

Chapter 2.

A model used by the World Health Organization and others to enable understanding of

relationships between different levels of health promotion program elements and impacts is the

Outcome Model for Health Promotion (Nutbeam, 2000a, p. 262) (see Figure 1).

| Health and Social Outcomes | Quality of life, functional independence, equity |
| | Mortality, morbidity disability |

| Intermediate Health Outcomes | Healthy lifestyles | Effective health services | Healthy environments |

| Health Promotion Outcomes | Health literacy | Social influence and action | Healthy public policy and organisational practice |

| Health Promotion Actions | Education | Facilitation | Advocacy |
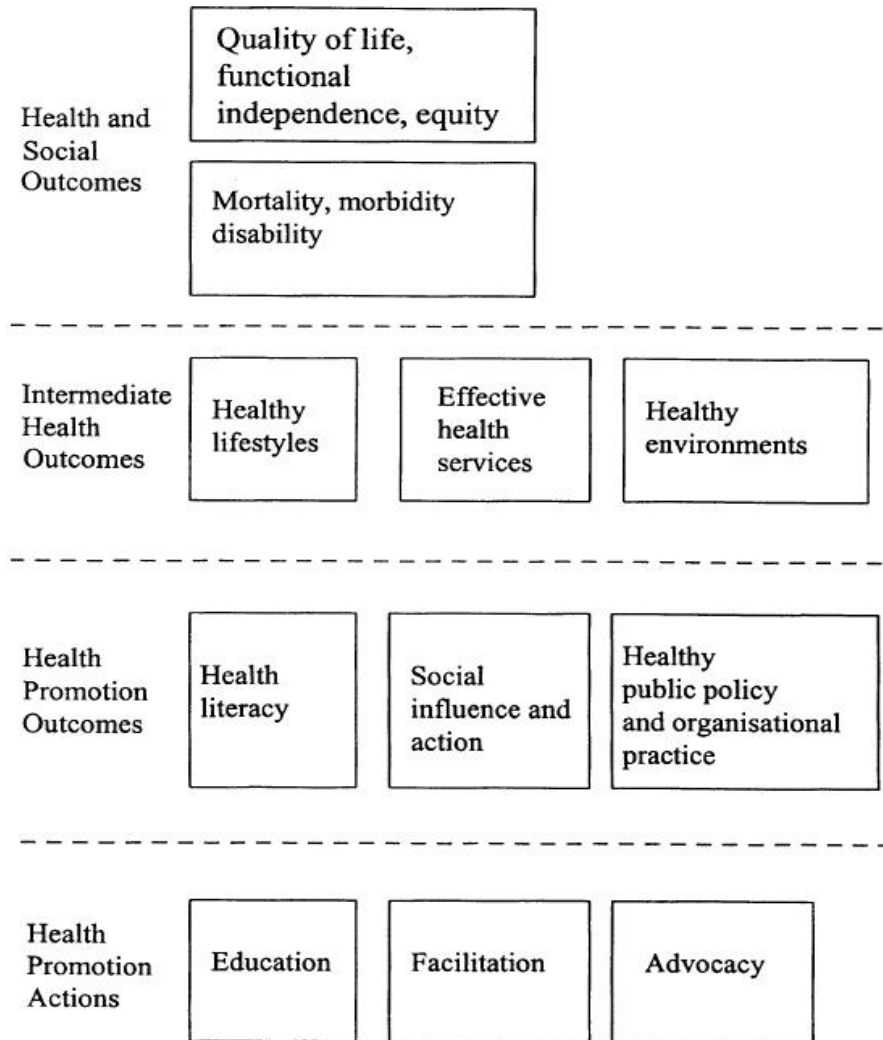
Figure 1: An Outcome Model for Health Promotion*

*Note. From "Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century," by D. Nutbeam, 2000, *Health Promotion International, 15,* p. 262. Copyright 2000 by Oxford University Press. Reprinted with permission.

In the Outcome Model for Health Promotion, health and social equity between population groups is at the highest level of health promotion outcomes. Because of the length of time sometimes needed to affect the determinants of health, and since the achievement of equity in health and social outcomes may be influenced by a number of determinants of health, it is often difficult to directly associate health and social equity outcomes with actions at the level of small community-based health promotion programs such as CFF. To clarify the role of determinants of health at a number of levels and aid in the evaluation of health promotion programs, the Outcome Model for Health Promotion differentiates two levels of health promotion program outcomes below the ultimate goals of health promotion. These are intermediate health outcomes (modifiable determinants of health) that are directly below the ultimate health and social outcomes in the Model, and health promotion outcomes (intervention impacts which may influence the modifiable determinants of health) that lead (up) to the intermediate health outcomes in the Model.

The value of using this model in seeking to understand the impact of health promotion programs and actions is that evidence which is sometimes very difficult to acquire, such as evidence directly linking health education or community development actions with reduced morbidity and mortality, is not required in order to show a positive difference (or not) resulting from a health promotion action. For the purposes of understanding the perceived impacts of the CFF program, for example, links can be made, based on previously existing evidence, between health promotion actions, health literacy, healthier lifestyles and ultimate health and social outcomes, to support the belief that perceived benefits of the CFF program (or of any small community-based program) are positive influences, at the outcome level on which they occur, on the ultimate level, in the Outcome Model for Health Promotion, of participants' health and well being.

Levels of education, literacy skills, and, in particular, health literacy,[4] are increasingly being recognized as significant determinants of health and of health equities/inequities between population groups (Nutbeam, 2000a). Health literacy is a relatively new concept that summarizes knowledge, skills and abilities, attitudes, motivation and self-efficacy related to one's ability to access and understand information and act on it in ways that promote and maintain health (Nutbeam, 2000a). These cognitive and social skills and abilities include basic literacy skills, but also interactive and emancipatory skills and states. While the earlier focus of health literacy was on illness-related behaviour and coping with medical situations, the most current model of health literacy expands the concept to include a focus on "health literacy as an asset" for life, suggesting that health literacy assets can move beyond supporting disease prevention and illness care to encompassing supporting positive health and well-being (Nutbeam, 2008). This study uses the Outcome Model for Health Promotion to assist in organizing and understanding the research findings, and uses the latest conceptualization of health literacy as an asset, in particular, as a framing and integrative concept for interpreting the study results as a whole.

Other concepts are also useful in understanding the role of a variety of social and economic factors in promoting health. Recent studies focus on both an absolute and a relative lack of resources, as well as inequities in the distribution of resources, as contributing to health inequalities. This understanding of the role of resources in health is now being widely applied to policy and program development, using the twin concepts of social exclusion and social inclusion (Cameron, 2006; Campbell & Jovchelovitch, 2000; Labonte, 2004), where social exclusion is seen as resulting from a lack of the resources needed by citizens to participate fully in their societies on an equal basis with others. The key health promotion concept of "participation" can also be understood, with respect to the determinants of health inequalities in

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[4] Health literacy is a health promotion outcome or an intervention impact in the Outcomes Model for Health Promotion.

sub-population groups, as a facilitator of health, but its achievement is thwarted for these groups by an exclusion from the opportunities to attain adequate amounts of resources to allow them to participate equally in society (Campbell & Jovchelovitch, 2000). Health inequities are said to result from a variety of types of exclusion; they result from "citizens experiencing systematic material, social, cultural, and political exclusion from mainstream society" (Raphael, 2004b, p. 4). Programs for vulnerable population groups can aim to affect some of these excluding factors and thereby to increase equity between groups in regard to the affected factors, facilitating their integration into mainstream society and thus producing more life opportunities for them. Other social and psychological constructs, such as social integration, social networks, social support, sense of mastery, sense of belonging, and empowerment are also relevant to this research, as they are both supportive factors to healthy eating and health literacy, as well as being directly linked to health and well-being. In Chapters 5 and 6, I discuss how the concept of health literacy as an asset can be used to combine and integrate the study findings in relation to the concepts and constructs of health promotion discussed above.

1.2 The inner city context of the CFF program

The CFF program was developed and operates in an area of significant poverty and disadvantage in Vancouver, Canada. Poverty is negatively associated with health status in many research studies (Ledrou & Gervais, 2005; Williamson & Reutter, 1999), and correlates with inequalities in health (Potvin, Mantoura, and Ridde, 2007; Starfield, 2006). There are many ways in which poverty affects health (Lynch, Kaplan, & Shema, 1997). Of importance to CFF participants, who were mostly women, Rice and Newsome Wicks (2007) found that "[p]oor women, in general, have more psychological risk factors such as low self-esteem and self-efficacy and high levels of depression, and are more likely to rate their health as fair or poor" (Rice & Newsome Wicks, 2007, p. 222). Although several different measures of poverty are used in Canada, the most commonly used are Statistics Canada's Low Income Cut-offs (LICOs),

data which have been collected for the past 30 years and which "have served as rough poverty lines in the absence of an official poverty line" (deGroot-Maggetti, 2002, p. 15). According to this measure, a significant proportion of Canadian children, including children in British Columbia, grow up in households that struggle to meet basic needs. As of the year 2006, (the latest year for which figures are available), British Columbia had had the highest child poverty rate in Canada for the past five years (First Call, 2008). The poverty rate for children in British Columbia increased over the five years from 2001 to 2006 (Klein et al., 2008), even though these were "good years" economically in the province. In 2006, the child poverty rate in British Columbia stood at 21.9% according to First Call, and at 16.1% according to Klein et al. (these differences refer to the calculation of rates based on before- or after-tax income, respectively).[5,6] Factors associated with child poverty include living in a lone-parent family, and/or at least one member of the family being: urban Aboriginal (on-reserve Aboriginals are not part of the same census), of a visible minority group, a recent immigrant, or having a disability (First Call, 2006, p. 11). These factors apply to a large percentage of the population in the low income areas served by the CFF program.

One of the most basic human needs is for adequate food and nutrition. Poverty is inextricably bound to deprivation, including a compromised relationship to food:

> Low-income children and their families are likely to experience chronic food insecurity. Families reduce the quantity and quality of food they purchase; they eat fewer fresh vegetables and fruit, rely upon food banks …. Mothers frequently compromise their food intake at regular monthly income cycles. (First Call, 2007, p. 1)

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[5] Not only are approximately one-fifth of British Columbia's children living in poverty, the depth of their poverty is also increasing. In 2006, "average incomes for both female lone-parent families and two-parent families with children living in poverty were more than $11,000 below the LICO poverty line" (First Call, 2008, p. 2).
[6] In Vancouver, many very poor families are clustered in several neighbourhoods in the north-east corner of the city, sometimes called the "Downtown Eastside," and widely known for its poverty and social problems. Most of the CFF programs examined in this study are situated in this area of Vancouver.

Food insecurity is defined as "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so" (Kirkpatrick & Tarasuk, 2008, p. 324). A significant number of households with children in Canada, including in British Columbia, are suffering from food insecurity, including not having enough food to eat (Health Canada, 2007) (see Chapter 2 for more details). A release from poverty, according to the LICO approach, includes "adequate economic resources to meet food, shelter and clothing needs, and to participate meaningfully in society" (Williamson & Reutter, 1999, p. 3e). Participating meaningfully in society, the basis of social inclusion, involves, among other things, being able to meet material needs, such as acquisition of the food necessary for a healthy diet, in non-socially stigmatizing ways.

Because of the depth of poverty and food insecurity in Canada, school-based subsidized feeding programs (lunch, breakfast, snack) have been implemented in many provinces. The Vancouver School Board's hot lunch program feeds several thousand students each school day. The ethnic composition of the Vancouver School District includes a large proportion of students who are potentially vulnerable to poverty and food insecurity. There were, in 2005 (the latest year for which these statistics are available), approximately 57,000 students in Kindergarten to Grade 12, of whom 61% spoke a language other than English at home (at least 110 different languages were spoken among the students). Two thousand Aboriginal students comprised about 3.5 % of the student body. As noted above, both urban Aboriginal and recent immigrant families are structurally and socially disadvantaged in Canadian society and many of them suffer from poverty and food insecurity. The Vancouver School District includes some of the most impoverished "inner city" neighbourhoods in Canada (Human Early Learning Partnership, 2005), and in 2005, unfortunately, the District Report stated that the spread of poverty was increasing among its children and their families. That year, 16% of the District's school children participated in a free or subsidized school meal program (District Review Team, 2005, p. 2).

The majority of the families that attend CFF programs are refugees, immigrants or urban First Nations. One common denominator these families share is that they are facing, or have recently faced, changes in regard to their diets. For First Nations families, many of their traditional foods are unobtainable, while for many new immigrant and refugee children, participating in the school meal programs presents a dilemma of adjusting to new foods that they and their parents know little or nothing about. A gap exists in terms of providing information, knowledge and skills pertaining to healthy eating within the dominant food system that these families are entering. Exacerbating this is the fact that most of these families, by definition as being "inner city," are facing severe economic constraints that impact on their ability to provide adequate nutrition for their children.

1.3 Background to the development of the CFF program

During the 1970's, school personnel in several large cities in Canada, including Vancouver, were concerned about the impact of poverty on their students' ability to learn (Herron, 2001). Teachers in Vancouver reported "apathy, alienation and [a] sense of helplessness" among students and their families who were living in poverty in degraded neighbourhoods[7] (Herron, 2001, p. 3). These educators lobbied for many years for hunger alleviation for children in schools in this locality. As a result, in 1992, the Vancouver School Board's free hot lunch program for inner city school students was instituted. The achievement of the hot lunch program spurred a community nutritionist associated with the school board to question whether more intensive nutrition intervention and support would be appropriate for these families, and the research that led to the development of the CFF program was born.

CFF was developed from 1994-6 through participatory action research involving the university, with myself as the research assistant/program developer on the project, and a number

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[7] in the areas that later became labeled as "inner city."

of community agencies and institutions.[8] To adhere to participatory action research principles, all levels of the school and community, including students and parents, teachers, administrators and support staff, were involved in planning, developing and implementing the program. The developers attempted to incorporate the principles and goals of health promotion as well as the principles of adult education (Imel, 1998) and lifelong, self-motivated learning (Cameron, 2006; Rickard et al., 1995) into both the development process and the program template. The Ottawa Charter for Health Promotion, a key document in health promotion, recommends using a multifaceted approach when creating health promotion programs for vulnerable populations such as these, with foci on creating supportive, nurturing environments, building personal skills and capacity, strengthening community action (empowering communities), and building public policies that foster greater equality (World Health Organization, 1986).

To facilitate the accomplishment of these types of goals, the program developers opted for creating a program model that could be adapted by implementers, with the broad health promotion goals of facilitating participants' empowerment, autonomy, and personal control over determinants of their health, but without specifying exact goals or curricula. The ultimate goal of the program is to facilitate healthy diets for both children and their families. Once the program concept was developed and tested, it was disseminated throughout Vancouver's inner city elementary schools. A program guide, "Cooking Fun for Families Programs" (Crocker & Milligan, 1998) (referred to hereafter as the "CFF Program Handbook"), gave ideas for others to consider when planning and developing the program. The overarching goal of the CFF program as stated in the CFF Program Handbook is "to support inner city families' physical, emotional and social health" (p. 1); specifically, to support the enhancement of inner city families' food and nutritional intake; participants' family cohesion; and families' social integration into the school

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[8] Collaborators included the Vancouver School Board, the Vancouver/Richmond Health Board, the Vancouver Board of Parks and Recreation, the Vancouver Food Bank, and the Institute of

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and community "through increased personal capacity and social and community integration" (Crocker & Milligan, 1998, p. 1). Each school that chooses to implement the CFF program takes on the responsibility of adapting it to its own context.

The CFF program fits into an organizational structure within Vancouver's inner city schools called the "Inner City Schools Project," instituted in 1988 (Herron, 2001). This Project provides additional funds accessed from the provincial government for staffing, programs and services to schools in Vancouver that are designated as inner city schools. The overarching goal of the Inner City Schools Project is to work towards equitable educational outcomes for inner city students (i.e., equitable compared with students living in wealthier areas of Vancouver). This goal statement resonates with health promotion's social justice-oriented goal of equitable health outcomes in populations. The Inner City Schools Project's goal of equitable outcomes is to be achieved by: implementing strategies and activities that work towards enhancing the social development and self-esteem of students; encouraging parent and community involvement in the schools to bring families, the school and the community into a seamless support network for the children; and promoting language development for both students and their families (Overgaard & Jenson, 1999, p. 4). The additional (non-classroom based) staff provided through the Inner City Schools Project funds usually consist of a teacher, called a project teacher, a youth and family counsellor, a staff assistant for primary classrooms, and a Neighbourhood Assistant. The Neighbourhood Assistant (NA), who is often someone who lives in and knows the neighbourhood well, is the staff person who most often develops and implements CFF programs in the inner city schools, and is very important to this research. These additional Inner City Schools Project staff work with other out-of-classroom staff in the school, such as multicultural support workers, other counsellors, and the principal and vice-principal, to organize and deliver additional programs (such as CFF) and services to families.

1.4 "Cooking Fun for Families" program model description

The CFF program uses a "community kitchens" format, which involves a group of people preparing one or more meals together that they will either then eat together or take home. The motives of planners, funders and participants in community kitchens programs may be financial (economies of scale, pooling of labour) or, as in the case of CFF, more social and educational. Although the most common community kitchens program model involves participants preparing several meals that are taken home and frozen for later use (also known as a "collective kitchen" program – to be explained in more detail in section 2.3.2.1 below) (Engler-Stringer & Berenbaum, 2005; Tarasuk & Reynolds, 1999), this is not the focus of CFF programs. Instead, the focus in CFF is on learning new recipes and how to prepare healthy, nutritious meals and snacks (while taking financial limitations into account), and also on social and recreational elements. Most of the CFF programs include participants eating the meal they have prepared together. Most also usually send food home with participants who would like it (for example, prepared recipes for families to taste; ingredients to allow participants to recreate the meal at home, left-over food, or food acquired by the staff specifically for distribution to the families).

All CFF programs take place in public spaces; most often schools, but occasionally, a community centre connected with a school. Some programs take place solely during the school day, while others last into the early evening. Most programs run three 9- or 10-week sessions per year, while the others run once every two weeks or twice monthly throughout the school year. Most programs are "universal," open to all school parents on a drop-in basis. Half of the programs, however, referred at least some parents/families to the program. The programs involve from about 4-15 parents each week. Most of the programs involve children in some program activities. All the programs are provided free of cost to the participants. A key to being able to implement CFF programs is the ability to access funds from outside the school system to pay for food and equipment, and for staff, if they are not inner city school Neighbourhood Assistants. A

round figure estimate of the cost to hold the program for thirty weeks during the school year, including paid outside staff, is from $5,000 to $6,000 per year. If the staff costs are covered by the Inner City Schools Project, the cost can be much less, and particularly if donations from the Food Bank are used.

1.5 Purpose of the research and methodological approach

The broad purpose of this study is to contribute to identifying innovative program models for supporting nutritional health in vulnerable inner city populations. Specifically, this study aims to examine a unique, small, school/community-based and developed health promotion program called Cooking Fun for Families, to ascertain the types of food and nutrition and psychosocial benefits it is perceived as providing to participants, and to characterize the program structure, format and operations in order to demonstrate how a generic model can be specifically implemented at the school/community level in different sites. The research utilized a responsive evaluation approach and addressed the following specific objectives:

1. To identify the goals, objectives and expectations that parents, staff and administrators hold for the CFF programs, and to understand how the program model is implemented in different sites, including identifying strategies used to achieve the desired goals and the supports and challenges experienced by those who implement the program;

2. To describe parent, staff and administrator perceptions regarding the program benefits; and

3. To situate these perceptions in relation to existing theory and literature and to comment on their implications for practice, policy and research.

The evaluation approach used in the study, responsive evaluation, is often used to examine small programs in educational settings (Stake, 2004). Responsive evaluation is predominantly, although not necessarily, a qualitative research approach (Stake, 2008). It requires intensive involvement with the context and research participants and is more suitable to

exploratory than to confirmatory research (Miles & Huberman, 1994). In this setting, where the researchers were interacting with vulnerable program participants, a responsive evaluation approach supported the awareness, sensitivity and flexibility needed to accomplish the research aims while protecting the participants from undue pressure or intrusiveness. It allowed for a sufficient amount of interaction with the research participants to find out what was meaningful to them about the program and to capture their ideas in their own words. In designing effective health promotion actions with a focus on supporting autonomy and empowerment, it is important to understand "how individuals and groups view their own world and their real social relationships, what they identify as problematic, and how they might be helped to create their own healthy communities and environments" (Coburn et al., 2003, p. 394). This type of knowledge can be created by using a responsive evaluation approach.

1.6 Significance of the study

Diet is understood to be a significant factor in promoting health across the lifespan, with substantial research suggesting that nutritional status in infancy and childhood has considerable influence on future health in adulthood (Caballero, 2002; Power, 2005). It is difficult for the population as a whole to consume a healthy diet, but for vulnerable populations there are even more barriers. A program developed with and for a vulnerable population may give insight into valuable program components for reaching and affecting families in these circumstances. Most small community-based health promotion programs remain undocumented in the research literature and unknown to the population of health promotion planners, with the consequence that promising programs and ideas go unnoticed and undeveloped, slowing the pace at which pressing community problems are able to be addressed and solved. These programs find it difficult to sustain themselves financially because of this invisibility, which makes them unstable and unreliable from year to year, diminishing their ability to plan long-range for maximum impact.

CFF is the first known community kitchens-type of program to operate within a special inner city project in a Canadian school system. There is no published research examining the perceived benefits of this type of program in a school context. Prior to this research, there has been no published documentation of the CFF program. Although most of those who developed or implemented the CFF program in different sites had the CFF Program Handbook to refer to, it was not clear what set of objectives they had chosen as most relevant to their situation or how they had conceptualized the goals and objectives of the program they were developing. As for program clients, there was no prior documentation of their expectations of what attending the programs would assist them in accomplishing. The research aims to describe the program as fully as possible and to discuss it in relation to similar programs to determine if the CFF program has unique benefits or program delivery methods that would indicate the advantages of implementing the program more widely.

The knowledge gained from this study will be of use to a number of constituencies. It will add to the academic literature about small community-based health promotion programs and that of how to support healthy eating in vulnerable populations. The interpretation of the results in terms of a broad definition of health literacy will add conceptually to the developing field of health literacy knowledge and practice. The study will inform health promotion and community nutrition practitioners about what is feasible when communities take the lead on implementing health promotion programs. It will provide decision-making information to governmental and non-governmental funding organizations that could help them decide how to support small community-based programs. And lastly, it will provide feedback to program implementers about program facilitators and challenges, informing them about potential ways of improving their programs.

1.7 Situating the researcher

I mentioned above that I was involved in developing the CFF program model in 1996, at one of the inner city schools studied in this research. Although that fact might raise concerns about my ability to evaluate the programs several years later, I had no contact with the programs that were developed and implemented, in Vancouver or elsewhere, after the model was articulated, until I began the current research. My prior involvement afforded me several opportunities congruent with present day community-based research. It gave me the background and experience to know how to work within the inner city school environment to conduct community-based research; allowed me to be able to identify the topic as worthy of research; and gave me a "heads up" in terms of understanding how to negotiate entry to the research sites and to collect valid data. It also alerted me ahead of time to how vulnerable the research participants would be, so that I could pace the data collection protocols so as to be as minimally disruptive to the programs and participants as possible. I was also able to apply this knowledge while overseeing a research assistant and three nutrition students who engaged in lengthy participant observation and data collection assignments. Prior to conducting this research, I had never met and did not know any but one of the research participants. [9]

1.8 Organization of remaining chapters

The remaining chapters follow the format of a traditional dissertation. Chapter 2 provides a review of the literature in three relevant areas: health promotion and population health theory; nutrition education and, specifically, promoting healthy eating among children; and poverty, food insecurity, and community kitchens as a response to food insecurity in Canada. Chapter 3 presents the methodology and methods used in the study. The results of the study are presented in the next two chapters. Chapter 4 begins with a section presenting a description of the program

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[9] I had met the current staff of the CFF program at the former research and development school when she was in a different role at that school in 1996.

participants. It then describes the program setting, structure and focus at the various program sites. This is followed by an in-depth look at program goals, objectives and expectations, followed by case study illustrations or vignettes of goals and program development and beginnings from four sites. Next, the strategies employed to achieve the goals are examined, followed again by case study illustration, using the same four sites to facilitate depth of understanding by the reader. Lastly, a variety of challenges experienced in program implementation are presented, illustrated by two case study vignettes.

Chapter 5 presents the perceived benefits of the CFF program. It is subdivided into two sections; food- and nutrition-related and psychosocial perceived benefits. The perceived food- and nutrition-related benefits are presented separately for parents and for children. This is followed by a comparison of responses over two time periods to two food- and nutrition-related questions on the adult participant questionnaire. A further section specifically looks at perceived benefits of CFF programs related to food security. Chapters 4 and 5 each conclude with a discussion of their respective findings in relation to the literature and relevant health promotion theory and concepts. Chapter 6 discusses the study findings in relation to the broader theoretical purpose of the study. It concludes with strategic directions for improvement of health promotion practice, for health-related policy, and for future research related to supporting vulnerable populations' equitable access to resources for food-related and psychosocial health.

Chapter 2: Literature Review

Resources – physical, psychological and social – are essential for maintaining health. Poor inner city families are often lacking in one or more of these types of resources. Research reveals that types of resources are interconnected in the ways that they facilitate health and should be addressed together in actions meant to enable the achievement of better health and control over the determinants of health (Raphael, 2004a; 2004b). Diet is an important determinant of health. A substantial amount of information is available about how children come to develop their eating habits, and a large body of research has also developed to study how children's eating patterns, once formed, can be improved, if necessary. Children's eating habits are, initially at least, similar to their parents' eating habits and their diets are under the control and influence of their parents. Another large body of research has been developed studying factors that influence adults' eating habits, and facilitators and barriers to changing these habits. This literature is important to this research not only in terms of assisting the adults in the programs to maintain and improve their diets but because the adults' behaviours are an important influence on their children's diets. For families living in poverty with food insecurity, improving diets and maintaining healthful diets can be especially difficult due to their lack of various types of resources. Many new immigrant families who do not yet speak English are also in need of information, experience and support as they adjust to a new food system and culture. Both these types of families are vulnerable to poor nutrition.

The first section of Chapter 2 reviews information related to problems and issues facing vulnerable inner city populations regarding their diets and nutrition. The second section reviews health promotion concepts used to understand the relationships among physical, psychological and social resources and the determinants of health that are relevant when designing or evaluating interventions aimed at supporting vulnerable families to maintain or improve their health. Finally, the third section reviews strategies and programs that have been developed to

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overcome some of the barriers to, and to facilitate healthy eating among, vulnerable populations. It examines community/collective kitchens in depth, since this is the type of program that the CFF program model is built on.

2.1 Food and nutrition-related issues that affect vulnerable inner city populations

Vulnerable inner city populations face a number of barriers to achieving good nutrition. To understand these barriers in context, and to identify possible facilitators to good nutrition, the first broad section begins with a review of factors related to diet and healthy eating, for children and for adults. It then reviews information related to population groups such as those who attend CFF programs who are in the process of changing their diets due to relocation or degradation of their traditional food sources. This is followed by a review of concepts related to hunger and food insecurity, a condition experienced by a large percentage of the participants in this study and a barrier to healthy eating. The focus in this section is to provide a picture of the current food security/insecurity status of the Canadian and British Columbian population.

2.1.1 Diet and healthy eating

Good nutrition, achieved by "healthy eating" as it is currently conceptualized in public discourse and in the research literature, is a key determinant of health and a prerequisite for a fulfilling life (McIntyre & Rondeau, 2009). Healthy eating "refers to eating practices and behaviours that are consistent with improving, maintaining and/or enhancing health" (Power, 2005, p. S37). Good nutrition/healthy eating can be conceptualized as an intermediate health outcome in Nutbeam's (1998, 2000a) Outcome Model for Health Promotion (see Figure 1, p. 7), as one component of the section labeled "healthy lifestyles." Good nutrition is important to health throughout life, which makes it important that both children and adults consume a healthy diet. There are many factors that influence what children and adults eat. The following sections

review factors influencing both children's and adults' diets, and look at additional factors that influence families who are in dietary transition.

2.1.1.1 Factors influencing food choice among children

Children's dietary behaviour, as other types of children's health-related behaviour, is influenced by both personal and environmental factors (Cullen et al., 2001), or, put another way, by a combination of "innate, learned and environmental factors" (Cooke, 2004, p. 31). Innate or personal preferences are for sweet and salty foods as opposed to sour and bitter foods (Cook, 2004; Schwartz & Puhl, 2003), and for higher-density (i.e., more calories per gram) foods (Cook, 2004). It is also natural for children to develop "neophobia" – a fear of or aversion to new foods (Birch, 1999), around the age of two years. Strategies to encourage children to eat a healthy diet need to consider these innate characteristics.

Learned factors include, in particular, factors relating to experiences within the family, such as parents' control and reward behaviours related to food, giving of health information, setting a good example, children's exposure to new foods, and the availability and accessibility of different foods – the types of factors most under the influence of parents (Cooke, 2004, pp. 32-33). Children's learned food preferences are formed early in life and their diets are highly influenced by their parents' diets (Cooke, 2004; Veugelers, Fitzgerald, & Johnson, 2005). Parents are important models for their children's eating behaviours (Cullen et al., 2001; Lee, Mitchell, Smiciklas-Wright, & Birch, 2001; Patrick & Nicklas, 2005; Veugelers, Fitzgerald, & Johnston, 2005). Birch and Davison (2001) explain the direct and indirect ways that parents' own eating behaviours influence their children's eating behaviours: directly through social modeling and by the choices of foods they offer their children, and indirectly through their child feeding practices. Parents also largely control the availability and accessibility of healthful foods in the home. Availability and accessibility of foods are significant factors in children's eating behaviours (Cullen et al., 2003; Hanson, Neumark-Sztainer, Eisenberg, Story, & Wall, 2005).

Lastly, parents' attitudes and behaviours towards their children's eating patterns are significant predictors of whether children will develop the self-control needed to adequately monitor their own nutritional intake (Birch & Davison, 2001; Patrick & Nicklas, 2005; Patrick, Nicklas, Hughes & Morales, 2005).

The wider environment is the third type of factor in Cooke's (2004) classification. It includes societal messages about food, such as messages about how to feed children, and food advertisements aimed both at children and adults (Schwartz & Puhl, 2003). This wider environment also has a significant influence on children's eating habits through such factors as "the nature of foods available in the physical environment, including at home, schools and in fast-food establishments. … The media, particularly television, also have an enormous potential influence and can overshadow familial influences" (Taylor, Evers, & McKenna, 2005, p. S20). Economic and socio-cultural environmental factors influencing diets include the market economy in which food is a commodity subject to global marketing influences, the socio-economic status of consumers with respect to their abilities to purchase foods, and the cultural encouragers and inhibitors on consuming various foods (Raine, 2005, p. S8). The relative contribution of each of these types of factors to children's diets is likely to vary according to personal and contextual circumstances.

Children are influenced by strategies their early feeders use regarding feeding them and introducing them to new foods (Benton, 2004). The way parents approach feeding their children has been studied and characterized as falling into one of three styles: permissive, authoritative, or authoritarian, with each style having a particular set of typical outcomes (Nicklas et al., 2001; Patrick, Nicklas, Hughes & Morales, 2005). The "authoritative" style is the most productive in terms of allowing children to learn self-control while establishing a diet of predominately healthy foods. A technique called "exposure" or "mere exposure" (Cooke, 2004, p. 33; Nicklas et al., 2001) seems to be the best way to increase children's familiarity with and acceptance of healthy

foods that are presented to them. It involves repeated offering of foods without pressure or coercion to children to eat them. An authoritarian parenting style and strategies, on the other hand, can push children in a direction that may not be desired. Several authors have written about parents' attempts to control their children's eating through forbidding certain foods, pressuring their children to eat certain foods, or telling them that certain foods are "good (or bad) for them" (Cooke, 2004), and have found that these strategies can have negative consequences.

In summary, there are a number of important determinants of children's food choices. These include innate preferences, learned behaviours and habits, social influences (such as parental and peer modeling and caregiver feeding style), environmental influences (such as advertising), and the types of foods that are available and accessible in the home and at school.

2.1.1.2 Factors influencing adults' purchase and consumption of healthy foods

Understanding the determinants of adults' food choices is a necessary step in designing interventions to facilitate healthy eating among children, since children's diets are so strongly associated with their caregivers' diets. Strolla, Gans, and Risica (2006) elicited information about a number of barriers to healthy eating for a mixed-ethnicity group of low-income adults in the United States. They delineated barriers to eating less fat, and to increasing fruit, and vegetable, consumption (separately), and also outlined motivators for healthy eating. Barriers to eating less fat included not liking the taste and not knowing how to. Barriers to eating more fruit and vegetables included the cost (fruit); not liking the taste (vegetables); it not being a habit (vegetables); and perceiving that they already ate enough fruits and vegetables (Strolla et al., 2006, pp. 469-470). Their families' taste preferences and refusal to change their diets were also stated by respondents as reasons for not eating less fat or more vegetables. Some respondents said they did not know how much fat was in foods and/or that traditional foods eaten were not low fat. Some also said that most food they eat is from restaurants, or that they saw no reason to eat less fat, or had no will power. Some stated that they did not have time. Some said that

vegetables were not appealing or satisfying, while comments about not eating more fruits included that good fruit was not always available, fruit spoils too quickly, and they were not used to the fruit in the local stores (Strolla et al., 2006, pp. 470-1). Knowledge of these barriers at this level of specificity is useful for planning aspects of interventions to assist low-income households to eat healthier diets. Additionally, the authors outlined the main categories of motivators for healthy eating for this group: "be healthier/prevent disease; lose weight/look better; feel better; set a good example for one's family; and feel good about oneself" (Strolla et al., p. 471).

In Canada, as in other developed countries, household socio-demographic characteristics (e.g., household size, composition, income and education) have a significant influence on food purchasing, particularly on fruit and vegetable purchasing (Ricciuto, Tarasuk, & Yatchew, 2006). Higher income and education are associated with greater purchase and consumption of fruits and vegetables (Ricciuto et al., 2006; Subar et al., 1995). There is also a gender difference in fruit and vegetable consumption, with women having higher intake of fruit and vegetables than men (Subar et al., 1995). In a Canadian study, households with the lowest income showed the strongest (inhibiting) effect of lower purchases of healthy foods (Ricciuto et al., 2006) The authors stressed the significance of this finding; i.e., that households at the lowest levels of income are the most vulnerable to unhealthy eating, due to circumstances beyond their control. Studies in other countries corroborate this interpretation:

> [E]ating more healthily costs more. A study by the Food Commission compared the cost of a basket of regular food with that of healthier equivalents, such as low-fat, reduced-salt and whole grain versions. In 2001, the Commission found that the average cost of healthier foods was 51% more than the regular items. (Attree, 2006, p. 78)

Other factors associated with the purchase and consumption of healthy foods, notably fruits and vegetables, include "price and season, food selection and preparation skills, convenience/time, family influences, experimentation, taste and sensory factors, perishability,

vitamins and health effects, and origin" (Uetrecht, Greenberg, Dwyer, Sutherland, & Stasey-Tobin, 1999, p. 172). Culture affects nutrition attitudes, food choices, and dietary intake, particularly for non-dominant cultures, for whom eating often involves retaining and reinforcing their cultural heritage (James, 2004). Changing one's diet under these circumstances may feel like a betrayal of one's culture and community. This suggests that interventions for healthy eating in non-dominant cultural groups may be more successful if they involve whole communities and stress that change does not mean loss of cultural heritage. Such interventions may have to include instruction on how to prepare healthy foods either within the groups' cultural heritage, or as a welcome addition to that heritage.

Income as a facilitator of, or barrier to, healthy eating, may manifest its effect on diets through a number of intermediary factors. For example, in the UK, researchers have suggested an intermediate concept in the study of food insecurity called "food deserts." Although the concept has not yet been clearly defined, it refers to areas or circumstances where either healthy food is not available, or it may be available but for some reason is inaccessible. It suggests a variety of circumstances potentially mitigating against eating a healthy diet, such as transportation issues (lack of adequate public transit, heaviness of food to be transported, fear of crime in the neighbourhood), food preparation issues (not knowing how to prepare healthy foods, not knowing how to use local foods), preferences associated with low-income issues (mothers not being able to afford to buy healthy foods that might go to waste due to children's preferences), inadequate income to buy healthy foods which cost more than less healthy foods, inadequate food storage or preparation facilities, and lack of markets selling healthy foods at affordable prices in the neighbourhood (Shaw, 2006).

In summary, many studies have found quality of diet and level of nutritional health to be related to families' socio-economic status (Friel, Newell, & Kelleher, 2005; Licence, 2004; Sweeting & West, 2005). Power's (2005) review of the determinants of healthy eating among

low-income Canadians suggests that "income affects food intake both directly and indirectly" (p. S37), with the indirect influence being due to social or socio-economic class. She suggests that while there is evidence to suggest socio-economic gradients in diet in Canada, there are also likely to be "income thresholds [the direct effect] for some food groups, including fruit, vegetables and dairy products" (p. S38).[10] In this respect, families with less resources to spend on foods tend to buy fewer fruits and vegetables and foods with higher levels of fats, sugars and salt (Attree, 2006; Gittelsohn et al., 2006).

2.1.1.3 Diets in transition

Most CFF participants are recent immigrants or refugees, or urban First Nations families, whose traditional diets differ from a standard "Canadian" diet. Reviews show that when recent immigrants and refugees acculturate their diets, although they likely maintain many aspects of their indigenous diets, they often move toward a less healthy diet over time, either by choice (e.g., they choose more processed, high-fat and high-sugar foods) or by necessity (e.g., they can't afford to purchase healthier traditional foods) (Hyman, Guruge, Makarchuk, Cameron, & Micevski, 2002; Satia-Abouta, Patterson, Neuhouser, & Elder, 2002). The circumstances differ for each group, but often they have been able to procure healthy foodstuffs (e.g., fruits, vegetables and fish) in their country of origin more inexpensively than they can here, and their financial situation in their new country is constricted. Foods that are more affordable in their new setting are often processed foods that are high in fats, salt and sugar. In other cases, people who are used to a diet mainly consisting of rice and vegetables begin to eat more meat and fast foods and reduce their intake of grains once they immigrate (Hyman et al., 2002). Other barriers to continuing with healthier former diets might include unavailability of types of foods, difficulties with transportation to acquire the foods, and the length of time needed to prepare traditional

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[10] Power explains that "[a]n income threshold refers to the likelihood that, beneath the threshold, income is the most important determinant of consumption; a socio-economic gradient suggests

foods, especially if it is necessary for food preparers to also hold employment outside of the home. When families with young children immigrate, the children often acculturate their diets more quickly due to exposure to the mainstream culture at school, and begin to prefer unhealthy processed foods and sugar-sweetened drinks (Satia-Abouta et al., 2002). Traditional foods hold meaning above and beyond their nutritional value; they are often used to express identity, cultural and religious values and ideals, kinship, wealth and social status and to celebrate life events (Hyman et al., 2002, p. 126). Satia-Abouta et al. suggest that there are potentially both positive and negative effects of dietary acculturation for new immigrants and refugees, and it is important, when counselling these people, to focus on the healthy aspects of both their traditional diets and of the mainstream diets of the culture into which they are moving.

Some of the same diet-related circumstances that apply to new immigrants and refugees also apply to Aboriginal/ First Nations cultures in North America. In many ways, however, the situation for Aboriginals/First Nations is more severe. Many Aboriginals/First Nations people are dispossessed of their access to traditional food resources due to:

> lack of access to traditional lands; the extinction and decreased density of plant and animal species; changes in animal migratory patterns; decreased transfer of cultural knowledge from elders to young people; a decrease in time and energy available for harvesting due to paid employment; loss of taste for traditional foods due to the uptake of market food; lack of money for expenses related to hunting and fishing; not having someone in the family to harvest; and disincentives to harvesting built into social assistance programs. (Power, 2008, p. 96)

Aboriginal/ First Nations cultures commonly suffer from poor health in North America, since their traditional foods are higher in nutrients than the market foods they must now use to replace them (Power, 2008, p. 96). Foods high in fats, sugars and salt, such as packaged and fast foods, snack foods and soft drinks most often are the most accessible and affordable types of foods for Aboriginals/First Nations (Kuhnlein et al., 2006, p. 1014), but these contribute to health problems. As well, studies of the determinants of healthy eating for indigenous cultures

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that other determinants, especially education, are also likely to be important" (2005, p. S38).

emphasize that, as for immigrants and refugees, traditional foods represent more than simply nutrition; they include cultural meaning and identity, and have medicinal indications (Kuhnlein et al., 2006; Willows, 2005). Embedded in the meaning of food and nutrition is cultural activity, relationships and responsibility, including aspects such as procuring, preparing, and sharing food. "For many Aboriginal peoples, these processes require the continued enactment of culturally important ways of behaving, which emphasize cooperation, sharing and generosity" (Willows, 2005, p. S33). In the face of the loss of a way of life and health, Willows suggests that certain circumstances and supports are essential if Aboriginal/First Nations people are even possibly to be able to achieve a healthy diet:

> Positive nutritional status might be possible to maintain when traditional food use is diminished if economic circumstances are favourable, a variety of high-quality, non-traditional foods is available, and education in the use of good-quality traditional food alternatives is on hand. (Willows, 2005, p. S32)

2.1.2   Income-related food insecurity

The greatest potential barrier to healthy eating among Canadian families living in poverty is the lack of resources to purchase adequate healthy foods (Power, 2005, p. S39). Depending on the severity of the lack of resources, families may suffer from varying degrees of deprivation related to food and nutrition, commonly labelled food insecurity. Several constructs have been developed for understanding dimensions of hunger and deprivation related to food and nutrition and are reviewed below. This is followed by an analysis of the food security/insecurity status of Canadian households.

2.1.2.1 Constructs used to conceptualize issues and strategies related to hunger

The "right to food," "food security," and "food sovereignty," or the closely allied term, "community food security," are constructs used to conceptualize issues and strategies related to reducing and eliminating hunger and malnutrition. In 1948, the "Right to Food" as a human right was recognized in the "Universal Declaration of Human Rights" (FoodFirst Information Action

Network, 2005). Although the right to adequate food and freedom from hunger is now recognized in the International Covenant on Economic, Social and Cultural Rights (Article 11), it still has to be "realized" or implemented, and although many nations subscribe to the idea of universal freedom from hunger, it is obvious that it has not been fully implemented, even in wealthy countries such as Canada.

Food security was defined by the World Bank in 1986 as "access by all people at all times to enough food for an active, healthy life" (Smith et al., 1993, p. 56). The concept of "food security" stresses the need for *access* to adequate food that is to be procured in socially acceptable ways. Food may be available (e.g., in stores), but people who need it may not be able to access it (i.e., purchase it). This is the case for many of those who are food insecure in wealthy countries such as Canada. Lack of food security is termed "food insecurity." Food insecurity may be temporary or chronic. Temporary food insecurity involves poverty and vulnerability, while chronic food insecurity also includes malnutrition (Smith et al., 1993).

Food security/insecurity is often studied at the level of the household, named "household food security." Che and Chen (2001, p. 11) conceptualized household food security and insecurity as points along a continuum, "progressing from uncertainty and anxiety about the household's food supplies, to depletion of those supplies, altering the eating patterns of adults, and ultimately, when food supplies and resources are exhausted, hunger among children." Kendall, Olson, and Frongillo (1996) delineated food security and insecurity into four groups of increasingly worse food insecurity status: secure, household insecure, individual insecure, and child hunger (Kendall, Olson, & Frongillo Jr., 1996, p. 1021.) When food insecurity is measured in Canada, it is conceptualized as income-related (questions ask about the inability to acquire food because of a lack of money) and is classified into two levels: moderate and severe (McIntyre & Rondeau, 2009).

Being in a state of food security implies not only the immediate satisfaction of hunger and nutritional needs but also expectations that these needs will be met in the future and that they will be met in a personally- and socially-acceptable manner (Che & Chen, 2001). Studies undertaken in the late 1980s and early 1990s identified four components of individual and household food security: quantity of food, quality of food, and psychological and social components (Kendall, Olson, & Frongillo Jr., 1995; Radimer, Olson, & Campbell, 1990). Detrimental aspects related to the quantity of food include "food depletion at the household level and insufficient food intake at the individual level;" while those related to the quality of food include "unsuitable food at the household level and an inadequate diet at the individual level." The psychological aspect includes "anxiety about the household food supply and individual feelings of deprivation or lack of choice," and the social aspect includes "acquiring food through socially unacceptable means at the household level and disrupted eating patterns at the individual level" (Connell, Lofton, Yadrick, & Rehner, 2005, p. 1683).

"Food sovereignty" and "community food security" are the third set of terms used to describe access to food. During the past decade, the concept of food sovereignty has gained prominence internationally, particularly in third-world countries and in relation to aboriginal peoples, but is not spoken of much in British Columbia. It relates to a world-wide movement and set of strategies to guarantee poor, mostly rural, food gatherers and producers an adequate resource base for them to produce or secure enough food for their own nutritional needs, or in lieu of this, an adequate income to be able to purchase the food they need. Aboriginal populations around the world suffer from diminishing access to their traditional foods and thus from a lack of food sovereignty. Definitions of food sovereignty all include four basic aspects: the right to food, improving access rights, establishing equitable trade policies, and practicing sustainable, ecologically-sound food production (FoodFirst Information Action Network, 2005, p. 4). The international food sovereignty movement sees entrenching ownership and food

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production rights for indigenous populations as essential to eradicating hunger and malnutrition, as well as preserving the world's food production capacity.

The concept of food sovereignty overlaps in many respects with the urban community food security movement in developed countries. The focus of the community food security movement is to support local, sustainable agriculture and increase local participation in food related activities as much as is feasible. Community food security is defined as "a condition 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" (Genauer, 2006, p. 130). Foci include the concepts of a sustainable food system and community self-reliance, and the explicit inclusion of social justice. Community food security initiatives include community-based strategies such as farmers' markets, community supported agriculture where, for example, buyers have direct and committed relationships with growers, community gardens and other food production based on ecological principles, redemption of ecological wastelands, community development, and community education about healthy eating, cooking and nutrition. The community food security movement does not yet have the political power, in most instances, to either demand ownership rights to production facilities for the poor or to ensure realization of their right to adequate food and/or to an adequate income. Initiatives such as community gardens and community kitchens that have been developed and popularized under the banner of the community food security movement have so far not been found to eliminate the food insecurity of low-income families in Canada (Johnston, 2003).

2.1.2.2 Canadian studies of household food insecurity

Several Canadian surveys measured household food insecurity in Canada during approximately the same time period in which the research on CFF programs for this study was conducted. The 1998-1999 National Population Health Survey found that about 8% of Canadians lived with anxiety about getting enough food, 7.8% lived with compromised quality of diet, and

4.1% lived with hunger (McIntyre, 2004, p. 178). Statistics from the 2000-01 version of the Canadian Community Health Survey suggested that in British Columbia during that time, members of 11.6% of households were worried about running out of food, of 14.8% were eating a diet of compromised quality, and of 8.2% were not having enough to eat. Statistics for the Vancouver region were similar with members of 11.5 % of households worried, of 13.5% having compromised diets, and of 9.3% running out of food (Fourster-Coull, Levy Milne, & Barr, 2004, pp. 27-30). The latest Canadian Community Health Survey statistics (Cycle 2.2, Nutrition [2004], as cited in Health Canada, 2007, p. 13, 97) [11] suggested that in 2004, 6.3% of Canadian and 6.9% of British Columbia households were moderately food insecure, and that 2.9% of Canadian and 3.5% of British Columbia households were severely food insecure. Of British Columbia households with children, 10.3% were moderately food insecure and 3.4% were severely food insecure. The highest rate of food insecurity was suffered by Aboriginals – more than 33% of off-reserve Aboriginal households in Canada (only off-reserve households were included in the survey) were food insecure, with 14.4% being severely food insecure (McIntyre & Rondeau, 2009, p. 192). There are no food security statistics available at the neighbourhood level for Vancouver.

Food security studies also identify the demographics of the poorest, most food insecure people. In the 1994 National Longitudinal Survey of Children and Youth, female-headed lone-parent families were found to be eight times more likely to report child hunger than the other families; children from families receiving welfare or social assistance were reported to be 13 times more likely to suffer from hunger than children from families not dependent on welfare; and off-reserve Aboriginal families were four times more likely to report hunger than other

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[11] This version of the survey dropped "worry" as an indicator of food insecurity, and categorized food-insecure households as either "moderately" or "severely" food insecure based on a number and combination of factors relating to compromised quality and quantity of food (Health Canada, 2007, pp. 9-12).

survey respondents (the surveys do not measure on-reserve Aboriginal families) (McIntyre, 2004, p. 179). In the 1996 and 1998 administrations of the same survey, similar statistics were found. Two groups were found to be especially at risk of food insecurity in both the 2000-01 and the 2004 Canadian Community Health Surveys – female-led lone parent families (33% in 2000-01; 24.9% in 2004) and off-reserve aboriginal households (31% in 2000-01; 33.3% in 2004) (Ledrou & Gervais, 2005, p. 48 [2000-01 survey]; Health Canada, 2007, p. 15-17 [2004 survey]).

The rate of child poverty in the Downtown Eastside of Vancouver, where most families who attend CFF programs live, is extremely high. Broughton, Janssen, Hertzman, Innis, and Frankish (2006) found in 2004 that the proportion of their study families who were suffering from food insecurity was 50%, five times higher than in Vancouver as a whole. The preschool children from food insecure families, who were tested with biological tests to determine nutritional inadequacies, were found to have inadequate levels of some nutrients, and one third of the children in the study were found to be overweight or obese (p. 215). The authors comment that compared to nutrient levels in American children in the 1980's, the majority of the study participants were lacking. This is cause for great concern regarding both the adequacy of the food supply and the ability of families to access adequate nutrition.

2.2 Social and psychological concepts associated with vulnerable population groups' increased access to control over the determinants of their health

Health is now conceptualized, in the public health domain, as representing not just the absence of disease and infirmity but as a positive state: "a state of complete physical, social and mental well-being" (World Health Organization, 1998, p. 1). The term "positive health," reflecting the new definition of health agreed upon by the World Health Organization, implies, in theoretical terms, having "the ability to cope with stressful situations, the maintenance of a strong social support system, integration in the community, high morale and life satisfaction, [and] psychological well-being" (Bowling, 1991, as cited in Locker and Gibson, 2006, p. 168).

From a personal point of view, it would include "feeling vital, full of energy; having good social relationships; experiencing a sense of control over one's life and living conditions; being able to do things one enjoys; having a sense of purpose in life and experiencing being part of a community" (Labonte, 1993, as cited in Locker & Gibson, 2006, p. 168). These descriptions of positive health imply access to the types of resources – physical, psychological and social – that work synergistically to support the attainment and maintenance of a complete state of health and well-being.

The scope of programs and interventions for achieving, supporting and maintaining health has changed. Health education's former principal strategy of imparting information in order to facilitate changes in health behavior was found to be largely ineffective for changing more complex health behaviours (perhaps partially because it was mainly focused on individuals taking action on their own to improve their health and did not include making changes in individuals' environments that would facilitate and support their proposed health-enhancing changes). New, more interactive models of health education for behaviour change were developed and tested (Nutbeam, 2000a), but even these new, expanded methods of facilitating health were found to be somewhat ineffective in improving population health. This is because, as it became clear, much health-related behaviour is not purely voluntarily chosen, but is under the influence of social and environmental conditions that had not previously been associated directly with health:

> The limitations of earlier disease prevention and health promotion programs … highlight the need for a major paradigm shift away from narrowly focused interventions aimed primarily at changing individuals' health behavior toward more comprehensive formulations that address the interdependencies among socioeconomic, cultural, political, environmental, organizational, psychological, and biological determinants of health and illness (Stokols, 2000, p. 23).

The expansion of the definition of health and the scope of action for promoting health coincided with research that identified large categories of important influences on health, forces

shaping lifestyles and environments "in ways that affect the health of populations" (Green &

Kreuter, 1999, p. 113). These have been named "determinants of health." A number of public

health agencies have produced lists of determinants of health that should be addressed for

maintaining and improving the health of populations.[12] Research linking health inequities

between population subgroups with measures of key determinants of health led to a focus in

health promotion on providing a variety of forms of support for vulnerable population groups

who suffered poorer health, to try to bring their levels of health up to that of more privileged

groups. Currently, health promotion's priorities for strategic action are conceptualized as

working toward enhancing health literacy, creating supportive environments, and strengthening

social networks (Mittelmark, Kickbusch, Rootman, Scriven, & Tones, 2008b).

 Community development, involving the facilitation of more intensive and focused action

and interaction among participants, became recognized as an important contributor to health

equity between population groups and therefore an important strategy for health promotion

(Jolley, Lawless & Hurley, 2008; Raeburn & Rootman, 1998). "To be effective, equity work is

likely to incorporate a range of strategies including community participation, partnerships,

advocacy and capacity building" (Jolley et al., p. 156). A key goal of community development is

the development of "agency": "the lifeblood of participatory processes lies primarily within the

agency of the participants themselves" (Ramella & de la Cruz, 2000, p. 272).

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[12] For example, In 1974, "human biology, environment, lifestyle, and health care organization" (Lalonde, 1974, as cited in Raphael, 2004a, p. 4); in 1986, "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity" (World Health Organization, 1986, p. 1); and in 2007, "income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture" (Public Health Agency of Canada, 2007, p. 1).

Many of the determinants of health rest within the domain of action of organizations and governmental branches other than "health." Therefore, there has been a move towards inter-sectoral and inter-organizational collaboration and cooperation in the service of improving the health of various groups within society:

> What had been a growing interest in the social environmental dimensions of health in the 1980s became a revival of the ecological perspective on population health in the 1990s. This perspective demanded more than merely taking forces outside the person into account in planning programs. It demanded an intersectoral, interdisciplinary, and interorganizational strategy for integrating the forces operating at several levels and in various spheres to support people in their efforts to gain greater control over the determinants of their health. (Green & Kreuter, 1999, p. xxvi)

Many concepts are used in health promotion theory to describe aspects of health promotion's priorities for action, including social integration, social networks, social support, social exclusion/inclusion, sense of mastery, sense of belonging and empowerment. "Social integration" refers to the "existence or quantity of social ties", while "social network" refers to "a person-centred web of social relationships" and "social support" is "the functional content of relationships" (Heaney & Israel, 1997, pp. 180-181). Social support is "always intended (by the sender of it) to be helpful, … is consciously provided by the sender, … and is provided in an interpersonal context of caring, trust and respect for each person's right to self-determination" (Heaney & Israel, 1997, pp. 180-181). Cassel (as cited in Heaney & Israel, 1997), an important early contributor to the study of social support, suggested that "social support serves as a key psychosocial 'protective' factor that reduces individuals' vulnerability to the deleterious effects of stress on health" (p. 182). There are two conceptions of social support in the literature on social support and health. The first, and more widely researched, is where social support is hypothesized to fill a need, as in times of stress or illness. The second, which is the conception relevant to this research, is more related to social integration and operates in social groups that are not focussed *per se* on need:

The hypothesis here is that others can influence cognitions, emotions, behaviors, and biological responses in manners beneficial to health and well-being through interactions that are not explicitly intended to exchange help or support. Examples of pathways through which these benefits might occur are the effects of human relationships on the diversity of our self-concepts, feelings of self-worth and personal control, and conformity to behavioral norms that have implications for our health. (Cohen, Gottlieb, & Underwood, 2000, pp. 4-5)

Research into influencing social networks to further health and well-being suggests that enhancing social networks and developing new social networks are two methods of providing increased opportunities for the exchange of beneficial social support (Heaney & Israel, 1997, pp. 190-195). Self-help and mutual aid groups are particularly promising as venues for providing "a new *set* of network ties. … In self-help or mutual aid groups, the roles of support provider and support recipient are mutually shared among the members. Thus, the ties often entail high levels of reciprocity" (Heaney & Israel, 1997, p. 193).

Social exclusion is a relatively new term in Canadian health promotion and population health discourse. The term has been in use in Europe and Britain for a longer time, and adds dimensions to, or replaces, the term "poverty" in many countries there (Shaw, Dorling, and Smith, 1999, p. 222). Social exclusion refers to "structural inequalities in access to social, economic, political, and cultural resources arising out of the often intersecting experiences of oppression as it relates to race, class, gender, disability, sexual orientation, immigrant status …" (Galabuzi, 2004, p. 238). These inequalities are manifested not only in socio-economic and political inequalities, but also through societal institutions, including "the school system, the criminal justice system and the health care system, as well as spatial isolation or neighbourhood segregation" (Galabuzi, 2004, p. 238). Aboriginal peoples, women and men from racialized (non-European descent) groups, and immigrants face marginalization in Canadian society (Galabuzi, 2004).

Some important psychological constructs also make up part of health promotion's armamentarium. One of these, sense of mastery, is an important component of Conservation of

Resources theory (Ennis, Hobfoll, & Schroder, 2000, p. 153). Sense of mastery and social support are called a "stress-resistance resources" in Conservation of Resources theory (p. 153) and have been found to be protective against depressed mood in situations of poverty (Ennis et al., 2000). Sense of mastery has been defined as "the extent individuals view their successful goal achievement to be in their general control" (Ennis et al., 2000, p. 153). Sense of mastery and related concepts such as self-efficacy have been found "to limit the deleterious impact of stressful conditions by increasing the likelihood that individuals will seek and sustain efforts toward solving problems" (Ennis et al., 2000, p.153).

Another important psychological concept in health promotion is sense of belonging. A sense of belonging has been recognized as a basic human need since Maslow's (1954) research on psychological well-being and self-actualization (McLaren, 2009). The Theory of Human Relatedness (Hagerty, Lynch-Sauer, Patusky, & Bouwsema, 1993, as cited in Kissane & McLaren, 2006) articulates the importance for humans of maintaining relatedness to each other: "[A] ubiquitous human concern is establishing and maintaining relatedness with other people, objects, environments, society, and the self, in order to survive, develop, and grow" (Kissane & McLaren, 2006, p. 244). Sense of belonging is one component in establishing connectedness, and is defined as "the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of that system or environment" (Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992, as cited in Hagerty, Williams & Oe, 2002, p. 794). One's sense of belonging is influenced by one's personality and upbringing, but is also amenable to enhancement at any age and can be facilitated for adults through interventions (McLaren, Gomez, Bailey, & Van Der Horst, 2007). A sense of belonging is important for mental health (McLaren, 2009, p. 1), which, in turn, is a key component of "positive health." Being related to others in positive ways, having "close, meaningful ties to others" is *sine qua non* to quality living (Ryff & Singer, 2000, p. 31). A sense of belonging and inter-relatedness is essential for the

production of social capital (Schellenberg, 2004). "Trust in others is vital for effective cooperation, communication and positive relationships" (Schellenberg, 2004, p. 16). In 2003, Statistics Canada's General Social Survey on Social Engagement, Cycle 17, found that only fifty-three percent of Canadians felt that most people could be trusted (Schellenberg, 2004, p. 21).

Empowerment is an important concept in health promotion. It is sometimes seen as the ultimate goal of health promotion, while at other times is spoken of as a strategy for reaching health promotion goals. Basic to the notion of empowerment is having power and control over one's life or, in health promotion, over the determinants of one's health. Empowerment is thus the embodiment of the World Health Organization's definition of health (Laverack, 2004, p. 12). Resources are seen as key to the empowerment of disadvantaged individuals and populations. "[I]t has long been known that the roots of health can be found in the organization of society and how resources are distributed among it [sic] members" (Raphael, 2004a, p. xi).

The literatures on empowerment, the social determinants of health, and resources are interrelated. Empowerment relates to power and control over resources. Resources include not only material but also intangible goods, "entities that either are centrally valued in their own right (e.g., self-esteem, close attachments, health, and inner peace) or act as a means to obtain centrally valued ends (e.g., money, social support, and credit)" (Hobfoll, 2002, p. e2). Health literacy (discussed in section 2.3.1.4 below) is critical to empowerment; it provides the context in which use can be made of resources to the end of promoting and maintaining health (Koelen & Lindström, 2005).

Many inner city neighbourhoods suffer from inadequate levels of resources for their resident families to integrate beneficially with each other and with mainstream society. Lack of personal and social/community resources predisposes families to be more negatively impacted by stressful life circumstances than might otherwise be the case (Hobfoll, Johnson, Ennis &

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Jackson, 2003, p. 632). "Conservation of Resources" theory holds that "resource loss is the principal ingredient in the stress process" (Hobfoll, 2001, p. 337). Unhealthy levels of stress are more present in impoverished circumstances, as individuals fight to keep from losing the meager resources they have, and to gain access to enough resources to ensure the survival of themselves and their families.

Social determinants of health are thus resources for health. Rappaport (1997) (as cited in Hobfoll & Lilly, 1993) suggests that empowerment is the key state necessary to security and well-being:

> Those who are empowered will do well because they have access to the resources necessary to control their lives and positively affect their environments. Those who lack power, in contrast, have limited access to opportunities to protect themselves or to gain access to the resources available to others in the society. Allen and Britt (1983) suggest, in particular, that those who are less empowered have more vulnerable resources. (Rappaport, 1997, as cited in Hobfoll & Lilly, 1993, pp. 128-129)

Lifestyle is an evolving concept in health promotion. Although it is often thought of as referring to an individual's unique habits, more recent formulations see lifestyle as a collection of individuals' habits, or a "collective pattern of life conduct" (Rütten, 1995, p. 1631). This understanding of lifestyle enables it to be related, for population groups, to determinants of health and health behaviours. One focus of health promotion is to create healthy environments, with environment referring to both physical and social. Environments greatly influence lifestyles. Social environments are particularly of interest in health promotion as they are a venue in which many of the determinants of health (the "social" determinants of health) interact and express their influence on health: "A healthy social environment gives people a sense of belonging and of being valued. It reduces stress, increases control, and reduces social isolation" (Lyons & Langille, 2000, p. 23). Healthy environments support "healthy lifestyles" as conceptualized as including a collective component (Frohlich & Potvin, 1999; Frohlich, Corin & Potvin, 2001; Lyons & Langille, 2000). Lifestyle is now seen as a multifaceted construct which includes

physical, psychological and social elements such as "effective coping, lifelong learning, safety and security precautions, social activity and volunteering, and a sense of purpose and meaning, spirituality and hope" (Lyons & Langille, 2000, p. 13). Coping is seen as something that is enabled by the context within which one lives, and is tied to the concept of "interdependence:" "Interdependence is the connectedness of individuals with their social environment" (Kelley, 1979, as cited in Lyons & Langille, 2000, p. 15). The nature of people's interdependence influences their identity, choices and lifestyle (Lyons & Langille, 2000, p. 15), and (the concept of) a healthy lifestyle "is understood less as acquiring strictly personal health skills, and more as acquiring competencies and an orientation to creating a mutually supportive environment for healthy living" (Lyons & Langille, 2000, p. 15). Education, too, must be more broadly conceptualized as containing elements of the environment, both external and internal: "'[H]ealth' as a benefit of learning can be viewed as the product of the interplay between knowledge and skills, social networks, and positive mental states and self-concepts that people cultivated through learning" (Narushima, 2008, p. 676). The concept that lifestyle is collectively determined is also reflected by the Public Health Agency of Canada:

> Definitions of lifestyle include not only individual choices, but also the influence of social, economic, and environmental factors on the decisions people make about their health. There is a growing recognition that personal life "choices" are greatly influenced by the socioeconomic environments in which people live, learn, work and play. (Public Health Agency of Canada, 2007)

There are thus a number of social and psychological constructs associated with health promotion and the determinants of health. Those that are of particular importance to strategies to improve the health of vulnerable populations are social and psychological constructs that increase connectedness with others and reciprocal social support. These types of connections assist vulnerable populations to cope with adversity as well as supporting social integration, a state in which more resources are available. Working in concert with the social strategies are psychological constructs that enhance people's abilities, motivation and self-efficacy, providing

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them with the strength and resilience to actively engage in opportunities to maintain and improve their health. Health promotion strategies focus on this type of active engagement of participants within supportive environments. Of particular relevance to this study are the three current priorities of health promotion: supportive environments, social networks, and health literacy, all of which can contribute to healthy lifestyles, conceptualized as being collectively determined and enacted in relationship with others.

2.3 Approaches and strategies to address food and health-related problems and issues facing vulnerable inner city populations

The final broad section of Chapter 2 examines strategies that may be, or have been applied to food and health-related problems facing vulnerable inner city populations. The first part focuses generally on education, literacy and health literacy approaches, while the second part focuses directly on a type of program, community kitchens, which the CFF program model is based upon, that is popular among both nutritionists and low-income parents. The review examines evaluations of community kitchens to see what others have found to be the possible benefits, for low-income families, of attending these types of programs.

2.3.1   Education, literacy and health literacy

Education is highly regarded in our society as a solution to many types of problems. This section reviews principles of adult education and nutrition education and looks at the benefits of a lifelong learning approach in our society. It then examines school-based interventions aimed at increasing children's consumption of fruits and vegetables, and finally, looks at the current literature regarding the value and contributions of literacy to health, examining the emerging construct of health literacy.

2.3.1.1 Principles of health education, adult education and nutrition education

Health education methods have evolved over the past several decades from a focus on simply imparting information towards more comprehensive methods that include personal contact, social support, and opportunities for skills development. These newer methods are also important strategies in health promotion, reflecting the current emphasis in health promotion on participation as a key strategy for supporting agency, ownership, control and empowerment. The goal of these expanded health education methods is to facilitate not only knowledge and skills but also motivation and self-efficacy (Nutbeam, 2000a). These types of more intensive methods of health education are particularly needed when working with marginalized or vulnerable population groups who are socially excluded, with the deficits in access to resources that social exclusion implies.

The quality of the relationship between the educator and the students emerged as the most important theme in a recent national (U.S.) review of nutrition education programs for low-income parents. The authors found that there must be empathy and trust between educators and clients, and sensitivity to and respect for clients on the part of educators, for the programs to be effective (Sigman-Grant, Rye, Loesch-Griffin, & Mitchell, 2008). In other studies, several principles have been identified as important to successful adult education, no matter what the learners' literacy levels (Imel, 1998). These principles can be used as guidelines when examining the adult educational component of the CFF programs. They include: learners' active involvement in experiences; use of small groups for teamwork, collaboration and sharing of responsibilities; involving learners in planning and carrying out learning activities; drawing on learners' previous knowledge that learners can share with each other, such as culture-specific knowledge and skills; maintaining an atmosphere conducive to building trust and respect among

all parties; attention and caring towards learners' lives and perspectives; and fostering

independence, autonomy and self-direction in learners (Imel, 1998).

Effective nutrition education curricula have been found to address all three domains of

learning, i.e., cognitive, affective, and behavioural:

> Cognitive understanding is needed to change eating behavior, but the focus is on the
> concepts and cognitive skills that are needed to carry out the targeted behaviors as well as
> to understand and analyze the causes, consequences, and contexts of behavioral change.
> The affective component focuses on exploring the beliefs, values, emotional meanings of
> foods to individuals, and motivations underlying these behaviors. The behavioral
> component provides practice in a systematic process of changing these behaviors.
> (Contento et al., 1995, p. 307)

Comprehensive reviews have been conducted to identify core components of successful

school-based nutrition education programs for children (Contento et al., 1995; Perez-Rodrigo &

Aranceta, 2003). For programs to be effective, as with adults, a behavioural focus rather than

simply an educational focus was needed ("instructional methods should be experiential, active,

and hands on") (Contento et al., 1995, p. 307); the larger community should be involved when

trying to, for example, change norms; and, for younger children, the inclusion of family

involvement is important. The reviews also caution that adequate time must be spent and the

programs must be suitably intense. For older children, self-assessment and goal setting and

feedback are also recommended.

Contento et al. (1995) also found that Social Learning Theory (SLT) was applied, either

alone or in combination with other theories, in most of the effective school-based behaviorally

focused interventions. Important SLT aspects for nutrition education in schools include:

> self-assessment of dietary intake or food-related practices to identify problem behaviors,
> setting personalized goals for change, observation of modeling of desired behaviors by
> peers and adults, enhanced self-efficacy through skill building, and reinforcements and
> incentives for change. (Contento et al., 1995, p. 307)

More recent reviews have corroborated these findings regarding attributes and strategies of

successful nutrition education programs for children and have stressed the importance of

involving parents in nutrition education programs for young (elementary-school) children (Perez-Rodrigo & Aranceta, 2003).

The most successful current nutrition education programs for low income adults involve hands-on experiences with preparing and tasting the new recipes. A study of food purchasing and preparation in households on two Native American reserves determined that the participants purchased many pre-prepared foods high in fat and sugar and commonly used high-fat cooking methods (Gittelsohn et al., 2006). The authors suggest providing "guidance in food preparation and tasting of new foods, in a culturally sensitive framework" (p. 167) as an appropriate intervention to increase the healthfulness of the participants' diets. The authors took the USDA Expanded Food and Nutrition Education Program (EFNEP) as their guide in making this decision, since the EFNEP program has been found to successfully facilitate dietary behaviour change in a cost-effective manner. "Food preparation and tasting strategies have been found to be effective in changing dietary behaviors" (Gittelsohn et al., 2006, pp. 167-168).

2.3.1.2 Benefits of lifelong learning

Lifelong learning is a philosophy of education that suggests that benefits can accrue over the lifespan when people continue to learn throughout their lives. This learning can be oriented towards employment goals or it can be for personal development. Either way, it can have social and psychological benefits and these can also predispose the learner towards improved health, both physical and mental. Schuller (2004, as cited in Narushima, 2008, p. 676) suggested that learning could create health benefits "through the interplay between knowledge and skills, social networks, and positive mental states and self-concepts that people cultivated through learning." Hammond (2004, as cited in Narushima, 2008, p. 677) further delineated the psychological and social benefits that continued learning may develop in individuals as including "self-esteem and self-efficacy, identity, purpose and hope, competences and communication, and social integration":

Educational research into the immediate 'soft' outcomes of learning suggests that learning can develop a number of psychosocial qualities including self-confidence, self-efficacy, self-understanding, competences, communication skills, civic engagement, and a sense of belonging to a social group. These psychosocial outcomes of learning may promote attitudes, practices, and life circumstances that are conducive to positive health outcomes. (Hammond, 2004, as cited in Narushima, 2008, p. 677)

For integration of refugees and new immigrants into their host countries, lifelong learning may have other types of benefits as well, social benefits related to establishing relationships with others outside their ethnic groups. These relationships are crucial to newcomers from other cultures, as they assist them in learning the unspoken, difficult to teach nuances of social skills and etiquette that may make the difference between being able or not to eventually secure employment and establish financial and social integration:

[For] refugees to become integrated, effective, competent members of [UK] society involves the process of assimilating into social networks, developing cultural understanding and knowing the rules of social engagement. Often it is through informal and non-formal learning opportunities that these implicit rules, norms and tacit knowledge are picked up and developed. (Morrice, 2007, p. 159)

Opportunities for informal, rather than formal, learning, can actually provide more of these types of experiences for refugees and immigrants. Morrice suggests that informal and non-formal learning creates important "social capital" and that lifelong learning should therefore be an important policy goal for reducing social exclusion for disadvantaged population groups: "Recognition of the significance of social capital calls for lifelong learning policies which promote social learning opportunities and recognize the importance of learning in informal and non-formal contexts" (Morrice, 2007, p. 156). Informal learning opportunities can have a number of positive outcomes, such as "Development of knowledge and understanding … Improved personal and social skills. Significantly increased self-confidence and self esteem. Greater autonomy" (McGivney, 1999, as cited in Morrice, 2007, p. 159). A caveat noted by those in the field of lifelong learning is that education is most effective when it takes into account the interests, strengths, and needs of the learner (Morrice, 2007; Narushima, 2008).

2.3.1.3 Educational interventions to promote healthy eating among children

Many school-based nutrition education research demonstration programs have been able to temporarily increase children's intake of fruits and vegetables (see, e.g., "5-A-Day" programs by Baranowski et al., 2000; Evans et al., 2006; Foerster et al., 1998; Nicklas, Johnson, Myers, Farris, & Cunningham, 1998; Perry et al., 1998; and Reynolds et al., 2000). However, the increases in fruit and vegetable consumption in these programs were often minimal (e.g., "generally falling short of even a single daily additional portion per child" Lowe, Horne, Tapper, Bowdery & Egerton, 2004, p. 511), and the changes were not generally sustained.

Finding that programs focused on children alone did not seem to achieve lasting results, some researchers turned to including parents in the interventions with their children. They found that children were more likely to improve their diets when their parents were involved in the intervention (Evans et al., 2006; Perry et al., 1989; Perry et al., 1998). "Parent involvement is one factor that appears to be critical in the establishment and maintenance of healthful behaviors in younger children" (Perry et al., 1989, p. 172). However, these studies also found that facilitating changes in the home environment conducive to increasing children's healthy eating were not easy, and pointed out "the importance of creating new and more potent strategies for parental involvement" (Perry et al., 1998). The authors recommended a multi-factorial behavioural model, "with an emphasis on healthful role models, skill rehearsal, personal and family goal-setting and reinforcement" (Perry et al., 1989, p. 178). This is because including a parent component in an intervention does not guarantee effectiveness. For example, one intervention that included a parent component was able to change the home environment (measured as increasing fruit and vegetable availability and accessibility, and parental social support), but did not succeed in increasing children's consumption of fruits and vegetables (Evans et al., 2006). The authors hypothesized that perhaps the intervention did not include

enough hours of instruction, citing studies showing that about 40 hours of education are needed to enable behaviour change. Alternately, they thought that the study design might not have had enough power to show an effect (Evans et al., 2006, p. 52).

A multi-factorial design was used by another set of researchers who did achieve a significant increase in the experimental group's fruit and vegetables intakes, versus those of the control group (Horne et al., 2004). This intervention was based on "three factors that reliably influence children's eating behaviours. These are taste-exposure, modeling and rewards" (Horne et al., 2004, p. 1649). The authors showed, as part of the study, that simply increasing availability and accessibility (i.e., providing free access to fruits and vegetables at the school during lunch) did not increase children's intake of fruits and vegetables, as it was not enough to motivate them to change (Lowe, Horne, Hardman & Tapper, 2006). By adding in three more intervention elements, "peer modeling" in the form of repeated videos using child actors shown eating and enjoying fruits and vegetables, extrinsic rewards (e.g., stickers, pencils, etc.) for tasting new fruits and vegetables, and having children keep charts of their F&V consumption with the help of adults, thus keeping their attention on the goal daily, the desired effect of increasing children's intake of fruits and vegetables occurred both at school and at home. The resulting increase in consumption of fruits and vegetables was still significant at the follow-up which occurred four months after the "intervention," but the follow-up period included some continued interventions which the authors called the "maintenance" phase of the study. This study and its related body of research shows that with a substantial intervention and continued maintenance of the gains in fruit and vegetable consumption, children will change towards a healthier diet.

2.3.1.4 Education, literacy, and health literacy

A concept that can be used to tie the numerous strands of education for health, including nutrition education, together, is health literacy. The term health literacy "represents a specific set

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of cognitive and social skills related to health decision-making" (Nutbeam, 2000b, p. 183). The World Health Organization defines health literacy as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good *health*" (World Health Organization, 1998, p. 10 [italics in original]). Health literacy builds on the concept of literacy. Literacy is an important determinant of health (Public Health Agency of Canada, 2007, p. 1). In fact, several sources have suggested that "literacy skills predict health status even more accurately than education level, income, ethnic background, or any other socio-demographic variable. … [Literacy is] directly related to both overall health status and to mental health status as well as co-morbidity burden and life expectancy" (Ronson & Rootman, 2004, p. 155-6), and that there is a "fundamental and long-established relationship between access to education, population literacy levels and health status" (Nutbeam, 2000b, p. 183).

Education and literacy are tied to the concept of participation in present day society, and thus to the concepts of social exclusion and inclusion. Access to opportunities for education, and opportunities that education provide, relate to one's state of social exclusion or inclusion and thus one's opportunities for participation in society. The British government has identified health inequities as arising from inadequate education:

> Education is vital to health. People with low levels of educational achievement are more likely to have poor health as adults. So by improving education for all we will tackle one of the main causes of inequality in health (Department of Health, 1999) (cited in Nutbeam, 2000b, p. 183).

Three levels of health literacy were identified by Freebody and Luke in 1990 (as cited in Nutbeam, 2000a). They range from the most individual, "basic/functional" health literacy, to more interactive "communicative/ interactive health literacy" to the most socially and politically active "critical" health literacy (Nutbeam, 2000a, pp. 264-5). *Basic or functional* health literacy has been conceptualized as the skills and abilities needed to comply with medical instructions

and regimes in support of health. The focus at this level is usually on basic reading, writing and listening skills and being able to follow directions. *Communicative/ interactive* health literacy includes "more advanced cognitive and literacy skills which, together with social skills, can be used to actively participate in everyday activities, to extract information and derive meaning from different forms of communication, and to apply new information to changing circumstances" (Nutbeam, 2000a, pp. 263-4). The focus in communicative health literacy is on social interaction skills and skills needed to apply new information and insight to making informed choices about health. Finally, *critical* health literacy involves "more advanced cognitive skills which, together with social skills, can be applied to critically analyze information, and to use this information to exert greater control over life events and situations" (p. 264). Critical health literacy enables people "to take an active role in bringing about change in environments which influence their health" (Nutbeam, 2000b, p. 183), or, in other words, to address social determinants of health. The three levels of health literacy are a hierarchy, with advancing levels implying higher levels of skills and abilities that support control over the determinants of health. As Nutbeam (2000a) notes, each step up to a higher level of health literacy enables a higher level of autonomy and personal empowerment (p. 264). Without basic/functional literacy, it is difficult to participate fully in society, both socially and economically, participation which allows one to "exert a higher degree of control over everyday events" (Nutbeam, 2008, p. 2072). In fact, the higher the level of health literacy one is functioning at, the higher the degree of control one will have over the factors that determine one's health. This reality identifies health literacy as an important strategy of health promotion, which is defined as "the process of enabling people to increase control over the *determinants of health* and thereby improve their *health*" (World Health Organization, 1998, pp. 1-2 [italics in original]).

Definitions and understanding of health literacy are evolving. An analysis of nine definitions of health literacy from 1997 through 2008 shows a move away from a focus on reading skills (functional health literacy) towards a focus on understanding and comprehending information and being able to make use of it (communicative and critical health literacy) (Canadian Council on Learning, 2008). Health literacy is thus seen as using information, to "make informed choices, reduce health risks and increase quality of life" (Zarcadoolas, Pleasant, & Greer, 2005, as cited in Canadian Council on Learning, 2008, p. 9) or "to promote, maintain, and improve health in a variety of settings across the life course" (Rootman & Gordon-El-Bihbety, 2008, as cited in Canadian Council on Learning, 2008, p. 9). Health literacy is now also seen as possibly an important factor in healthy eating: "A low level of health literacy may have an impact on an individual's food choices, understanding of dietary terms and concepts, and overall health in general" (Boehl, 2007, p. 380).

Literacy has a cultural context; understanding needs to occur within a mind set or cultural context. An Aboriginal researcher's definition of health literacy sees it as "a way of life with a holistic world view balancing mind, body, heart and spirit as in the four components of the medicine wheel" (Antone, 2004, as cited in Ronson & Rootman, 2009, p. 174). Another First Nations author, Marie Battiste, states that literacy is "a social concept more reflective of culture and context than of formal instruction" (Battiste, 1984, as cited in Ronson & Rootman, 2009, p. 174).

Paolo Freire's work in increasing literacy with disadvantaged populations is well known to health promotion activists. His focus on action for change fits with his description of literacy as an "active phenomenon. …. [Freire's] work helped transform understanding of literacy from a received ability to read and write to an individual's capacity to put those skills to work in shaping the course of his or her own life" (Rootman & Ronson, 2005, p. S65) and has influenced current understandings of health literacy as an asset for facilitating health in a broad sense.

Research with illiterate groups shows that they can be enabled to attain high levels of "critical health literacy" that allows them to exert greater control over their lives, without having to attain functional literacy (reading, writing, etc.) (Nutbeam, 2000a, p. 264): "In fact, any communication practice that enables a person to function effectively in their local social and cultural contexts and participate in decisions that affect them must also be understood as literacy" (Nason & Whitty, 2004, p. 3). Thus the concepts of literacy and health literacy must be expanded beyond skill building in reading and writing to encompass cultural differences in approaches to knowledge. In programs such as CFF that operate in multi-cultural settings, it is important to be aware of the implications of the ways that culture and situation influence both conceptualizations and applications of the idea of health literacy.

Nutbeam (2008) suggests that health literacy has now branched into two major divisions: health literacy related to clinical situations, where lack of health literacy is seen as a risk to health; and health literacy related to public health, community health, and health promotion, where health literacy is seen as an asset and a resource for health. In clinical settings, an analysis of the concept highlights the following attributes as essential to health literacy: "reading and numeracy skills, comprehension, the capacity to use information in health care decision-making, and successful functioning as a healthcare consumer" (Speros, 2005, p. 663). While Speros (2005) defines health literacy in a nursing/clinical situation as entailing the use of "advanced cognitive and social skills" in "new and changing health-related [read 'health-*care* related'] circumstances" (p. 633), Nutbeam (2000a) adds "personal skills" when he defines health literacy in a broader, more inclusive environment; i.e., in the community as well as the clinic. Health literacy, according to the wider view, refers to: "the personal, cognitive and social skills which determine the ability of individuals to gain access to, understand, and use information to promote and maintain good health" (p. 263), a more health-*promotion* oriented definition that omits reference to the healthcare consumer. Nutbeam does not specify what these "personal" skills are,

but in regard to this dissertation, for example, these types of skills could refer to the knowledge

and skills needed to choose and prepare healthy meals at an affordable price.

The new expanded term health literacy incorporates previous key health promotion

concepts: "personal health practices and coping skills" (Public Health Agency of Canada, 2007,

p. 1),[13] and "individual and community empowerment" (Tones, 2002, p. 288):

> Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal *lifestyles* and *living conditions*. … By improving people's access to health information, and their capacity to use it effectively, health literacy is critical to *empowerment.* (World Health Organization, 1998, p. 10 [italics in original])

Although the evidence base for health literacy as an asset still needs to be built (Nutbeam,

2008; Peerson & Saunders, 2009), there is a growing interest in defining a broad based

conceptualization of health literacy related to the public's health in everyday life settings:

> Our concept of health literacy includes information and decision-making skills occurring in the work-place, in the supermarket, in social and recreational settings, within families and neighbourhoods, and in relation to the various information opportunities and decisions that impact upon health every day. (Peerson & Saunders, 2009, p. 289)

From another angle, however, Goldberg (2007), speaking from a narrower conception of

health literacy, nevertheless argues that since low literacy is connected to both poorer

socioeconomic circumstances and lower health literacy, it might make more sense to address

socioeconomic disparities, i.e., address the root of the problem, rather than focusing on trying to

raise literacy and health literacy rates (p. 19). This is an important argument about strategy for

health promotion to consider, and one that applies to CFF programs and health literacy, or

competencies, related to food and nutrition, as discussed in this thesis. What could be perceived

as an opposite approach to what Goldberg (2007) is suggesting (to the same end of increasing

equity and health equity among populations, or reducing health inequalities) is that of Nutbeam

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[13] "Personal Health Practices and Coping Skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health." (Public Health Agency of Canada, 2007)

who argues that (critical, especially) health literacy should be used to focus attention on and address the social determinants of health: "Health literacy … is seen as a means to enabling individuals to exert greater control over their health and the range of personal, social and environmental determinants of health" (Nutbeam, 2008, p. 2074). For this to happen, the concept of health literacy has to include "motivation and activation" as well as skills, competencies and understanding (Peerson & Saunders, 2009).

2.3.2   Food security strategies

There are three types of strategies aimed at addressing food insecurity among vulnerable families and individuals (Community Nutritionists Council of BC, 2004). The strategies lie along a continuum from least to most likely to be able to alleviate food insecurity adequately and permanently. The first type of strategy is said to be an "efficiency" strategy; it meets emergency needs but does nothing to address the underlying problems. Charitable food programs fall into this category. The second type of strategy is called "participation/ transition" and includes nutrition education and programs such as community kitchens and gardens. These types of programs provide opportunities for active participation and/or knowledge and skill development and are aimed at building individual and community capacity. The third type of strategy is called "system redesign" and is realized through changes in organization, policies, and legislation to address structural problems causing inequalities and inadequacies (Community Nutritionists Council of BC, 2004).

The most common charitable food programs are initiatives such as food banks and subsidized or free meal/feeding programs. The first food bank was opened in Canada almost thirty years ago. By 2007, the number of persons using a food bank in Canada was above 700,000 per month (Canadian Association of Food Banks, 2007, p. 7), and during the past year,

food bank use increased by 15% in British Columbia (CBC News, 2009). Numerous studies have shown that using food banks is stigmatizing and demeaning, and that the quality and amount of food obtained is not sufficient to support a nutritious diet (Tarasuk, 2003; Tarasuk & Beaton, 1999; Teron & Tarasuk, 1999; Yadlowski & Theriault, 1998). Factors related to the astronomical rise in food-bank use in Canada including increasing unemployment and low-wage jobs, rising costs of housing and other basic needs, and decreased social services (e.g., welfare, Employment Insurance, Workers' Compensation) (McIntyre, 2004; Power, 1999; Yadlowski & Theriault, 1998). Even so, not all people who are struggling to acquire enough food actually use a food bank; estimates run as high as that only one of every four or five people who are struggling will resort to using a food bank (Canadian Association of Food Banks, 2007, p. 8). These types of programs clearly do not meet the long-range needs of people suffering from food insecurity.

> Food banks, community foundations, school breakfast and lunch programs, emergency shelters, and a huge network of family caregivers and volunteers struggle to meet the needs of people failed by the education system, facing discrimination in the job market, living with chronic health problems, or trying to balance raising a family with working. (Canadian Association of Food Banks, 2007, p. 7)

Charitable children's feeding programs have also become institutionalized across Canada in many schools, churches and community centres. These have also been criticized for failing to attract those who really need them and for stigmatization of potential recipients (McIntyre, Travers, & Dayle, 1999). Charitable programs are problematic in that they do not support the right to food, citizens' entitlement to food and an adequate standard of living. They are stop-gap measures, and without providing real solutions, at the same time seem to "render the experience of the problems unknown" (MacAulay, 2005, p. 43). That is, because of the "band-aid" solution, finding a real solution gets put onto the "back burner." This criticism of charity and aid-based solutions has been made over many years by social activists (Poppendieck, 1998; Power, 1999; Riches, 1997; 1999a; 1999b; Tarasuk, 2001) and is echoed by the food banks themselves (Canadian Association of Food Banks, 2007, p. 8).

Participation/ transition or "capacity building" programs, the second type of response to food insecurity, include community kitchens, community gardens, farmers' markets, food box programs and other programs that attempt to involve producers and consumers in a mutually-beneficial relationship. These types of programs contribute to building relationships in communities and some (e.g., community kitchens, community gardens) often provide some instrumental support in the form of food. An important goal of participation/ transition programs is to provide a setting where participants can develop a sense of agency; a sense of being more active in solving problems and having more power and control over determinants of their health. In most cases this type of program is unable to provide enough food assistance to enable its participants or recipients to escape from a state of poverty or food insecurity. The CFF program is built on the community kitchens model, which will be discussed in more detail below.

The third type of response to food insecurity, policy and structural change, is likely to be, if adequate, the most successful strategy for reducing families' food insecurity (Community Nutritionists Council of BC, 2004, p. 30). These types of changes, such as changes in taxation, social assistance, disability and employment insurance benefits policies, as well as changes in minimum wage requirements, and the availability of sufficient employment, adequate child care – in short, economic policies to provide for full participation in society of all citizens, are beyond the scope and experience of the CFF programs and this study. That is not to say that they are not important; they are very important, and should be a focus of future research and action on solving the problems of poverty and food insecurity.

2.3.2.1 Community kitchens programs

"Community kitchen" is the generic term used for a number of types of programs where a group of people cook, and often eat, together. The focus, as illustrated by the Vancouver Community Kitchens Project's definition of community kitchens, is on healthy eating and a balanced diet, as well as providing several meals to be taken home:

A community kitchen is a group of individuals who meet regularly to cook healthy, nutritious meals. Everyone is expected to participate in the menu selection, shopping, preparation, and cooking; the only requirement is an interest in food. Good nutrition plays a key role in each community kitchen. Participants learn new recipes and are introduced to new foods that contribute to a more balanced diet. As well, several meals are usually taken home and frozen for later, thus furthering healthy eating habits. Members share food and nutrition knowledge as well as culinary skills. (Greater Vancouver Food Bank Society, 2009, para. 2)

The strategies applied during the sessions are working together, learning new recipes and being introduced to new foods. The Australian Community Kitchens Website draws on what they call the "Canadian community kitchens concept" with a similar definition, but which also includes the members of the kitchen socializing and enjoying meals together:

A Community Kitchen involves a group of like-minded individuals coming together on a regular basis to socialize and cook before enjoying delicious, affordable and nutritious meals with new friends. Many kitchens buy and cook in bulk to allow the production of many meals at low cost. Participants can then take meals home to enjoy on subsequent days. The participants have ownership over their kitchen and direct how they would like their kitchen to run. (Australian Community Kitchens, 2009, "What are Community Kitchens," para. 2)

The goals of the programs are to promote "healthy eating and the development of personal skills and social support networks within the local community" (Australian Community Kitchens, 2009, para. 1).

Community/collective kitchens (CKs) have become popular among the poor during the same time period (roughly the last 20 years) that food banks and charitable feeding programs have become ubiquitous in Canada. The driving force for these programs has been food insecurity; the underlying goal of the various types of community kitchen programs is to increase members' access to nutritious food.

Community kitchens have been seen by many in the community as part of the community food security movement, a set of strategies focused on achieving local solutions to hunger and food insecurity (Community Nutritionists Council of BC, 2004; Tarasuk & Reynolds, 1999). Tarasuk and Reynolds (1999) distinguished among three types of community kitchen programs,

which they called collective kitchens, cooking classes, and communal meal programs. Collective kitchens are most commonly comprised of a few participants who meet once or twice a month to prepare several meals to take home and freeze, to provide for their families over a several-day period. The purpose of collective kitchens is to produce the maximum amount of nutritious food possible for the participants and their families while saving on food costs and pooling labour. Collective kitchens are often subsidized by public health or other community-based agencies.

While collective kitchens often have a social and educational focus in addition to the purpose of food preparation (Engler-Stringer & Berenbaum, 2007), cooking classes are more clearly focused on education. The main goal is similar to that of collective kitchens, i.e., to improve food security while supporting and encouraging healthy eating. However, cooking classes aim to achieve this goal by "[exposing] members to new foods and different methods of food preparation … [under the premise that] enhanced food preparation skills will enable participants to use their food dollars more effectively and to prepare more varied, nutritious, low-cost meals at home" (Tarasuk & Reynolds, 1999, p. 13). In the cooking classes examined by Tarasuk and Reynolds, participation was somewhat limited to watching and helping with demonstrations, and sampling and taking home a small amount of food.

The third type of community kitchen noted by Tarasuk and Reynolds (1999), communal meal programs, is focused on participants preparing and sharing a meal together. The programs are often subsidized, but the main focus (as well as the provision of a meal) is to provide a venue for social and recreational interaction, rather than being directly educational or cost-saving for participants. There is often a secondary focus of introducing participants to other social services and forms of potential support.

Until recently, there had been few evaluations of these types of programs, and the criteria that would be used to evaluate them were said to be unclear (Tarasuk & Reynolds, 1999). The evaluation studies that have been conducted are primarily qualitative, descriptive studies, using

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interviews (Fernandez, 1996; Ripat, 1998), a combination of observations and interviews (Engler-Stringer, 2005; Engler-Stringer & Berenbaum, 2005; 2006; 2007; Tarasuk, 2001; Tarasuk & Reynolds, 1999) or focus groups (Marquis, Thomson & Murray, 2001) to capture program descriptions and the perceived impacts of participation in the programs. Two studies used questionnaires; one employing a pre- and post-program design to capture participants' perceptions of change on topics such as whether a nutritious diet was affordable and/or time consuming to prepare (Crawford & Kalina, 1997), and the other employing a cross-sectional design to obtain participants' perceptions of changes that had occurred in their lives since they had joined the collective kitchens (Fano, Tyminski & Flynn, 2004). No studies have employed detailed dietary assessments or other measures that could be used to confirm changes in nutritional status due to attending the programs, or sophisticated measures of change in household food security status over time due to attending community/collective kitchens programs.

Most of the community kitchens referred to above can be described as collective kitchens, with their main goal being to supplement participants' food resources with extra meals to take home. The underlying assumption made by most of the instigators of the collective kitchens was that for the participants, purchasing and preparing food in large quantities (i.e., in bulk) would be a cost saving/food insecurity alleviation factor. Examination of the collective kitchens found that a large proportion of the interviewees said that they had joined the programs for financial reasons: "They felt they could make more of their limited funds with the savings incurred from cooking in bulk (often with some subsidy)" (Engler-Stringer & Berenbaum, 2007, p. 79). Most of the collective kitchens were organized, at least during their initial period of operation, to provide subsidies towards food purchase and/or donations from charitable food distributors such as food banks. It was assumed by the program developers in many cases that as the programs advanced, participants would learn to procure cost savings measures related to bulk

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buying and food preparation, and perhaps increased food planning and preparation skills, that would reduce or eliminate their need for the subsidies.

However, research examining CKs has shown that there are limitations to the ability of CK programs with respect to alleviating household food insecurity (Kirkpatrick & Tarasuk, 2009). From the first published evaluation of collective kitchens in Canada, community kitchens were associated with "building food security" but at the same time were acknowledged to not be able "to solve all the problems associated with food insecurity" (Crawford & Kalina, 1997, p. 197). Soon after this publication, Tarasuk and Reynolds (1999) reported that the community kitchens programs they evaluated had "limited potential to resolve food security issues rooted in severe and chronic poverty because they do not alter households' economic circumstances in any substantial way" (p. 11). And although the Calgary Collective Kitchens Program did not list food security in its objectives, Fano, Tyminski and Flynn (2004), in their evaluation, stated that community/collective kitchens "address food insecurity" (p. 74) and that "[t]he Collective Kitchen Program was initiated to alleviate the consequences of food insecurity in Calgary" (p. 78). They were, however, inconclusive about the issue in the results of their study of collective kitchens, saying only that the collective kitchens they studied "may increase members' capacity to attain food security and to achieve improved nutritional health" (p. 72). An overall finding in the review of the literature on community kitchens conducted by Engler-Stringer and Beranbaum (2005), meanwhile, was that participants themselves were somewhat surprised that the programs did not contribute to assisting with food insecurity as much as they had thought they would.

To clarify this question of whether or not participation in collective kitchens and community kitchens was felt by participants to overcome food insecurity, Engler-Stringer (2005) looked at a number of aspects of food security/insecurity that are discussed in the literature (hunger, quality, variety, worry and stigma) in her study. She found that although most collective kitchens did address some aspects of food insecurity, such as participants adding more variety of

foods to their diets as well as increasing their families' consumption of vegetables, and possibly other aspects of healthy eating/nutrition such as lowering fat intake, they did not generally address the problem of lack of sufficient quantity of food unless they provided additional food resources (subsidized) as part of the program. She found that only where participants were able to take home at least five meals per month for their families, many of which collective kitchens involved subsidies, were the programs perceived to contribute to food security. Also of note is that the method by which this increase in food security was said to have occurred was through an augmentation of food resources (Engler-Stringer & Berenbaum, 2007). Respondents in her study reported on a variety of issues that they felt were related to their food security, such as financial savings (because of the subsidies and/or of the bulk buying aspect); improved food quality (due to not having to use the food banks as much; to increased variety of foods, particularly the use of more vegetables than they would be able to afford on their own; and also the focus on healthiness and increased use of vegetables); and increased dignity because of not having to rely as much on charity or on other socially unacceptable ways of procuring foods. Engler-Stringer and Berenbaum (2007) agreed with Fano et al. (2004)'s remark that an increase in consumption of fruits and vegetables attributed to being in the program is a significant increase in food security because of the "greater nutrient values per dollar spent" (Engler-Stringer & Berenbaum, 2007, p. 81), and that, likewise, learning to cook more meals from "scratch," which some participants (mostly younger ones) accomplished, can increase food security, at least marginally, due to the increased buying power of participants' incomes. Many low-income women, however, have developed the art of living on a budget to a high degree and do not have a margin for improvement in this area (Tarasuk & Maclean, 1990; Travers, 1995). As Engler-Stringer and Berenbaum (2006) concluded, "[m]any participants felt that they already had significant skills in managing their limited resources" (p. 180).

It is helpful to think about food insecurity as a dearth of resources; it then becomes clear that some collective kitchens, particularly if they are subsidized, can help increase participants' access to resources. Tarasuk and Reynolds (1999), in their study of community kitchens (i.e., collective kitchens) as a response to income-related food insecurity, found, similarly to Crawford and Kalina, that although this type of program is not able to alleviate food insecurity to a significant extent, "in some cases, community kitchen participation may enhance coping skills and provide valuable social support" (Tarasuk & Reynolds, 1999, p. 11).

Analysis of how to support the type of community development needed to reduce food insecurity has been lacking in the community kitchens movement in most of Canada. The exception is the collective kitchens movement in Quebec, which includes a substantial focus on political awareness of the causes of poverty, although Engler-Stringer and Berenbaum (2006) commented that in their study, the Montreal collective kitchens participants' "knowledge of the roots of poverty did not appear to be more sophisticated" than that of the participants interviewed in Saskatoon and Toronto (p. 182). Thus, as Tarasuk and Reynolds (1999) noted, although community kitchens have been identified by community workers in Canada as "a means to empower those vulnerable to hunger and food insecurity through the provision of skills, resources, and support" (p. 11), given the circumstances, it is unrealistic to expect that CKs "[would] have a major impact on income-related food insecurity" (p. 16).

A review of evaluations of collective kitchen programs (Crawford & Kalina, 1997; Engler-Stringer, 2005; Engler-Stringer & Berenbaum, 2005; 2006; 2007; Fano, Tyminski & Flynn, 2004; Fernandez, 1996; Marquis, Thomson & Murray, 2001; Ripat, 1998; Tarasuk, 2001; Tarasuk & Reynolds, 1999) shows that most collective kitchens include an educational focus as well as their primary goal of increasing food quantity and quality for their participants and their families and have perceived social, educational and psychological benefits to participants. For example, one evaluation stated that "[the community kitchen program] is shown to be an

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effective format for the development of enhanced food-related capacity, self-efficacy, social

support, mutual aid and community awareness among participants" (Crawford & Kalina, 1997,

p. 197), while another listed the perceived benefits of community kitchens as "socialization, peer

support, increased nutrition knowledge, increased variety of foods used, and improved cooking,

shopping, and budgeting skills" (Marquis et al., 2001, p. 131). A third noted that community

kitchens (i.e., collective kitchens) in Winnipeg provided a socially acceptable venue for

acquiring more food for families (as opposed to food banks), as well as other benefits, such as

"skill building around cooking, budgeting and nutrition" (Ripat, 1998, p. 7) and a variety of

forms of social support and access to community resources, and were instrumental in supporting

individual empowerment/individual capacity building and community empowerment/community

development. Participants seem to enjoy the programs, benefit from the social support and

mutual aid aspects of the programs, and most participants develop new food and nutrition-related

skills. The education is of a practical nature, focused on increasing knowledge and skills

regarding healthy eating, coupled with encouragement and support in applying their knowledge

and skills towards behaviour change that can positively influence personal health practices

(Engler-Stringer & Berenbaum, 2005). The types of knowledge and skills mentioned by low-

income participants in the most extensive evaluation, (Engler-Stringer, 2005; Engler-Stringer &

Berenbaum, 2006), focused on things such as learning to use recipes and to prepare dishes from

basic ingredients, how to utilize more fruits and vegetables, and how to consume less fat "('like

trimming the excess fat off my meat before I cook it')" (Engler-Stringer & Berenbaum, 2006, p.

180). Participants also mentioned learning skills such as how to read labels on food packages,

and some participants changed their buying habits to include more buying in bulk.[14]

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[14] It is not clear from the report as to whether participants got together to buy in bulk, or, if not, how low-income participants were able to afford to make this behaviour change.

Perhaps the most elequent description of what community kitchens can provide comes from the review of collective kitchens in Winnipeg (Ripat, 1998). Community kitchens apply the principles of health promotion, particularly the strategy of "participation," to developing community solutions to community problems. They are responsive to community needs in that they provide a format and tools for the program, but allow the participants a large degree of control over the organization, goal-setting and content of the program:

> Community kitchens attempt to challenge the status quo of disconnectedness and hopelessness at both the individual and community levels, and draw from the principles of self-help and community development. They aim to transform and change the relationships, and surroundings of a group and the individuals who comprise it. They stress the benefits of identifying and solving problems using the insight, potential, and power of the group. Beyond the material accomplishments of the community, group, and individuals are the internal feelings of self-worth and accomplishment that accrue from such an undertaking, and the potential for further action. (Ripatt, 1998, pp. 20-21)

2.4 Summary

While the poor in our society face many problems related to a lack of resources that likely impacts poorly on their health, the main focus of this study is on nutrition; specifically, two aspects of nutrition – healthy eating, and food security/insecurity. The context surrounding these aspects of nutrition is complex and there are no simple, obvious solutions to the challenges involved for all, and particularly more disadvantaged, citizens to achieve access to adequate nutrition. With the poor receiving less income-related support from government agencies than in previous decades, the attention of health promotion endeavours has shifted to understanding the determinants of health and attempting to positively influence them, particularly for and with vulnerable societal groups.

Much has now been learned about the social determinants of health. We are now aware that feelings of agency and ownership are necessary for citizens to be able to increase their sense of control over their health and lives. It is likely that this type of empowerment needs an everyday context in which to develop, making community-based programs a strategy of choice

for supporting the development of the current health promotion priorities for action: supportive environments, social networks and health literacy. However, evaluations of small programs that arise out of the community and are owned and run by the community itself are scarce, in part because many of these small community-based programs are under the radar of academic and government institutions that conduct most program evaluations. And although there have been a few evaluations of community-based community kitchens programs for low-income population groups, there have been no studies describing the implementation or perceived benefits of this type of program within an inner city school setting. The development, within inner city schools, of health promotion programs that are based on a community model is a field of practice about which little is known. This review of the context and factors surrounding healthy eating and food security in the community thus exposes a significant gap in the literature. What can small school/community-based health promotion programs contribute to achieving the current health promotion priorities? What might these types of small programs look like and how do they operate? This study examines one such program to gain answers to these questions.

Chapter 3: Methodology and Data Collection Methods and Analytic Procedures

3.1 Methodology

Two main philosophical frameworks are used to guide research in the social sciences: positivism and interpretivism (Williamson, 2006). While positivism focuses more on hypotheses and on measurement of an assumed objective and stable reality, interpretivist paradigms are more suitable for studying the social world, in which the object of study, human experience and its meanings, is constantly being re-evaluated and interpreted by humans. "Understanding" and "meaning" are some of the main tools and terms used to describe the methods of analysis of an interpretive approach when used in evaluating social programs:

> Evaluators using an interpretive approach hope to gain an understanding of program impacts and effects from a variety of perspectives. The emphasis would be how the program is "known" to the various parties involved. This type of evaluation is concerned more with establishing *what* the impacts and effects of a program are than with measuring the extent of presupposed impacts and effects. (VanderPlaat, Samson, & Raven, 2001, p. 81 [emphasis added])

Constructivism (Downes, 1998; Guba & Lincoln, 1994; Williamson, 2006), one of the paradigms[15] falling under the interpretivist philosophical framework, "refers to a cluster of related approaches to the study of science" (Downes, 1998, p. 624) that hold that scientific representations of reality are constructed rather than discovered by scientists, and that knowledge is constructed between the researcher and the researched through shared communication, wherein each influences the other. "Its methodology is hermeneutic, that is, interpretive, and dialectic, in that it involves a constant comparison of differing interpretations. It is a process of iteration, analysis, critique, reiteration, reanalysis, synthesis, and so on" (Labonte & Robertson, 1996, p. 434). Constructivism assumes that there is not one, objective truth to be found, but that partial truths may be comprehended from numerous standpoints; thus its stance to ontology is

said to be relativist. The focus of the inquirer is on understanding, which includes interpretation, and this can only be accomplished in dialogue with the evaluands. There is no one particular method of inquiry that is inherently superior to other methods when formulating knowledge in the constructivist paradigm. This means that the choice of research method(s) should follow the contours of the needs of the research, with the subject matter leading to an understanding of which method or methods are most appropriate.

This study can be characterized as a responsive evaluation in the form of a case study (Stake, 1995; 2004), based on the constructivist paradigm. Its intent is to understand the benefits that the CFF programs are perceived to provide to participants and their communities, relating to the typical evaluation question posed by Greene (1994): "How is the program experienced by various stakeholders?" (p. 532). The study design and methods were influenced by the case study and responsive evaluation work of Robert E. Stake (Abma, 2005; 2006; Abma & Stake, 2001; Stake, 1978; 1994; 1995; 2000; 2004; 2005, 2008). The study adhered to Stake's idea that interpretation, a sharpening of the "awareness of the multiplicity of realities," and not confirmation, is the aim of constructivist research (Abma & Stake, 2001 p. 17). The study questions, methodology and data collection methods were responsive to the context of the program: the fact the program was undocumented and formerly unresearched necessitated a mainly qualitative approach to facilitate the greatest possible understanding and interpretation of the meaning and value of the CFF program to the community. Stake, a master in educational research, stresses the importance of noticing and conveying the particular, stating that in his experience, education is most often improved by practitioners' learning from particulars rather than by a central authority's attempts to impose change based on summative theory (Abma & Stake, 2001).

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[15] A paradigm is a set of basic beliefs; "the basic belief system or worldview that guides the investigator." (Guba & Lincoln, 1994, p. 105)

Stake contrasts responsive evaluation with "standards-based" or "criterial" evaluation (Stake, 2004). Responsive evaluation applies an interpretive approach to data analysis, that is, examining the data to gather understandings in an emergent manner to identify and to pursue knowledge about issues that are of interest and importance that need to be examined. Standards-based or criterial evaluation, on the other hand, approaches a study with issues, constructs and variables already defined and standards available by which to measure attainment of critical levels of the criteria. Standards-based is not as effective as responsive evaluation in following a series of thoughts or events (Stake calls them "episodes") over time to see what arises and where they lead. According to the postmodern conceptualization of truth, rather than matching facts to theory (through the use of standards) to discover truth, it may be discerned, as far as possible, by "discovering [a] range and scope of interpretive standpoints" (Rosenau, 1992, p. 134).

The focus on understanding the program led me to interpret my approach as a form of ethnography (Marcus, 2008) and to think of myself as a field worker: "Field researchers seek to get close to others in order to understand their way of life. To preserve and convey that closeness, they must describe situations and events of interest in detail" (Emerson, Fretz, & Shaw, 1995, as cited in Silverman & Marvasti, 2008, p. 216). I was experienced with this particular field, having worked on developing the program several years earlier. The study focused on understanding the program, both from the points of view of its constituents and from my own point of view, which included my historical knowledge of the program and the observations I made of the current programs. The goal of the understanding was to delineate the boundaries of what the program is perceived to be able, or not able, to achieve, in the health promotion priority areas of creating supportive environments, strengthening social networks and enhancing health literacy (Mittelmark et al., 2008b) (in this study, health literacy as related to food and nutrition), as well as examining the effects of these potential achievements on healthy eating and food security for the study participants. The focus on understanding required finding

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out what was important and significant about the program to its constituents, and presenting this to the reader in a way most likely to convey both the similarities and the differences between various constituents' conceptions, while trying to create a meaningful overview based on all the information. The presentation of the findings was structured to present the reader with a description of the program that was detailed and sophisticated enough to allow the reader to form a complex mental picture of the program, thus applying Stake's concept that description/perception and judgment happen concurrently and the one depends on the other.

Identification and description of issues from a variety of viewpoints, and judgment of the quality of the program in dealing with those issues, are the main objectives when conducting a responsive evaluation (Stake, 2004). Dialogue is one of the keys to accomplishing this, as ideas about issues are developed and pursued through discussing and questioning. This study was responsive in that it examined the CFF programs in an open-ended manner, using participant observation and relatively unstructured interviews with evolving questions and lines of analysis based on ongoing interpretation of results as they were obtained. Some aspects more typical of a standards-based approach were also used to guide the study, in that a conceptual framework was developed early in the research process, based on prior experience and reviews of the literature. The conceptual framework indicated that both food and nutrition-related and psychosocial perceived impacts of the program were likely to be found. This conceptual framework was used in putting together a questionnaire for adult program participants, which was planned to complement the qualitative approaches that were being used. Once more experience was gained in the research field, through observing the programs and administering the questionnaire, the planned qualitative aspect of the study took on more prominence in developing the interview questions that were more tailored to the specific situation and to the different groups of interview respondents. This staged approach is typical of responsive evaluation: "Its design is slowly developed, with continuing adaptation of evaluation goal-setting and data-gathering" (Stake,

2008, p. 1). Stake (2004) discusses the application and merits of the two types of approaches (responsive and criterial or standards-based) and advocates using a combination of them, based on the specific needs of the situation.

The responsive evaluation framework suggested specific foci for the data collection. They were: examine what happens in the programs, and ascertain why people implement the programs in the ways they do. To understand what happens in the programs and to ascertain why people implement the programs in the ways they do, the researchers should examine the goals and objectives that people hold for the programs and the strategies they use to accomplish their goals, and should identify supports, obstacles and challenges to the program. This is to avoid "black box research" wherein the impacts are articulated but there is no indication of why these impacts were relevant or how they were accomplished. Knowing the reasons and goals that people hold for the program makes it possible to look at these reasons and goals in relation to the structure and strategies that are implemented when studying the perceived impacts of the programs and make connections related to why the program is making a difference or why it might not be making as much of a difference as one would want it to. To incorporate the complexity of the setting into the interpretation, the baseline characterizations of the clientele are also important.

The CFF program model as a whole was conceived of as the case, with each school treated as a site that was part of the case. Case study methods are appropriate for naturalistic (constructivist) evaluation "because they are concrete, contextual, and open to different interpretations" (Williams, 2005, p. 273). A case may be "simple or complex" (Stake, 2000), and may be, for example, an individual person (Stake, 2000), an initiative or program (Bloxham, 1997), or a decision, an event, or a study of organizational change (Yin, 1994). A case is, however, "an integrated system," (Stake, 1995, p. 2) and most, if not all, programs, are integrated systems, with boundaries. The level at which an object (i.e., a case) is studied relates to the

research questions and what will be most useful in answering them. Stake (1995) suggests that the complexity that the case study method or style of writing allows is one of its strengths. "The important thing is … not to write down so as to minimize misinterpretation but to write up so as to maximize reader encounter with the complexity of the case" (Stake, 1995, p. 126).

3.2 Methods

3.2.1 The research project and team

The research project was supported by a Social Sciences and Humanities Research Council of Canada (SSHRC) – "Society, Culture and the Health of Canadians" research grant (SSHRC ORS #00-3462) for a two-year period, beginning in April, 2001. The premise for the funding was that a small, school/community-based health promotion program of this nature might be perceived by those involved to be of value in the context of combining aspects of culture, health and the broader society to provide unique health-related benefits to a particularly vulnerable population, i.e., poor, multi-ethnic inner city families. It was thought that if the program were found to be of enough perceived value to those it served, it might also be of use to a larger Canadian population and be worth expanding beyond the inner city of Vancouver. The study was therefore to examine not only the benefits of the programs, but the context, and the relationship between the benefits and the context, to provide a platform for thinking about the merits of possibly expanding the program.

I had taken the lead on writing the grant proposal, and also in conducting and writing up the study, which would constitute my dissertation, under the guidance of both the research team and my doctoral studies committee. The research team consisted of four faculty members from the University of British Columbia (UBC) and a community advisor, and my doctoral committee consisted of the same four faculty members from UBC and an additional professor from Simon Fraser University. The areas of expertise in the guiding teams were nutrition, health promotion, political science, women's studies, and evaluation.

3.2.2 Review of study protocols by ethics review boards

The study received approval from the University of British Columbia Behavioural Research Ethics Board (Certificate #B01-0173) (Please see Appendix A), the Vancouver School Board (Appendix B) and the Vancouver/Richmond Health Board (Appendix C). Copies of the letters of introduction to research participants (in three languages) are in Appendix D. Copies of the accompanying consent forms for parents are in Appendix E. The consent form for staff and administrators can be found in Appendix F.

3.2.3 Conceptual framework and data collection framework

I had worked on the development of the CFF program from 1994-96 and had conducted an (unpublished) evaluation of the pilot program at that time. I was therefore familiar with some of the possible issues and impacts of the programs and was able to begin collecting preliminary observational data and conduct a few exploratory interviews almost immediately when the research began. This initial glimpse at the current CFF programs served to help inform the development of a conceptual framework to guide the creation of the data collection instruments and the study analysis and interpretation. The conceptual framework was based on literature review and previous experience with the program. It hypothesized that the main benefits of the programs would fall into two areas: food-nutrition related and psychosocial. In the food-nutrition related benefits, of particular interest would be whether or not, and if so, how the program was able to increase vulnerable participants' food security. A data collection framework was created to summarize how the study concepts, types of data collection tools and categories of study participants were related to each other (please see Appendix G).

I was in charge of all aspects of liaising with the programs, collecting and analyzing the data, and writing up the results. During the second and third years of the study, I had a half-time research assistant who was a Master's student with training and experience in qualitative research methods to help with data collection and analysis. I also oversaw three nutrition

students who volunteered at the programs and collected observational data under my supervision, and I acquired observational notes from another nutrition student who had volunteered at one of the programs. The design of the study included a questionnaire for adult participants, document review, observation of the programs and of the staff networking meetings, and interviews with adult participants, staff and administrators. The more qualitative observational and interview data were the main source of information for the study.

I decided to use the same set of basic questions at each program site to produce comparable information about the programs and to support building an overall evaluation of the strengths and limitations of the program model as a whole. To facilitate description of the program model and understanding of its strengths and limitations, information would be collected, at each program site, about the:

- Setting and participants (number, brief description)
- Origin and history of the program
- Staff - roles, job descriptions, time spent on program
- Administration - roles and responsibilities
- Budget and program costs
- Program goals and objectives
- Monitoring and evaluation data collected, if any, and
- Program activities

To answer questions about the perceived benefits of the programs, interview questions would focus on the theoretical areas of:

- Food and nutrition
- Food safety
- Hunger and food security
- Social support
- Social integration
- Self-efficacy
- Sense of belonging
- Relationship to the school
- Satisfaction with the program

Although these concepts were used in formulating the interview questions, the questions asking about perceived benefits were open-ended to allow participants to state their ideas in their own

words and concepts, and to allow for other issues to also emerge. This process reflects the interplay between the use of a quasi-criterial theoretical framework to give some structure and guidance to the research, and ensuring questions were open-ended to allow new concepts to emerge, reflecting the dominant responsive approach of the research.

3.2.4   Instrumentation developed for the study

The data collection and management instruments used in this study were developed over time, as needed, as is appropriate for an evaluation based on a constructivist paradigm. A structured set of data collection instruments was needed to ensure the equivalence of data collection at multiple sites by multiple data collectors. The data collection approaches and instruments included participant observation at CFF programs (see Appendix H) and staff networking meetings; a set of interview guides (for adult participants (Appendix I), staff (Appendix J), and administrators (Appendix K); an adult participant questionnaire (Appendix L) and a staff questionnaire (Appendix M). Data management tools that were developed included implementation-data grids (see Appendix N) and a table for collating data from the staff evaluation forms (Appendix O). Each instrument, as it was being developed, was informed by preliminary research in the field, was submitted to the research advisory committee for feedback and suggestions, and was also pilot tested with respondents. Each was revised accordingly, and is described below.

3.2.4.1 Participant observation at CFF programs

I developed a program observation guide that included: the school name, date and time of the program; a description of the setting; the number of people present; parent, child and staff activities; menu; and interactions and conversations among participants (see Appendix H). I used the guide myself and also instructed my research assistant and the nutrition students I was supervising to use the same format for writing up their observations. The nutrition student

volunteers participated fully in the programs they were observing (e.g., helping with the children, discussing menus and nutrition information with parents, suggesting and teaching menus, and sharing in set-up, food preparation, clean-up, and meals). My research assistant participated less actively but still helped with clean-up, talked with parents and staff, and ate with the groups, while I participated in conversations at the programs and occasionally helped with clean-up but did not participate in the food preparation or consumption due to my own dietary limitations. I trained each nutrition student I oversaw in basic research protocols and methods before they were allowed to attend the programs, organized their attendance at the three programs they took part in, supervised and oversaw their participation (in conjunction with the staff of the programs they were attending), and reviewed and monitored their written observations, giving them feedback and suggesting areas for ongoing inquiry while in the field.

Observational/field notes were written up by all researchers as soon as possible after leaving the program. Preliminary data analysis was begun immediately after the collection of each observation. To this end, the write-up of my own observations sometimes included a section at the bottom for comments and ideas about what to look for during the next observation. At other times I created a separate contact summary sheet, "a single sheet with some focusing or summarizing questions about a particular field contact" (Miles & Huberman, 1994, p. 51).

3.2.4.2 Interview guides

The semi-structured interviews with parents/grandparents were based on an interview guide that included about twenty open-ended questions to be used in a comfortable discussion-like interview (Appendix I). The interviews lasted from 40 minutes to one hour, and were tape recorded and transcribed. The interview questions asked how people had become involved, what they had hoped to get out of the program, what they liked about the program, how satisfied they were with it, and what a typical day at the program day would be. They were then asked what they thought the benefits of the program were, both to themselves and to their children. There

were a few probes, such as asking what had they learned at the program, whether and how had it affected their family's food habits, their relationships with other parents, their children's relationships, and their relationships to the school and community. Finally they were asked if they had suggestions for improving the programs.

The semi-structured staff interview guide (Appendix J) was developed to cover the following areas: program training and follow-up support; administrative support (including level/adequacy of resources, security of program support, school staff reactions to the program); parent and community reactions to the program; implementation of the program model; perceived program effects &/or impacts; and critical rating, based on McConney, Rudd and Ayres (2002). Staff were also asked to define their version of the program model by discussing their goals and objectives for the program and the strategies they used to achieve those goals and objectives. Each area of inquiry included a set of sub-questions related specifically to CFF programs. The interview was particularly focused on development and implementation issues.

Although two administrator interviews were conducted early in the data collection, the remaining interviews with program administrators were scheduled late in the data gathering period. At that time I didn't need much more data about the programs but wanted the administrators' opinions about how the programs fit with their school (or in two cases, community centre) and their schools' / community centres' mandates, what they would like to see the programs accomplish, and what they thought they were accomplishing. The interviews with administrators who were not school principals (about half) were from forty minutes to one hour long. The interviews with school principals were shorter, ranging from fifteen to thirty minutes (see Appendix K for the interview guide for administrators). All but one administrator interview were tape recorded and transcribed. The exception was a school principal who requested I not tape record; in this case I took detailed notes.

3.2.4.3 Parent/grandparent participant questionnaire

Using the constructs shown in the data collection framework (Appendix G), the research team developed a questionnaire for adult program participants (Appendix L). The intent of the questionnaire was to provide pre- and post-program information that could be analyzed to determine changes that took place during the time frame from before participants attended a program to after they had attended a 10-week session, as well as providing some demographic information. Three question sets related to food and nutrition (fruit and vegetable consumption, self-efficacy regarding serving fruits and vegetables to one's family, and food security), one question to families eating together, one to self-rated health status,[16] and one question or set of questions to each of social support, social integration and social capital. Validated, reliable questions from the literature were found to use for the basis of most of the theoretical questions. However, some assurance of the questions' validity may have been lost for questions that were altered to suit the participants' circumstances, and by sending the completed questionnaire to a "plain language" editor (because of the low English-literacy level of a significant proportion of the study group), who simplified the language and the response categories. The questionnaire was pilot tested with 10 parents from 2 schools and was revised. Due to my concerns about the potential lack of comparability of the fruit and vegetable consumption and food security questions with the literature, after the pilot testing I chose to substitute a validated question on fruit and vegetable consumption from the Canadian Community Health Survey, cycle 1.1 (Statistics Canada, 2001) to replace a question the research team had crafted, and to re-insert the standard validated set of questions on household food security status from the same survey. Each person who had completed the pilot test was asked to, and did, complete the revised questions, so that they could all be included in the data analysis.

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[16] The standard question used in the National Population Health Surveys (Statistics Canada, 1998).

3.2.4.4 Staff evaluation forms

During the CFF development project, when creating the Handbook, the community nutritionist and I had created a sample evaluation form for staff to use to summarize each 10-week session. The sample evaluation form for staff included the following topics: program goals, average weekly number of participants, menus, average weekly food expense, children's and parents' activities, staff's opinion on what was working well, what needed improving, and a space to record feedback from parents. The community nutritionist collected these completed forms from most programs for the first several years of the programs. For the study, staff evaluation forms (n=29) were acquired and collated from each program, with coverage for each program ranging from one term to several terms. I developed a summary table for the information from each program during the first summer (Appendix O), and used this information, plus the other initial data I had collected and analyzed, to create the staff survey.

3.2.4.5 Staff survey

In September 2001 I created a one-page survey (Appendix M) for staff that I administered at a staff networking meeting. The survey listed fifteen potential program goals and asked staff to first indicate how important each goal was to them, and then to rank the goals in order of importance to each of them. The staff questionnaire was administered to all staff present at a staff-networking meeting, which included most of the program staff at that time. This survey showed that there was a wide range of goals among the staff. Some of the surveys were not completed according to the directions, however (e.g., some people indicated "high" importance for all the potential goals, and ranked all goals the same or nearly the same). To offset these results, staff were asked again during their interviews about their goals for the program.

3.2.4.6 Implementation grids

A template was developed to assist in the collection and analysis of information related to the implementation of the programs (Appendix N). It included the following headings, with a set of questions under each heading: setting, participants, demographics, activities, goals and objectives, strategies, site-specific program history, recruitment, staffing and administration, budget and funding, evaluation, and outstanding observations. Over the data collection period, these templates for each program were gradually filled in, and blank areas alerted us to questions that still needed to be pursued at various programs.

3.2.5   Staff networking meetings observation and participation

Informal staff networking meetings were hosted for CFF program staff by the community nutritionist associated with the program approximately once every two months. I attended eleven of these meetings over the 2 ½ year data collection period. I was given a ten-minute spot on the agenda at some of the meetings to discuss the research plans with the staff for their feedback and understanding. I listened to the staff share experiences and challenges, and this broadened my understanding of the programs. Increased understanding gained from attending these meetings informed, in particular, the data collection protocol/procedures for the participant questionnaire and the creation of the interview schedules. Since there was no administrative head in charge of the CFF programs, I was able to use these staff networking meetings to meet the staff of the various programs, talk with them about the research, and gain entry to the programs through them.

3.2.6   Research sample

Of eleven potential CFF programs, eight were selected for participation in the study. (Three were excluded for the following reasons: two did not operate during the first year of the study, and in the third, the staff was already included in the study from another program, and

none of its participants spoke English [all spoke Cantonese and I didn't have a translator/interpreter at that time]. I observed this program once and decided that it would not yield sufficiently important additional information to the study to be worth the extra effort including it would involve.) The number of adults attending each study program at any time ranged from 4-15.

All adult program participants who were present during any administration of the CFF questionnaire consented to complete it, resulting in a total of 88 adult program participants who completed the questionnaire (i.e., there were no refusals or non-responders to the questionnaire at the seven schools at which it was administered). Each adult participant who participated in a research interview (except for those from the school that chose not to have the questionnaire administered) had also completed the questionnaire. Six program participants at the eighth study program (in which the questionnaire was not administered) also took part in the research. Therefore the total number of adult CFF program participants who became research study participants was 94.

The number of adult participants interviewed from each program was determined by theoretical sampling to ensure approximately equal numbers of interview respondents from each study program as well as approximately equal representation of the different ethnic-language groups attending the programs. (The demographic characteristics of the program participants are presented in Section 4.1.) Twenty-seven parent/grandparent (three were grandparents) program participants were interviewed (please see Table 1). Two were interviewed twice; one to test added questions about program strategies and the other because of faulty tape recording halfway through the first interview. Recruitment for the interviews was done through the staff of each program. To guard against a recruitment bias that perhaps the first to be interviewed would discuss the program differently from those who were not as forthcoming to be interviewed, at one program (School E) I attempted, and succeeded in interviewing all (five) current

participants. At another program (School D), all but one current participant were interviewed. No

significant differences regarding their opinions about the programs were found among these

interviewees. Of the twenty-nine interviews with twenty-seven program participants, twenty-

three were conducted by myself and six by my research assistant. Only four interviewees who

spoke English as their first language were not of First Nations heritage. Of eight Cantonese

speakers interviewed, five were interviewed with an interpreter and three chose to speak in

halting English. One participant was interviewed in Mandarin and one was interviewed twice in

Vietnamese, both with the help of the interpreter. Seven First Nations participants were

interviewed in English. The remaining six participants were interviewed in English, although

their first languages were Hindi, Tagalog, Spanish and Italian. The interpreter later reviewed the

tapes of all the interviews she had conducted with me against the typed transcripts and added a

few explanatory comments.

Table 1: Number and ethnicity of parent/grandparent participants interviewed at each program

School/ Program	Number and ethnicity of parent/grandparent participants interviewed			
	Chinese	First Nations	Other	Total
D*	2	1		3
E		1	4	5
F	2	1	3	6
H	2		1	3
I		1	1	2
K	3			3
L		1	2	3
M		2		2
Total	9	7	11	27

*All schools that had ever implemented a CFF program were coded A-M. (Two schools, A and B, were the program development schools from 1994-6.) The schools involved in the present research are the ones listed in this table.

All but two of the staff of the study programs over the two-year data-collection period

were interviewed. Those who were missed had left their jobs before the staff interview guide was

developed and the main set of staff interviews was started. This resulted in fourteen staff

interviews (with thirteen staff). Of the fourteen staff interviews, nine were conducted by myself and five by my research assistant. The staff who were interviewed consisted of the five Neighbourhood Assistants who ran the CFF programs in their schools (one was interviewed twice – once by me and once by my research assistant); one project teacher; one multi-cultural worker; five staff hired from outside the school system (three involved in one program); and one parent who had taken over the role of facilitator for her program. They were all women; four were Chinese and the rest were Caucasian. The in-school staff had all been in their positions for years, while most of the outside staff, with the exception of one, were involved with the program on a short-term (less than one year) basis.

At least one, and sometimes more than one, administrator was interviewed for each program. These included all school principals of programs running in schools, community centre administrators of programs running in community centres, and other adults in supervisory roles. The number of administrators interviewed totaled thirteen. All administrator interviews were conducted by myself. The group I have labeled "Administrators" consisted of six school principals (of the six schools that held CFF programs within the schools); the program administrators from the two community centres; one school nurse who set up a CFF program in one of the community centres; a multi-cultural worker involved with one of the programs; one Neighbourhood Assistant who didn't participate in the program but did recruit parents to it; one Inner City Schools Project consultant/administrator; and the director of KidSafe, an project that operates after school and holiday emergency programs in several of the schools that have CFF programs. The school principals were all male, while all the other administrators interviewed were female. Two of the administrators were Chinese, one was Japanese, and the others were Caucasian.

3.2.7 Time line

The data collection and preliminary analyses can be divided into four phases over a 2 ½ year period, as shown in Table 2.

Table 2: Four phases of study data collection

Phase	Dates	Written program observations	Parent Interviews	Staff Interviews	Administrator Interviews	Adult Participant questionnaires		
						1st time	2nd time	3rd time
1	Apr-Dec 2001	39		3	1			
2	Jan-June 2002	18	6		1	45		
3	Sept-Dec 2002	10	7			33	20	
4	Jan-Sept 2003	8	16	11	11	10	13	9
Total		75	29	14	13	88	33	9

Each phase of data collection supported the development and refinement of the next phase. The first phase, which began in the late spring of 2001 and continued to the end of December, 2001, consisted of my attending three CFF staff networking meetings, observing all the programs that were in operation at the time, training and supervising two nutrition students to be participant observers at three programs, and conducting four interviews, three with program staff and one with a Vancouver school board administrative consultant for the Inner City Schools Program. Analysis of these data allowed me to develop a tentative list of program goals, some of which were shared by most of the programs and others which were more unique to certain programs. Since there was no written documentation of the CFF program model aside from what the community nutritionist associated with the program and I had developed years earlier as an aid to the initial dissemination of the program model, collecting this preliminary data about program goals was helpful for planning the next data collection instruments. A great deal of time during this period was also spent constructing the adult participant questionnaire, which the research team planned to use in a pre- and post-test manner to triangulate with the qualitative

data in determining the benefits of the programs for participants attending during each 10-week CFF program session.

The second phase of data collection was from January through June, 2002. During this time, I attended four more staff networking meetings, carried out more program observations, trained and supervised another nutrition student to collect observational data, conducted another administrator interview, developed the parent interview guide and conducted six parent interviews, and pilot tested, revised and administered the first round ("pre-test") of the questionnaire to 45 adult program participants (mostly parents, with a few grandparents). During this time I became aware of potential problems with the questionnaire implementation. These problems included the fluid, drop-in nature and changing clientele of the programs; the fact that some program participants had actually been attending for a long time, or over several years, before the data collection began; and the fact that the time required to develop rapport with the clients, many of whom spoke little or no English, before they would or could participate as research participants meant that it was impossible to gather pre-program data. The programs simply did not operate on a schedule that could accommodate pre- and post-testing.

Administration of the questionnaire did not go as anticipated, however. The format of most of the programs did not include a definite beginning and end for a particular group of participants. Instead, many participants had been attending for months or longer when the research began, and other participants dropped in and out. This made it impossible to interpret the data as pre- and post-test. Even if there were to have been a definite beginning to a program, it would not have been possible to collect data on the first visit to a program. The research had to be explained and trust had to be established, and this took time and more than one visit. Other problems related to language barriers and understanding of the meaning of the questions, and still others to the inability to isolate participants from each other – for example, at some programs, people were translating for each other and talking among themselves as they did the

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questionnaire. The question about food consumption was not compatible with Asian food habits, and questions that I had created about whether attending CFF had led to people attending other programs or gaining access to other resources could not be explained adequately. The time needed to administrate the questionnaire, in some programs, became a real burden at programs that only had a couple of hours to complete the preparation and sharing of a meal.

Every effort was made to include all participants in filling in the questionnaire. This was done by attending the programs prior to the questionnaire administration to familiarize participants with the study and develop feelings of trust, by scheduling questionnaire administration at the convenience of the program participants, by hiring and training a translator/interpreter who spoke several languages in common with participants during the second year of the study, and by offering remuneration to programs where participants participated the study. The questionnaire was also translated into Chinese during the second year of the study.[17]

One school had concerns about the questionnaire after the staff and administrators had reviewed it prior to its administration. The staff and administrators at this school met with me and my research assistant about their concerns with the questionnaire. They felt there was too much focus on poverty and income in the questions and did not want their clients, who lived in poverty, to be subjected to these types questions. They said that their clients were subjected to too much inquiry about their living circumstances and they wouldn't support more of this type of interrogation. We decided together at this meeting to forego the questionnaire at this program, and concentrate on the observations and interviews there.

By the end of phase 2, the observations, staff evaluation forms (documents), the first six parent interviews and one administrator and two staff interviews were analyzed and used to

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[17]We attempted to get the Chinese version of Question 1 about fruit and vegetable consumption from the Canadian Community Health Survey staff in Ontario, but were unsuccessful.

develop an initial list of codes and data points for analyzing the qualitative data. I was assisted in developing the code list by the project's research assistant.

The third phase of data collection ran from September, 2002, through to December, 2002. By September, it had become clear to me that translation and interpretation were needed for many of the program participants to be able to participate in the research, particularly for the relatively large proportion of Chinese and Vietnamese participants, and possibly for a few Spanish-speaking participants. I arranged for a UBC staff member to help with the Spanish translation, but needed to hire someone for the Chinese and Vietnamese. Through the CFF staff network, I found a parent in another CFF program (not part of the research) who spoke Cantonese, Mandarin and Vietnamese, and read and wrote Chinese. I interviewed and subsequently hired her to work with me part-time (about six hours a week). The Neighbourhood Assistant who had recommended her spoke, read and wrote Vietnamese. With their assistance, the questionnaire was translated into Chinese, and the letter of introduction, consent forms, and parent interview guides were translated into Chinese and Vietnamese. I took the parent research assistant with me to all the programs that required Chinese and Vietnamese translation for the duration of phase 3 and for phase 4. She assisted me with recruitment to the research project, the second and third round of questionnaire administration, and adult participant interviews. During this time, the project's research assistant began observing programs and collecting some of the required data, as well as continuing to assist me with data analysis.

The fourth and last phase of data collection was from January through September, 2003. During this time I developed a staff and an administrator interview guide and with the help of the project's research assistant and the parent research assistant, where required for translation and interpretation, administered a third round of the questionnaire and conducted the remainder of the staff, school principal and parent interviews. Throughout all the phases I attended staff networking meetings and continued observing the programs.

Over the course of the study, therefore, 75 observations were written, 29 interviews conducted with 27 parents and grandparents, 14 interviews conducted with 13 staff, 13 administrators were interviewed, and 88 adult program participants completed the questionnaire once, 33 completed it twice, and 9 completed it three times. Please see Appendix P for a complete table of data collected by phase and CFF program session, by school.

3.2.8   Ethical issues, considerations and procedures

Despite following the protocols required by the ethics committees of the university, school board and health department, some ethical and procedural concerns arose during the study. One of the key concerns centred around the participants' understanding of the meaning and scope of the research and the voluntary nature of their participation. Many of the program participants didn't speak English well, or at all, and the interpreter the project eventually hired was not extremely fluent in English. It was difficult to explain the research to the participants and to feel that they really knew what they were consenting to participating in. It was not clear that parents/grandparents who joined the program during the research period understood the difference between the program and the research. The second concern related to the time needed to conduct the research. At most programs the participants had limited time to accomplish their food preparation goals, and the time the research took, including explaining the procedures, was time that had to be taken from program activities. I relied on the program staff to help me in terms of endorsing the research to the program participants as something that would ultimately be good for the program and that would not take too much time. At some of the programs, unfortunately, the research took a lot more time than I would have liked, as participants had so many questions regarding the questionnaire. When possible, my assistant and I scheduled the questionnaires and interviews before or after the program or on other days. This was not possible most of the time, however, since we didn't know the participants very well and some were nervous about seeing us outside of the program time or setting, and without the program staff.

Many of them also had commitments immediately before and after the programs or could not be depended upon to appear at a pre-determined time for research purposes. Although we always presented the information about the research at a program session ahead of the date we planned to actually collect data (we handed out the letters of introduction and consent forms, discussed them and the research, and encouraged the participants to take the papers home and think about it), invariably when we returned to the next program session, there were people who had not been there the week before, and most of those who had been there the week before seemed to have put the research entirely out of their minds, so we had to spend more time trying to explain the research again before starting to collect data. It was difficult to conceive of immediate benefits to the program participants of participating in the research, and also difficult to accomplish the research goals without interfering with participants' activities in the program. At some of the programs, the research team (particularly the nutrition students, who attended for a whole term) assisted with the program, which balanced the give-and-take required of the programs, and in all cases of data collection from program participants and from staff, monetary remuneration was offered.

My insights regarding how to approach research participants and enable them to talk with me comfortably highlights the strengths of the responsive evaluation approach that I used, based on time-consuming contact to develop trust, understanding of the nature of the research, shared commitment to the research, and comprehension and shared construction of the roles of researcher and research participants. In this kind of setting where participants are not familiar with the academic research approach (as well as many of them being unfamiliar with the school system and even with the English language), it is important to give the participants time to understand the process and what it does and does not ask of them before involving them in it, to avoid compromising them in any way. This being said, for some participants, understanding of the research process could only evolve as they were involved in it, and so I was extremely

careful during the data collection, and instructed my assistants likewise, to safeguard the integrity of the research participants. This is especially important in situations such as the inner city schools, where ongoing crisis is the *modus operandi*. I was constantly alert to possibilities of boundary violations with the vulnerable research participants (both parents, and in some cases, staff), and spent considerable energy and attention to making sure these participants did not feel that they were giving more than they were receiving, in terms of personal revelations or relationships with the researchers. Finally, in what acted as an additional safeguard for the integrity of the research, between the data collection and the data analysis, synthesis and writing of the dissertation, several years intervened (due to personal circumstances), which assisted me in being able to discuss the programs in a way that would not reflect on any particular program or person and allowed me the freedom to state my conclusions apart from being influenced by, or influencing, any persons or programs.

3.2.9 Remuneration to research participants

Each program that participated in the research by allowing observation and/or completing questionnaires was offered $60 per term. Most accepted, while a few declined. Most who accepted spent the money on extra food for the program; two funded barbecues with the money. At one program the participants decided to use the money to treat themselves to going to a restaurant together for lunch, something they would never have been able to afford otherwise. One program preferred to have the $60 divided equally among the parent participants, and at one program, during the last questionnaire administration, I gave each person who completed a questionnaire a $10 honorarium.

All program participants who were interviewed were given an honorarium of $20 at the conclusion of the interview. Participants were not informed of the honorarium beforehand, to reduce the likelihood of feelings of coercion. After the first or second interview at each program, however, word sometimes got around about the honorarium. Only once did someone refuse to be

interviewed and then change her mind and asked to be interviewed once she learned (from another parent) about the honorarium. In this case, I had already arranged for what I needed and said I would call her if I needed someone else. Staff who were interviewed were also offered the $20 honorarium. Most declined it, but a few accepted it; some of them donated it to the program. We made these funds available because we were cognizant of the financial need of the program participants and wanted to contribute in a small way to their well-being.

3.2.10 Data analysis: Treatment of the questionnaire data

Responses to the questions were noted for the whole group of 88 questionnaire respondents at the first time each of them completed the questionnaire, and for a smaller subset of the participants who completed the questionnaire a second time (either approximately six or twelve months later). Statistical significance calculations to assess change over time on each question related to the theoretical constructs were done, for participants who had completed the questionnaire a second time, using both parametric and non-parametric tests. The Statistical Package for the Social Sciences (SPSS), Version 11.5 (SPSS Inc., 2002) was used for the calculations, which are described below. Given the small sample size and the difficulties encountered with the questionnaire (described above), the questionnaire findings are primarily reported using descriptive statistics (e.g., frequencies). A limited number of inferential tests were conducted on the quantitative data because I felt they would be of questionable value in terms of adding meaning to the study.

Further statistical analyses were conducted for two food- and nutrition-related questions that were of particular interest to the study, one relating to healthy eating and the other to household food security. For the question set related to healthy eating (fruit and vegetable consumption), a variable was created to sum the responses to the six sub-questions into one statistic to represent respondents' total fruit and vegetable consumption per day at the first time they completed the questionnaire. Another similar variable was created for those participants

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who completed the questionnaire a second time. These two variables were used in calculating the mean, median and mode for fruit and vegetables consumption at the two time periods, and for calculating the number and percentage of respondents who were consuming at least five servings of fruits and vegetables per day, the minimum number recommended by Canada's Food Guide (Health Canada, 2007). Finally, since participants had been attending CFF programs for varying lengths of time both before the first questionnaire administration period and between the two administrations used for comparison, "dose-response" variables were created for the question on fruit and vegetable consumption and the question on household food security, to see if time spent in the program (measured as the number of weekly program sessions attended at the last time the questionnaire was completed) correlated with either higher consumption of fruits and vegetables or higher household food security.[18] To do this, two nearly equal groups (in number) of participants in terms of program attendance were created: Group 1, who had attended CFF programs from 1-10 times, and Group 2, who had attended CFF programs 11 or more times (at the last questionnaire). Two independent samples t-tests were calculated, one for each of the summary variables, against the number of times attended (Group 1 against Group 2).

The question of whether attending the program contributed to food security for participants was of particular interest due to debate in both academia and in the community surrounding the adequacy of different types of responses to food insecurity. To shed further light on this question, responses to the three questions on household food security were also inspected by hand for participants who had completed the questionnaire more than once, to learn how many of these participants had experienced change in the various aspects of household food security during the study time frame and whether their situations had improved or deteriorated in this respect.

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[18] The measures used were (a) total fruit and vegetables consumption at the last time measured and (b) a summary statistic for food security at the last time measured.

3.2.11 Data analysis: Treatment of the interview, observational and document review data

3.2.11.1 Coding the data

Verbatim transcripts were produced for each interview and were verified for accuracy for all taped interviews. As they were completed and checked, the transcribed interviews and the typed observations and staff evaluation forms were entered into Atlas/Ti (Scientific Software Development, 1997), a software program for organizing and managing qualitative data. The first six interviews with adult program participants were used to develop an initial set of codes for data analysis. These interviews were analyzed by reading through them line by line and noting phrases that could be developed into constructs related to the benefits of the program, using open coding, a grounded theory method (Strauss & Corbin, 1990). The 79 phrases that resulted were then organized, using the constant comparative method, into forty-one constructs within seven independent groups (Strauss & Corbin, 1990):

1. parent-parent relationships,
2. child-child relationships,
3. parent-child relationships,
4. multi-cultural relationships,
5. parent personal growth,
6. child personal growth,
7. accessibility (program, food)

Abbreviations were developed to enable naming codes in a manner that would facilitate coding the whole data set (Miles & Huberman, 1994). Perceived benefits to parents were separated from those to children (kids), naming them BP and BK respectively, and food and nutrition-related benefits were separated from psychosocial benefits, naming them KS (knowledge & skills related to food and nutrition) and P-S (psychosocial). Finally, a code related to benefits to families, BF, was created. Sub-benefits within each of these categories were delineated, based on the forty-one constructs. The final set of codes related to perceived benefits included twenty-two codes. Another set of codes was developed for the implementation data. These were developed from observing at the programs and by reviewing written observational data (both my own and

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that of the other observers under my supervision). The final categories for the implementation

data included categories related to goals and expectations; program description, organization,

and strategies; and program challenges and suggested improvements. Each of these codes

included a number of sub-codes, for a total of 39 codes related to the processes of the programs.

Please see Appendix Q for an annotated list of the codes (in alphabetical order), and Appendix R

for a complete list of the codes organized into categories.

My research assistant and I used this set of codes to individually code several more

interviews, comparing our use of the code list, and revising the list and our understandings of the

inclusion and exclusion criteria for the codes until we were able to code interviews with a high

rate of inter-rater agreement. At this point, we divided the remaining qualitative data between us

for completion of the coding.

3.2.11.2 Data tables

Once all the data had been coded and thus organized into the categories outlined above,

the data within each code were condensed to a table (by school and category of respondent

type)[19] to allow an overview of all the data related to each code (Miles & Huberman, 1994). This

act of condensing reams of data within each code to a set of terse statements, organized by

school, type of respondent, and code, created another but more focussed set of phrases

comparable to the first act of data analysis undertaken at the beginning of code development. The

phrases in these tables captured multiple facets encompassed by each code and supported a

deeper understanding of all aspects of the programs. I spent months working with these data

tables and created a number of cross-case comparison tables for a variety of codes as a method of

pursuing and researching questions of importance to the study. Thus the data analysis moved into

interpretation (Wolcott, 2001). Examples of the types of questions that were pursued are: "What

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[19] Respondent type was either parent interview, staff interview or sessional evaluation form,
administrator interview, or researcher observation.

did children learn about food and nutrition either by attending the programs themselves or because their parents attended and then involved them in related activities at home?" and "What was the relative importance attached to food-related outcomes versus psychosocial outcomes by the various groups of interviewees?" In the process of answering the study questions, each transcript was also re-read as a whole, so that the context of the information would remain clear. The process of going back and forth between condensing the data through sub-coding the tables and reviewing whole transcripts or documents followed an hermeneutic process with understanding gained by cycling back and forth through the data analysis methods.

3.2.12 Study rigour

Achieving rigour and trustworthiness (Guba & Lincoln, 1989) were a concern throughout this mostly qualitative study, and were addressed in many ways. Credibility and dependability were supported by the long-term engagement in the field (2 ½ years) by two researchers and several nutrition students, as well as by the continued involvement of the community nutritionist in the study. Rather than using a sequential process, all programs were continually visited over the duration of the data collection period, allowing deep relationships to develop between the researchers and the staff, administrators and some of the participants. This presented opportunities for on-going observation and discussion about the programs. The interview sample included all administrators and all but two staff of the programs over the duration of the study, while the study itself included eight of the nine programs in operation during the study period. The response rate to the parent/ grandparent questionnaire was 100% of those present on each data collection day, and those who were absent during a questionnaire administration day completed the questionnaire the next time they and a researcher were present. The participant interview sample was balanced to reflect the ethnic diversity among the programs, with approximately 1/3 of the interview subjects belonging to Chinese, First Nations and other ethnic groups, respectively. Translation and interpretation were offered for the adult program

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participant interviews and questionnaires in four languages other than English. The research protocols and data collection instruments were discussed with staff on an ongoing basis at staff networking meetings. During data analysis and write-up, the data were reviewed many times and in different ways, using tables, searching for words and phrases throughout the software management program to pursue questions raised while analyzing and writing, and re-reading transcripts of interviews, studying the history of the inner city schools and their context, looking at the CFF questionnaires manually, and studying the data summaries created on the "implementation" templates.

Initial analysis of the results was fed back to the community through a large laminated poster and a video of and about the program, both of which were used extensively by the community in meetings and to promote the program to the provincial government. In writing the dissertation, "thick description" (Stake, 2000, p. 444) in the form of vignettes was used to give readers the opportunity to form a mental picture of the programs and to come to their own conclusions about issues, weighing them against my conclusions. I also maintained contact with the programs after the end of the data collection period by working on two committees that were involved in planning for the expansion of the program throughout the province, and have remained in contact with the community nutritionist involved with the program. Finally, I worked with another member of the research team to prepare several presentations of the data that were given at academic conferences.

Chapter 4: Findings: The Participants and the Program

Chapter 4 focuses on research findings related to the first objective of the study: to identify the goals, objectives and expectations that parents, staff and administrators held for the CFF programs, and to understand how the program model was implemented in different sites, including identifying strategies used to achieve the desired goals and the supports and challenges experienced by those who implemented the program. The chapter begins by presenting a description of the program participants, using results of the adult participant questionnaire to characterize participants' food-related attitudes, consumption of fruits and vegetables, food security status, and other attributes relevant to the research. Next, program settings, structure and overall focus are briefly described. This is followed by an in-depth look at program goals, objectives and expectations, illustrated by vignettes of goals, program development and beginnings at four program sites. Next, the strategies employed to achieve the goals are examined, followed by illustrative vignettes of the same four sites. Then, a variety of challenges experienced in program implementation are presented, illustrated by two vignettes. Discussion of the findings presented in this chapter follows.

4.1 Description of CFF participants: Demographic profiles, food-related attitudes and behaviours, food security status, and social connections

Characteristics of CFF participants from seven of the eight participating schools were ascertained through responses to the study questionnaire, which was completed at least once by 88 people (84 women and 4 men), as detailed in Table 3. More than half of the respondents had only attended CFF 1-10 times when they first completed the questionnaire. The remaining respondents were longer-term attendees. The majority had begun attending CFF in 2000 to 2002 (i.e., during the data collection period).

Table 3: Characteristics of CFF participants who completed the questionnaire (n=88)*

	N	(%)
Number of times attended CFF		
1-10	52	(59.8)
11-20	15	(17.2)
21-30	7	(8.0)
31-40	5	(5.7)
41-50	4	(4.6)
51+	4	(4.6)
Year first attended		
1998	2	(2.4)
1999	4	(4.9)
2000	13	(15.9)
2001	22	(26.8)
2002	37	(45.1)
2003	4	(4.9)
Language spoken at home		
English	32	(36.4)
Chinese (Cantonese, Mandarin)	31	(35.2)
Other	25	(28.4)
Participants' self-rated health		
Excellent	4	(4.5)
Very good	27	(30.7)
Good	36	(40.9)
Fair	21	(23.9)
Poor	0	(0)

* Within categories, the number of responses may be less than 88 because of non-response to specific questions.

About one-third of the program participants who were involved in the study spoke a Chinese dialect at home, one-third spoke English, and the remainder spoke one of a number of other languages (in descending order: Spanish, Vietnamese, Filipino, One [a First Nations language], Hindi, Indonesian, Italian, Persian, and Tamil). (Most of the English-speaking participants were of First Nations heritage, as noted by participant observation at the programs.) Participants were not asked to state their age on the questionnaire, but most had children in elementary school, while a few were either grandparents or had children who had recently gone on to secondary school. Most respondents rated their health as good or very good, but a

significant minority of about one-quarter reported only fair health the first time they completed

the questionnaire.[20]

Responses to food- and nutrition-related questionnaire items are shown in Table 4.

Table 4: Food- and nutrition-related characterizations of CFF participants from questionnaire

Fruit and Vegetable Consumption	n	(%)
Servings per day		
0-4.9	37	(58.7)
5+	26	(41.3)
Mean = 4.9		

Fruit and Vegetable Self-efficacy	Yes		No	
	n	(%)	n	(%)
"Do you think you could give your family fruits and vegetables …				
-even if they were expensive?	67	(78.8)	18	(21.2)
-even if it took more time to plan and prepare them?	74	(89.2)	9	(10.8)
-even if not everyone in the family would eat them?	63	(76.8)	19	(23.2)
-even if you had to learn new ways to prepare them?	81	(97.6)	2	(2.4)

Household Food Security	n	(%)
"How often did you or someone in your family …		
-worry there would not be enough food to eat		
Often	19	(22.4)
Sometimes	35	(41.2)
Never	31	(36.5)
-not have enough food to eat		
Often	4	(4.7)
Sometimes	25	(29.4)
Never	56	(65.9)
-not eat the quality or variety of foods wanted		
Often	17	(19.5)
Sometimes	42	(48.3)
Never	28	(32.2)

Respondents consumed a mean of 4.9 servings of fruits and vegetables per day. Just over 40% of

respondents indicated that they were consuming at least the minimum five servings a day

recommended by Canada's Food Guide (Health Canada, 2007). Respondents indicated high

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[20] Participants rated their own health using the self-rated health question from the National Population Health Survey (Statistics Canada, 1997).

levels of self-efficacy pertaining to feeding their families fruits and vegetables, with almost everyone responding that they could still give their families fruits and vegetables even if it took more time or if they had to learn new ways to prepare them, and most respondents saying they could, even if fruits and vegetables were expensive or if not everyone in the family would eat them. Responses to household food security questions showed, however, high levels of worry and compromised diet in terms of quality or variety among the group as a whole. Only one-third of the group never worried about running out of food at home or did not have to compromise their diets. Most disturbingly, one-third of the group reported that someone in their family sometimes or often did not have enough to eat.

Another set of questions focused on social relationships (please see Table 5). A question bridging both food-related and social behaviour asked how many times a week participants' families ate a meal together. Although about three-fifths of respondents said their families ate a meal together every day, the remainder said their families ate together less often. With regards to social integration, most participants indicated that they had a friend in their child's school and that they attended parent-teacher conferences at their children's schools. The majority, however, did not attend Parent Advisory Council (PAC) meetings at the schools. Only about one-third reported ever attending these meetings. (About one-half of the questionnaire respondents either didn't answer this question or reported that they didn't know whether they attended PAC meetings, raising the possibility that they either didn't understand the question or they didn't know about the meetings.) A four-part question assessing social support in relation to other program participants showed that the majority of participants felt that there were people in the program who cared about them. Although about one-third of respondents didn't know whether there were parents in the program who would provide assistance if needed (e.g., childcare, loan or gift of food), the remainder of the participants generally thought there were, while a few thought there were not. (This result may reflect differences between respondents who were new

to the programs and those who had attended for a longer time.) Finally, a modified five-part version of a question about social capital was used to assess participants' feelings about the broader community, with most of the questions focussed on whether participants trusted other people in their children's schools. There was a high degree of uncertainty about whether or not participants felt they could trust people in their children's school. It is possible, however, that this might have related to lack of understanding of the meaning of the word "trust" in the questions. For those who did answer "yes" or "no," the majority did feel a sense of trust in others within the school environment.

Table 5: Social relationships reported on the CFF questionnaire

Frequency with which families ate a meal together:	N	(%)
Every day	51	(58.6)
Every 2nd day	6	(6.9)
A few times a week	18	(20.7)
Once a week	10	(11.5)
Never	2	(2.3)

Adult participants' relationship with their children's school:	Yes		No		Don't know/no answer	
	N	(%)	N	(%)	N	(%)
Number of participants who had a friend in their children's school;	75	(85.2)	10	(11.4)	3	(3.4)
Number of participants who attended parent/teacher conferences;*	75	(85.2)	7	(8.0)	6	(6.8)

Attendance at monthly Parent Advisory Council meetings.	7-10 times		4-6 times		1-3 times		Never		Don't know/no answer	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
	5	(5.7)	6	(6.8)	20	(22.7)	10	(11.4)	47	(53.4)

Participants' perceptions of connectedness and caring with other program participants:	Yes		No		Don't know/no answer	
	N	(%)	N	(%)	N	(%)
There are people from this program who care about me;	70	(79.5)	0	(0)	18	(20.5)
There is a parent … who would help me if I was sick;	54	(61.4)	2	(2.3)	32	(36.4)
There is a parent … who would look after my child if I was sick;	43	(48.9)	10	(11.4)	35	(39.8)
There is a parent … who would give/lend me food if I needed it.	49	(55.7)	8	(9.1)	31	(35.2)

Participants' feelings of trust towards their children's school and people in general:	Agree		Disagree		Don't know/no answer	
	N	(%)	N	(%)	N	(%)
Most adults in my child's school can be trusted;	42	(47.7)	7	(8.0)	39	(44.3)
Most children … can be trusted;	44	(50.0)	6	(6.8)	38	(43.2)
People in my child's school are willing to help you if needed;	64	(72.7)	4	(4.5)	20	(22.7)
My child's school is a pretty safe place;	70	(79.5)	4	(4.5)	14	(15.9)
Most people can be trusted.	51	(58.0)	5	(5.7)	32	(36.4)

*At least some of those who didn't attend parent-teacher conferences would have been those who didn't have children at the school any more, but continued to attend CFF programs.

In summary, CFF participants were an ethnically diverse group, with about one-third from Chinese, one-third from First Nations, and the remaining one-third of participants from a variety of other cultures. About half were attending CFF for their first 10-week session when they first completed the questionnaire, while the remainder were longer-term attendees. Most participants had begun attending CFF programs in the years 2001-2002. Although the majority rated their own health as good or better, about one-quarter self-rated their health as only fair. While most indicated a high level of self-efficacy regarding feeding their families fruits and vegetables even in the face of a number of potential barriers, only about 40% indicated that they were meeting Health Canada's guideline of eating five servings of fruits and vegetables daily. Two-thirds reported suffering from some aspect of household food insecurity; one-third reported that family members went hungry at times due to lack of financial resources to purchase an adequate amount of food. About 60% reported that their families ate a meal together at least once a day. As far as social connections within the school and community, most had at least one friend in their child's school and attended parent-teacher (but not Parent Advisory Council) meetings. Some felt that others in the program cared for them or would help them if they were in need, and some felt a sense of trust of others in the school community, but a large proportion also reported that they didn't know whether others in the program cared for them or whether or not they trusted others in their school community.

4.2 Description of program setting, broad focus and structure

All CFF programs studied were connected with inner city elementary schools[21] but only six actually took place in schools while the other two occurred in nearby community centres (please see Table 6).

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[21] One school had lost its inner city school funding status just before the research began, but the program, which was held in a nearby community centre and administered by the community centre program planner, continued.

Table 6: CFF clientele and program characteristics, and main foci of each program

Program/School	D	E	F	H	I	K	L	M
Setting, staffing and child involvement in the programs								
Setting:								
School: Dedicated parent room/space		x	x	x	x			
School: Lunchroom or staff room	x							x
Community Centre						x	x	
Staffing:								
Neighbourhood Assistant (school-based)	x	x	x	x	x			x
Outside paid staff	x			x			x	
Parent volunteer (paid an honorarium)			x			x		x
Child involvement in the program:								
Full time							x	x
Part time	x			x		x		
Client and Program Characteristics								
Ethnicity:								
Predominantly Asian	x		1/2	x		x		
Predominantly First Nations			1/2					x
Mixed (First Nations and Other)		x			x		x	
Usual number of adults attending	4-6	4-6	4-15	9-10	4-6	6	4-8	4-6
Food Security Status (Group mean):								
Group food security status reported on questionnaire (mean), (range: 3-9; with 3=lowest, 9=highest)	N/A	5.5	6.5	7.6	6.5	8.0	7.0	6.7
Main focus of program								
Food and nutrition-related:								
Information, skills and motivation for low cost, healthy eating	x	x		x	x		x	x
New food preparation skills for parents	x	x		x	x		x	x
New food preparation skills for children							x	x
Eat a substantial meal at the program		x	x	x		x	x	x
Take a meal and/or extra food home	x	x			x	x		x
Psychosocial related:								
Feel comfortable in school or community centre	x	x	x	x	x	x	x	x
Families spend time together eating or doing food prep at program				x		x	x	x
Families spend time together eating or doing food prep at home		x		x	x		x	
Cross-cultural integration	x		x	x	x		x	
Type of community kitchen:								
Collective kitchen								
Communal meal program		(x)*	x			x	x	x
Cooking class	x	x		x	x	(x)*	x	x

*A secondary but important focus in this program

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Five of the in-school programs were run by Neighbourhood Assistants (NAs) who were working full-time in the schools as school-parent liaison staff under the auspices of the Inner City Schools Project. In three schools, dedicated space in the form of "parent rooms" complete with kitchens had been developed, to facilitate the integration of parents into the schools and the provision of services to parents (mandates of the Inner City Schools Project). In a fourth school, the program was held in a multi-purpose annex on the school grounds designed for before- and after-school daycare, but in which the Neighbourhood Assistant had her office and held all her programs. In these four schools, these rooms functioned as a home away from home for some parents, with the CFF program being only one of many events to happen in the rooms each week. The two other CFF programs that took place in schools were in either the staff room or the school lunchroom (used for serving the hot lunch program). In the community centres, each program had the use of a full kitchen and an attached recreation area. In these four programs, the parents did not have the same type of opportunity to socialize with each other at other times during the week, because of the lack of a dedicated space.

Two of the Neighbourhood Assistants ran programs by themselves, while three had a co-facilitator (an outside staff person, or a parent given extra responsibilities and an honorarium). The other three programs ran with either one or two outside staff. (In one case, after the outside staff person left, a previous participant took over running the program.) Two programs took place after school and provided full programming for children. Three programs included children part time, either in activities or in eating a meal with their parents. Where children were involved full-time, two staff were required. Three of the programs also benefited during the research time framework from the part-time involvement of volunteer nutrition students connected with the University of British Columbia.

The duties of the NAs and other program facilitators related both to food and nutrition and to social facilitation. Food and nutrition-related duties included meal planning (usually done

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with the parents), shopping, organizing and overseeing activities, and demonstrating food

preparation. Socially-related duties included recruiting and retaining participants, facilitating

positive parent interaction, liaising with school staff and administration, and planning and

implementing learning activities for children. One facilitator made the following comment about

the variety of skills required to run the program:

> I think you have to have a number of skills. You have to be good at multi-tasking. You
> have to like people. You also have to have extensive cooking experience and also know
> how to teach, because you can be the most fabulous cook in the world and if you don't
> know how to get the information across to the participants, most of whom don't speak
> English, then you're going to have a very, very dull program. … And also, of course,
> you've got to be concerned about safety. You've got kids around, and also people who
> may or may not be experienced with using various tools, so you've got to have safety
> foremost, but also you need to get the information across in a very short period of time.
> (Staff #12, School D)

Four programs were attended predominantly by, or by a large proportion of, Asian

(Chinese and Vietnamese) adults. Two of these programs were facilitated by a parent of the same

ethnicity. The focus in these two programs was on sharing knowledge and recipes from their

traditional cultures, with some activity related to learning about western foods. These programs

were more like a special form of support group, geared towards supporting cultural values and

identity. Most of the other programs were more focused on teaching healthy, low-cost

approaches to eating "Canadian" foods. The other two programs with a predominant group of

Chinese and Vietnamese clients were both facilitated by hired staff from outside the schools, and

were very focused on teaching and learning about healthy versions of western foods. All the

programs that were attended by a significant number of Chinese and/or Vietnamese parents had

the benefit of a multicultural worker of their ethnicity to recruit them to the programs and

support them in attending them.

Three of the other programs were similar to each other in that their clientele were more

food insecure and the programs were more strongly focused on teaching the parents to prepare

low-cost nutritious meals and encouraging to make changes at home: namely to increase their

healthy food preparation and consumption, to include their children in food preparation activities and to eat together more often as a family. These three programs all took place in schools, with the Neighbourhood Assistants as the primary staff. One also had the assistance of a volunteer parent who was a dietitian to co-lead. The eighth program took place in a community centre with one or two hired facilitators, included children full time, and was focussed on preparing snacks and a meal to eat together. While these staff continually tried to introduce new foods, they were often met by resistance from some of the parents.

Staff and participants were free to choose recipes they wanted to learn, share, practice, demonstrate, or eat, providing they were within the program's budget. Occasionally the programs prepared special dishes for cultural celebrations. Discussion in the programs sometimes brought out participants' particular health concerns (e.g., diabetes, heart disease), and sometimes the staff would do some research to find recipes related to these concerns, and the parents would learn them. Most of the time, staff were trying to implement healthy eating guidelines. Some of them explicitly tried to teach and implement the guidelines from Canada's Food Guide. In the two programs facilitated by former program participants, however, the focus was on preparing ethnic food from their cultural groups.

The previous review of the operations of the CFF programs allows a tentative stage model of the programs to be identified. These stages became apparent as a result of my analysis of the similarities and differences between individual programs. The first stage consists of someone deciding they would like to have the program and getting organized to present it. This involves many sub-steps such as organizing funding, space, equipment, storage, staff, program plan, and curricular materials. None of this is necessarily available or set-up within either the school system or an alternate system such as the community centres; it all requires effort and negotiation. Organizing and starting the programs often extends to one or two years as the program begins to take hold in a school or community centre.

The second stage is recruitment and retention of participants, which also requires significant effort, since individual contact usually has to be made, often several times, with potential program participants. Once participants have started attending, most require continual encouragement to become regular attendees. Most of this encouragement has to come from the staff, although in established programs with a core group of participants they can take over some of this function. Because of the circumstances of the clientele, programs often remain in the recruitment phase for several years or indefinitely, encouraging participants to try the program and to commit to attending on a regular basis. The third stage is reached when a program has a core group of regular attendees who get to know each other and develop supportive relationships, as well as learning and practicing food/nutrition/ healthy eating skills. Ideally, this core group remains open to including newcomers as space is available. A fourth stage could be conceived of as happening when the program clientele are ready to "graduate" out of the program. This stage was only reached at one of the programs during the research. A plan was put into place to hold three 10-week sessions per year at this program, with different participants at each, because of the long waiting list. The same participants could, and would, however, sign up again the following year, and many of them had attended for several years.

In summary, most programs took place in elementary schools and were developed and run by inner city school staff. Each program was developed in relation to both the clientele it was to serve and the local circumstances in which it was to be implemented, which created a degree of diversity amongst the programs. Several schools had developed parent rooms or dedicated spaces equipped with kitchens, which were used for the programs. Program staff provided a mix of services; those related to food, as well as socially-oriented services. Not all programs focused on western cuisine; some focused more on Asian cuisine and were facilitated by Asian parents. Programs varied in the degree to which they focused on eating together. Some culminated with a shared meal, while others sent prepared food or ingredients home. Most programs encouraged

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parents to involve their children at home with food preparation and eating together. A few

programs modeled these aspects during the program. Some programs explicitly focused on

building a sense of community among the participants and used a shared meal to facilitate this.

Programs that used outside staff were the most focused on education and skill development,

since these staff were not available to participants at any other time during the week, while the

programs given by Neighbourhood Assistants tended to focus on more of a combination of

education/skill development and social and emotional support and encouragement of participants

to work towards changing their families' eating habits.

The programs offered a hands-on approach to learning about food, nutrition and healthy

eating that is appropriate for the multi-ethnic, often low English literacy population that attended

them. Participants were exposed to ideas such as the importance of and preparation of fruits and

vegetables; balance and variety in meals; and low-fat, low-sugar and low-salt food preparation.

Both adult and child participants learned new recipes and food preparation skills, with exposure

to "western" cooking, Asian cooking and dishes from other cultures, and a focus on inexpensive

but healthy meals. Safe food handling techniques such as hand washing, workspace sanitization

and proper refrigeration were also part of the programs.

4.3 Goals, objectives and expectations of the CFF programs

A variety of sources were used to explore CFF program goals, objectives and

expectations. These included the CFF Program Handbook (Crocker & Milligan, 1998), written

evaluation forms completed each term by CFF program staff (both prior to and during the

research), and interviews with adult CFF participants, staff and administrators. The goals,

strategies and underlying assumptions for the programs are presented in the CFF Program

Handbook: "The overarching goals of the programs are to strengthen families and communities

and to improve nutritional well-being and food security" (Crocker & Milligan, 1998, p. 1).

Strengthening families and communities is to be done by using food, "a universal bonding

agent," and concern for children, to build relationships between parents, children and schools. Improving nutritional well-being and food security is to be done through the development of food-related and other life skills. Programs should begin by drawing parents into schools within a safe, comfortable, supportive, non-threatening atmosphere. Active learning should be the educational mode, using exploration, discovery, trying, and experimenting with foods and recipes through cooking and tasting. Parent participation enhances family learning and the integration of new skills into daily habits. Enjoyment and pleasure in making and eating new foods together should be encouraged as it assists in learning and the subsequent adoption of new food habits. The goals are to learn and then to adopt new food habits (Crocker & Milligan, 1998).

Data collected through the research interviews and by reading staff evaluation forms corroborated the goals, strategies and assumptions recorded in the CFF Program Handbook. While parents' stated "expectations" for the programs focussed on learning food skills and new recipes and on having fun cooking with others, the more extensive program goals stated in the staff evaluation forms and the staff and administrator interviews were similar to those in the CFF Program Handbook. Specific objectives and particular implementation strategies were most often chosen or developed by the staff, who initiated most of the programs, rather than by the administrators. Five distinct focal areas for goals and expectations emerged from the data:

1. Development of food and nutrition knowledge and skills;
2. Increased healthy eating behaviour;
3. Increased food security;
4. Strengthened family relationships; and
5. Increased opportunities for social integration (with other families, school, community), social support, personal development and recreation.

A comparison of the goals and expectations that emerged from the data analysis with the initial statement of the program goals in the CFF Program Handbook showed that they were, for the most part, the same. This reflected the dissemination process for the CFF programs: the

distribution of the CFF Program Handbook, the work of the community nutritionist to talk about and give presentations about the program model, her assistance to anyone who wanted to set up a program, and the monthly networking sessions she hosted for several years at which CFF staff got together to discuss their programs and learn from each other. The written goal statements contained in the staff evaluation forms also closely reflected the stated goals and suggested objectives from the CFF Program Handbook, which had been distributed to potential program developers (including potential CFF staff) when they had shown an interest in the program. Each of the five goals/expectations areas will be discussed in depth below.

4.3.1 Development of food and nutrition knowledge and skills

The most widely shared goal among the parents, staff and administrators was for the programs to provide hands-on education, for those parents who desired it, in planning, preparing and encouraging their children to eat, healthy, affordable meals and snacks. A typical comment regarding the objectives of the program was this, from one of the staff evaluation forms: "To offer an educational program for low income parents to learn to cook healthy, economical dishes in a supportive environment" (Staff Evaluation Form, School D). This goal was formulated more specifically by staff as objectives in the following ways: "participants will learn to prepare nutritious inexpensive meals," "will learn cooking skills and techniques," "will share recipes and learn new recipes," "will learn recipes from a variety of ethnic backgrounds (western, Asian)," "will learn food safety skills," and "will learn nutrition information." Staff from a few programs articulated more specific subsets of these objectives, e.g., "participants will learn to make balanced meals" or "will learn about Canada's Food Guide;" "participants will learn to make healthy snacks and meals that their children will like;" "participants will learn to increase their consumption of fruits, vegetables and fibre (e.g., whole grains), will learn to use seasonal and local foods, and will learn to decrease their consumption of fats, salts, and junk food." Parents at most of the schools, meanwhile, reported that their main expectation of the program was to

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try/taste and learn to prepare new recipes, Canadian recipes, and/or recipes from other cultures. This objective was also ranked as important by about half of the staff. Learning nutrition information *per se* was mentioned as an important objective by about half of the staff and by a few administrators but not by any parents. The development of food and nutrition-related skills included learning to prepare foods or recipes that are nutritious, inexpensive, new to the user, and perhaps culturally different, as well as focusing on food safety, budgeting and shopping. Nutrition knowledge presented by staff included a variety of topics such as the benefits of consuming certain types of foods (e.g., lentils, tofu, fruits and vegetables) and of increasing or decreasing consumption of various commodities such as milk, herbs and spices (increasing), salt, and sugar (decreasing). It also included discussion and practice in reading and using recipes, including how to measure and how to adjust and substitute ingredients within recipes.

4.3.2 Healthy eating behaviour

Healthy eating outside of the program by program families, as a goal of the program, was mentioned separately from food and nutrition knowledge and skills most often by staff. Goals included staff wanting participants to think of cooking as a daily part of life, to make nutritious food at home, for parents to feed their kids healthy foods at home, for participants to eat better meals and make good food choices, and to lower fat and salt in their foods; i.e., for participants to have healthy eating habits. Widely shared objectives among the staff related to increasing healthy eating included encouraging families to: increase their consumption of fruits and vegetables and the variety of foods consumed; plan and eat balanced meals; appreciate and eat foods from different cultures; and decrease their consumption of sugars, fats and salt. Two program staff also focused on participants' becoming familiar with and learning how to prepare locally-grown, seasonally available produce. In addition to the parents being encouraged to make these changes, there was a significant focus in the programs on how parents could assist and motivate their children to make these types of changes. The exceptional program in this regard

was at School L, in which children had been intensively involved for several years. At this program, parents, staff and administrators all voiced aspects of healthy eating behaviour outside of the program as goals for the programs. For example, one parent, when asked what she thought the health orientation of the program was, said,

> Getting people to eat better meals. Watching what they eat and how much of it they eat. They watch your salt intake. Basically what they're trying to do is introduce the families into more nutritious meals for their children. (Parent #5, School L)

4.3.3 Building food security

Food security was another term, like nutrition, that was not widely used in describing goals and objectives for the programs, although some goal description statements fit with the concept. Two high-level administrators, however, one who oversaw the CFF program and other out-of-classroom programs in several schools and one who consulted with the school board for the Inner City Schools Project, did mention the term and focused on food security as the highest goal for the program. One said her main goal for the program was "more than anything, basically, to really empower the people that were in the program so that they'd start doing stuff on their own, and sort of have an expanded view of how they could access food" (Administrator #10). The other stated that food security was very much an issue in the inner city schools and that she hoped that the CFF program could help in this regard. When asked whether she thought the kind of education provided by the CFF programs could improve families' food security, she hesitated, then said:

> Well, I think it will, because I think that they'll share ideas about, you know, I think that part of the education is where to get fresh vegetables, learning about the Good Food Box, learning about economical ways, sort of like the old, the Community Kitchen idea, because I think this is a spin-off of that kind of idea. So, I think it'll lead to food security [respondent hesitated and made a face]. I mean, food security, let's face it, they need a lot more money to lead to *real* food security, but I think it will help. I think it will help just to know that there might be more sources of food, or ways to meet together to cook in bulk, but I don't know. Obviously food security needs a lot more, you need housing, you need better salaries, so to say it would do that would be pretty ambitious. But I just think the isolation of a lot of these families and a lot of the stress that they're under, the fact that they could come together and have fun, and have a good meal, and enjoy it. And

that's not food security, but that's security, that's loving relationship, that's a good positive experience around food. And hopefully it will lead to better access as well, I'm not familiar enough with how much of that education is done, in terms of connecting them to food sources in the community. (Administrator #1)

This administrator faced the problem that although food security is a concept that community kitchens programs often use to describe their rationale, the term has to be deconstructed into components that can actually be addressed by the programs.

Few parents mentioned goals relating to securing their access to food, although many of the parents were from food insecure families. Two parents from one of the programs stressed the importance to them of learning how to prepare healthy foods on a budget or for little money, while one parent mentioned that one of her expectations of the program was to get healthy food at the program that she couldn't afford to buy. In contrast, staff from almost all the programs mentioned goals related to food security, such as teaching participants to learn to cook healthy economical dishes, preparing healthy economical dishes for participants to eat at the program, and for participants to eat better diets that cost less. One staff stated a main goal as providing parents and families with food, and another as sending leftovers home to families.

4.3.4 Strengthening families

Goal statements that included the words "strengthening families" and related ideas (likely a reflection of having read and absorbed the goals stated in the CFF Program Handbook) were made by staff from six of the programs and administrators from two. There were three types of focus. One included involving parents and children in activities together at the programs. A second related to families spending time together in activities at home. For these activities, some staff suggested that families preparing food together at home was a goal, and some wanted to encourage and facilitate families' eating together at home. The third focus related to providing community support to families, such as introducing new services to families because of

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accessing communication with families through the CFF programs. As one program

administrator commented,

> Families in need … are so overwhelmed by their issues that they have difficulty
> branching out. So this is an opportunity for them to branch out and expand their social
> network. And then we use that venue also to present to them different kinds of programs
> and options that they might have within the community and within our community centre.
> (Administrator #4, School L)

4.3.5 Social integration (with other families, school, community), social support, personal

development, and recreation

A good number of staff, administrators and parents all had goals in the social area. In all

of the programs that had a large proportion of non-native English speakers, one of the goals was

to support their learning and practicing English. This goal was shared by parents, staff and

administrators at these programs. Being together, sharing, and doing things together (i.e.,

cooking, eating, sharing recipes) were stated as goals and expectations by a number of parents

and some staff. The getting together of different cultural groups was also a stated goal at several

of the programs, both by parents and by staff. A related goal was to reduce social isolation, get to

know neighbours, meet new people and make new friends. Parents, especially, stated this as an

expectation of the programs. Some people described this goal as socializing or building social

networks. A few parents and staff each mentioned the recreational aspect of the programs, with

having fun as a goal. One parent said she was looking for "a comforting place where no one

judges you" (Parent #29, School F). One administrator explicitly mentioned breaking down

barriers between the school and the community, particularly for those new to Canada, as a goal,

and developing a community of lifelong learners: "To show that schools are here for different

reasons. For example, the hope is of schools as centres of learning – that learning is lifelong, and

that's a tradition of our educational system here in Canada" (Administrator #6, School D).

Finally, a number of staff and administrators saw the programs as a good opportunity for making

a connection between families, schools and/or community centres, for parents to feel comfortable coming into the school or community centre, and for parents to get involved with the school. Helping children was seen as the ultimate reason for involving parents in the schools, as this comment from a school principal illustrates:

> Anything that can get parents into the school, especially from both the First Nations culture that doesn't really necessarily have trust in the school system, or a lot of traditional Asian parents who don't feel they want to interfere in the school system, but if we can get those groups, which are our main two groups, into the school realizing that we want them, you know, we can do more *with* them than we can without them to help their children. (Administrator #5, School F)

4.4 Vignettes illustrating program beginnings and goals, objectives and expectations of the CFF programs

Vignettes illustrating aspects of the programs have been written with careful attention to detail to enable readers to develop a deep understanding of aspects of the programs. The programs chosen for inclusion in this section were selected for a number of reasons. For describing the beginnings of the programs, schools where the original program developers were still involved and could give detailed information about the program beginnings were chosen. For describing other aspects of the programs, schools were selected to illustrate differences in length of operation, types of environments, program focus and goals, and types of programming for children. The first set of vignettes illustrates how program implementers (usually staff) organize the programs to achieve their goals.

4.4.1 School M

The impetus to start the program at School M came from the Neighbourhood Assistant, who said she had been thinking of running a cooking program for a couple of years prior to starting CFF, being concerned about the level of hunger in her constituents, and also about modeling families' eating together:

> I was concerned about nutrition and I was concerned about families not having enough food, and also families not having the opportunity to sit together and share a meal. (Staff #8, School M)

The Neighbourhood Assistant had heard about CFF from the community nutritionist associated with the program and spoke to her Principal about starting a program. He gave her approval, and the community nutritionist advised her about obtaining funding. She wrote an application to a community organization requesting start-up and operational funds, and was pleasantly surprised that the organizational representative even assisted her in writing the application. At the time the interview was conducted, she felt that there had been no barriers to starting and running the program. Once the program was running, the NA's concerns for her families was confirmed, as illustrated in the following comment:

> I know for a fact that some of these parents don't have food. [And how do you usually find out?][22] When you get the connection with the family. And a good example is, we have a parent who had a fire, and when myself and another staff member went to help her get what she could out of the house, we realized just how much she didn't have. (Staff #8, School M)

The Neighbourhood Assistant had a variety of goals/objectives for her program. These broadly included "supporting parents," in the areas of food and nutrition, parenting and family relationships, self-esteem, and social and community relationships. The "program goal" as she stated it on the quarterly staff evaluation form was: "Strengthen Families, Improve Nutritional Well Being. Provide Parents & Children with a sense of inclusion and acceptance" (Staff #8, School M). Goals stated by the Neighbourhood Assistant during her interview included, in the food and nutrition area,

> My goal is to support parents – to provide them with more food than they have, to provide them with nutrition advice (healthy foods): how to cook foods, what's out there, what's available. … [It's for them] to get a little bit of extra food to help them with meals and to get a little bit of knowledge, to learn something new, whether it be hygiene or how to cook something, but in a very pleasant atmosphere. (Staff #8, School M)

and in the social area,

> … a sense of community, a sense of importance, that *they're* important. That their opinions are important, their children are important, that this is *their* community, and for them to feel good about themselves. (Staff #8, School M)

When asked if she thought the program was accomplishing these goals, she said, "I think we do."

She also said, in relation to how many people could be in the program at one time, that the size/numbers related to what the program could accomplish, and that to her, the program had to combine the social with the food and nutrition benefits:

> When you get a program that gets too big, you lose that intimate stuff. … I mean, we could do a program where it's *just* strictly cooking, but I really think it's important to do more than just the cooking. (Staff #8, School M)

4.4.2 School E

CFF was initiated at School E by the Neighbourhood Assistant in the fall of 2000, soon after she began work at School E. The parent president/head of the School Consultative Committee, who had heard about CFF in another school, said that the parents would like a CFF program at their school: "She came to talk to me and say how good it would be to have one (a CFF) at School E" (Staff #1/14, School E), and the idea resonated with the NA.

The Neighbourhood Assistant's goal for the program was to motivate parents, some of whom she felt were depressed and had lost hope due to living in such difficult circumstances, to see cooking dinner meals at home as part of their daily activities, and to learn how to prepare healthy meals on a budget. She stated that she felt that while some of her participants were providing family meals at home, they did not like cooking and felt it was a great chore and a "sacrifice." Her strategy for influencing these participants was to foster the experience that cooking could be a lot of fun. Overall, she was trying to provide a new model of family life for the participants, that included doing things with your kids, cooking with your kids, eating

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[22] Square brackets indicate interviewers' questions or comments.

together with your family, and cooking meals at home on a regular basis instead of eating out,

and all this becoming second nature to the participants.

> Being an inner city area, I think that the goal is to provide the parents with a way of cooking meals that they can be involved in and sharing. And I feel, and I may be wrong, but in many cases, parents don't cook, or they don't have the right ingredients to cook, or they don't have a chance to shop that much, or they are without money in the middle of the month. And you know, I feel that, in many cases, with being involved with all the social-economic problems that exist in their life, there is a certain kind of indifference that may be the result of being, how can I say it? I think that they are depressed about the situation, and when you are depressed, you know, depression is more crippling than arthritis to me. So they don't get around to prepare the meal, or supervise their kids and do it together, and so I see the program as, "Let's make it fun, let's do it with our kids, let's see what we have, and what we can cook with what we have." You know, to give them an interest, to give them a chance to go around. And not everybody's the same, don't get me wrong. But also the fact that we have a concern about nutrition and so we work around that, and together they can get the whole picture. But also I see it as the kids growing up with the idea of seeing cooking a meal as brushing their teeth. So it happens automatically, not that it is a big task, and "now I have to do that, and I don't want to do it." You know, something, getting into the habit of making cuisine fun and excitable and every day. And if they participate together, they have a chance to do it with Mom at home. (Staff #1/14, School E)

She expressed a concern that the families of her participants weren't eating meals

together at home, and said that in her background that had been very important to her, and she

felt it was important to families of this generation to eat together:

> But to go home, really, and do things together, especially doing it with their kids. I think that's what the goal should be. I think that it fosters more of a family life. I think that even in the case where they are single mothers it's very important, that kind of bonding with their kids, and usually it happens that if you cook together you also eat together. (Staff #1/14, School E)

The Neighbourhood Assistant thought that most of the parents had initially joined the

program because they were eating out a lot and it was more expensive than they could afford:

> I think that mainly it was that they joined the program because of the fact that it cost them too much to go out all the time, and they were probably looking at alternatives that give them a source of food for less. (Staff #1/14, School E)

Over time, however, she thought that the participants' reasons for staying in the program had

changed:

I think that now they like to get together and they like to come here and have fun. They like to joke with one another. They make it their social forum. Sometimes I have to interrupt them and I think it fosters a good group feeling. And it got to give them a chance to get to know one another and each other's kids and you know, so they walk home together sometimes. So I think isolation and loneliness was really part of their life and coming out to school programs was seen before as, "Oh no, that's not for me. It's another task," but now it's seen as having a full social life for them. (Staff #1/14, School E)

4.4.3 School L

The school nurse initiated planning for the program at School L after having heard about CFF from the community nutritionist involved with the program. The nurse advocated for the program with the inner city school staff, who agreed to support the program by referring families. It took about a year to get funding in place to start; this was arranged by the community nutritionist. Since the program was held at a nearby community centre because of the lack of a suitable kitchen in the school, the program administrator there took on administrative responsibility for the program. Families were recruited through the school newsletter and also by "more personal referral of people who were working with the counsellors or the Family Advancement workers" (Administrator #13, School L). These were people who, according to the nurse, were:

> identified as fitting the criteria for what the program was, and that was around isolation, social isolation. It was around multiple issue families, and it was around need, whether it was nutritional or socialization, … in need of getting to know neighbours, in need of a bit of nutritional involvement on a community level with their children. (Administrator #13, School L)

In this case, perhaps because the program was run at a community centre rather than a school, instead of the staff having developed the goals/objectives and the program itself, two administrators were at the forefront of setting the goals and objectives of the program. The community centre administrator and the school nurse seem to have developed a set of shared goals for the program. From the point of view of the community centre administrator, one of the major goals of the program was to provide a milieu for families from the low-cost housing

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complex, close to both the school and the community centre, to branch out into the community

and become comfortable using the services provided by the community centre. These goals

related to reducing social isolation and increasing social integration and social support.

The school nurse took the goals of the program from her understanding of the CFF Program

Handbook. Her goals were:

> [to recruit] a diverse group of people to form social networking, build capacity through skill building and providing another teaching method to help parents be more actively involved with their children around nutrition issues. (Administrator #13, School L)

However, since the school nurse did not actually facilitate the project on a weekly basis, these

goals had to be translated through both the community centre administration and the program

staff, who also changed from year to year or in some years, from term to term. Thus a variety of

staff and administrators had developed their own goals and objectives for the program. The

parents and staff considered the program an opportunity for the participants to try (taste) new

foods that they wouldn't otherwise have the opportunity to try and to learn how to prepare new

recipes. They also considered it an opportunity for parents to learn how to involve their children

in food-related activities.

> Cooking, learning how to cook with your children, the do's and don'ts in the kitchen with the children, especially small children. And new *recipes*, that she [the program leader] thinks that people would like to try out. New ideas, new cooking techniques. And just generally to share your interest with other people about dishes. (Parent #5, School L)

4.4.4 School F

The Neighbourhood Assistant's main goal at School F was to provide a communal meal

that a variety of the school's cultural groups participated in creating and eating together. The

main goal of the program, from the NA's point of view, was enjoyment and sharing a meal

together:

> I think it's always really exciting to cook together, and the choice of menus have been really good. We've done one week ethnic, one week Canadian, and food always brings people together, and so that's one thing that I think is always really exciting. And then

sharing with, you know, a few people on staff. And it's just really good to see the collaboration of parents, when they actually cook together. So I think that foods always works, especially in a school like ours. … For me the goal would be to bring people together in all of this, because I know that some people, they say the goal is to teach people about budgeting. I don't think I need to teach any people about budgeting. People here are pretty poor and they know how to budget better than I do. And so probably the biggest thing for me is when I see all the groups sitting down together. And it's nice sometimes when staff comes down and joins us too, and that it feels like a real Community Kitchen. And so that's probably the goal for me. Just bringing people together and everybody just having a good time and really enjoying cooking together. (Staff #6, School F)

4.5 Summary of goals, objectives and expectations and program beginnings

Each CFF program was organized and started by someone, either staff or administrator, who was concerned about the level of disadvantage within their school population and saw the CFF program as a way to assist families within their school. The goals and objectives for the CFF programs voiced by the staff and administrators in interviews and on staff evaluation forms conformed quite closely to those presented in the CFF Program Handbook: the development of food and nutrition knowledge and skills; increased healthy eating behaviour; increased food security; strengthened family relationships; and increased opportunities for social integration, social support, and personal development and recreation. Participants' expectations of the programs were expressed more in terms of learning new recipes and food skills and having an enjoyable social experience. Staff and administrators' goals and objectives were thus more oriented towards longer range health outcomes while participants expressed more proximal goals.

Each program was developed with an orientation towards a selection of these goals, according to staff's and administrators' perceptions of what was most important for their particular group. Thus some programs were more focussed on education and skill-development goals, others on psychosocial and school-community integration goals, and some were equally focussed on both. All programs aimed to support participating families, based on the families'

needs. No programs were focussed on solving the larger problems of poverty and food insecurity that beleaguered the clientele, but each staff and administrator was cognizant of the situation and aimed to alleviate the worst aspects of food insecurity while trying to facilitate the development knowledge and skills that might assist families to eat healthier meals and snacks for less cost.

4.6 Strategies used in the CFF programs

Strategies used in the programs reflected the two main foci of the programs – those related to food and nutrition, and those related to social and psychological support. Educational strategies involving demonstration, explanation and engagement of participants in food preparation tasks were common. Safe food handling techniques were taught both for the communal food preparation activities at the programs and also to be used as applicable at home. The provision of the program free of charge was a strategy aimed at facilitating participation in the programs by low-income families. Strategies related to psychosocial aspects of the programs included those related to providing a safe, welcoming environment for the participants, and those related to providing opportunities for participants to expand their social networks and to develop supportive relationships with each other and with staff. Each of these types of strategies will be elaborated upon in the following sections.

4.6.1 Strategies related to food and nutrition

Program strategies related to food and nutrition included demonstration and active participation in food preparation activities; provision of food for participants; participants eating together at programs; focus on safe food handling and sanitation; direct teaching by program staff; and encouragement of practice at home. All the program staff or volunteer facilitators spent a significant amount of time and energy demonstrating food preparation techniques or walking participants through the techniques while explaining and demonstrating them. This is the defining aspect of the learning method employed in the programs. The participants were all

engaged as fully as they wanted to in the food preparation, serving, eating and cleaning up activities. At some programs the staff had to assign duties to some participants until they felt comfortable volunteering for activities. Over time, all participants were self-motivated and actively participated. At some programs, occasionally a parent would take on this role for a certain recipe that she brought from home. At one program, run by a former program participant, participants focused on making the ethnic dishes from their homeland together and learning variations and techniques from each other, as well as learning the recipes the facilitator brought. At another program run by a former program participant, the sessions were divided equally between "Asian" and "Western" food, with different participants demonstrating recipes from different cultures. At the remaining programs, the staff brought and "taught" most of the recipes, usually, but not always, after consulting with the participants. Only one program showed evidence of conflict and disagreement over recipes; at that program, the staff wanted to "teach" healthy eating, while the participants sometimes resisted trying new foods or changing their food preparation methods.

Another food and nutrition related aspect of the programs was the fact that they provided food for their participants. Two programs provided a sit-down lunch, three a sit-down dinner, two dinner food or a recipe and food to take home, and the other involved participants tasting the food and taking any leftovers home. This strategy was particularly important for programs that included children, as a means of encouraging them to try new foods. Adults, too, often needed to be encouraged to try unfamiliar foods. Besides the eating together aspect, all the programs, at least some of the time, sent extra food home.

The provision of food ingredients and a free program was a strategy used by all the programs to draw in and retain participants. Most of the participants made it clear that they would not be able to afford to pay for the program. Along with the provision of ingredients, there

was an ethic at all the programs that the food prepared and served was to be healthy food and that eating healthy food was a value promoted by the programs.

Most of the programs practiced exemplary sanitation and safe food handling techniques, such as sterilizing food preparation and eating surfaces with bleach, and using different cutting boards for preparing vegetables and meats. Many staff taught safe food handling skills, such as when to refrigerate, how to check meat, and how to cook meat. One staff mentioned her concern about her clients' lack of awareness of food safety:

> One of the focuses of the program is to cook safe. It seems to me that in many households maybe food has been left out and they're not so aware of salmonella, you know, dealing with chicken. (Staff #1/14, School E)

Some of the parents were very interested in learning safe food handling skills, and some programs assisted participants with arrangements, including funding subsidies, to take Safe Food Handling courses and gain certification.

A couple of the programs, however, were lacking in supplies, such as hand soap and paper towels, and in one program, facilitated by a "volunteer," I felt the standards of cleanliness and sanitation should definitely be improved. This program often lacked dish soap and other cleaning supplies, and in one instance I observed a child with a running nose being held on his mother's lap while he wiped his nose with his hands and then put them into the salad that was being prepared for everyone and mixed the salad. One of the staff I interviewed at that program mentioned how difficult it was to get parents to focus on the nutrition and sanitation aspects of the program while what they were interested in was producing a delicious meal.

Some of the program staff provided didactic information about nutrition, and a few branched out into topics such as teaching participants how to decipher labels on food packages, how to buy and prepare foods in season, and/or how to reduce the use of salt, sugar and unhealthy fats in participants' diets. One staff took her participants on a super-market tour once a year.

Finally, most of the programs encouraged parents to cook at home, utilizing knowledge they had gained at the programs. Some programs focused on facilitating participants' repeating at home what they had learned at the program by sending ingredients home so that participants could practice the recipes again. Some of the programs also encouraged parents to get their children involved in food preparation activities at home.

4.6.2 Strategies related to social and psychological support

Program strategies related to social and psychological support for participants included creating a comfortable setting; exchange of emotional support; discussion and group decision-making; focus on literacy; the preparation of special foods for cultural celebrations; and the facilitation of cross-cultural interaction and acceptance.

Strategies common to all the programs related to the goal of providing a program where participants would feel comfortable, welcomed and valued. Staff spent a great deal of energy on this and many of the participants did also, welcoming, encouraging and caring for other participants. Most administrators (school principals, community centre administrators) also made a point of dropping in to the programs to show caring, attention and appreciation for the participants' culinary skills, and to open the door for further communication with the parents.

All of the staff showed a significant focus on providing and modeling individual emotional support, and at most of the programs, the participants also took on this role, over time, of supporting each other. Besides working in preparing food together, several other strategies worked to facilitate the exchange of social support, including having participants share recipes from their cultures with each other and having participants eat together at the programs. Eating together as a strategy was used as a method of building a sense of community and, where children attended, modeling the benefits of families eating together. As one parent commented,

> By eating all together, (we sometimes have twenty-two to twenty-five people sitting at
> the tables altogether), it sends up a message of community and sharing. We prepare with

a lot of love, I think, because we have a lot of families doing it – learning, sharing while we cook, and socializing and being with each other. (Parent #12, School L)

Most of the programs incorporated a substantial amount of discussion among the participants and the staff about the foods they were preparing and learning about, and about what the participants wanted to learn or do next. This discussion and sharing of power was enjoyed by the parents, and was an operational norm of most of the programs.

Most programs incorporated a focus on literacy by working from recipes for more complicated dishes, and some programs handed out copies of these recipes for participants to take home. A few programs gave participants binders to keep their recipes in at home. Depending on participants' need and interest, staff at some of the programs taught the use of equipment, how to measure, how to read recipes, how to double or halve recipes, and how to substitute in recipes. In two programs, staff focused on teaching English terms related to the food and preparation for participants who spoke no or little English. Two other programs with similar clientele did not focus on English; one program was conducted in Chinese and the other had a multicultural Chinese worker who attended with participants. The other four programs consisted of mostly English-speaking participants, but where there was an ESL participant, parents and staff encouraged them and helped them to speak English.

At most of the programs there were opportunities for participants to sometimes take the lead in presenting healthy ethnic recipes from their own cultures to the others, who would learn how to prepare them and show much appreciation and enjoyment when eating them. In this way, the program supported participants' sense of pride in their own cultures, and openness to learning about and sharing with other cultures. Preparing foods for cultural celebrations was an aspect of most of the programs. There were two different foci in this regard. Some programs focused on preparing traditional "Canadian" foods at program sessions close to celebrations such as Thanksgiving, Christmas, and Easter. Some programs also allocated time and money for

participants to prepare their traditional dishes for the group, and some groups that were composed of participants mostly or solely from other cultures prepared their cultural foods together as part of the program experience.

4.7 Vignettes illustrating strategies used in the CFF programs

4.7.1 School M

The program was held in the school staff room every second week and began around 1:30 or 2:00 PM so as not to interfere with the teachers' lunch hour. It continued until about 6:00 to 7:00 PM. The Neighbourhood Assistant said that although the teachers were nervous at first about having the parents and children using the staff room, the parents had learned to leave the room "cleaner than they find it," and the teachers became supportive of the program. The program was targeted to families that the counsellor and youth-and-family workers thought would particularly benefit from it, and operated by invitation, but also was open to "self-referral," meaning that a child could refer his or her family by asking the Neighbourhood Assistant for permission to attend, or an adult could ask to attend the program and be allowed to attend with his or her children. The clientele were mostly First Nations families and all spoke English. About three to seven parents, and their children, including several toddlers, attended regularly. The Neighbourhood Assistant said that "with the kids, we average fifteen to twenty for dinner" (Staff #8, School M). This was as large a group as the staff room could handle. In any case, one of the Neighbourhood Assistant's strategies was to keep the group small enough that the participants got to know each other and developed mutually supportive relationships and a sense of community.

The Neighbourhood Assistant at School M said that she had found in home visits that many families didn't eat meals together. She used the communal meal at the program to model eating together and building a sense of community:

I really, really do push in our program (putting) up all the tables and if there's fifteen of us, we all sit down together. We pass the food, we share, we joke, we encourage each other. I just think it's so important. (Staff #8, School M)

The program at School M was fortunate to have, as a volunteer, a mother in the school who was a dietitian. She was put in charge of meal planning, shopping and food preparation. Her food preparation duties also included involving parents in the food-related activities by encouraging them to participate, demonstrating food preparation, and overseeing the parents' food preparation activities. The Neighbourhood Assistant took on more of the administrative functions; she "support[s] the recruitment, the planning, the supplies, the writing of grants, the funding kind of stuff, and support[s] her [the volunteer] in the program itself" (Staff #8, School M). These two program leaders involved the parents in discussing the next week's menus each week: "What we do is, each program we'll sit down with them throughout the program and say, 'What do you guys want to do next week? What would be interesting?'" (Staff #8, School M), and the Neighbourhood Assistant said that long-range, she would like the parents to take over the shopping. At this early point in the program's development, though, the leaders still did much of the food preparation at the program, as they were in the process of "modeling" food preparation behaviours. They had found it a struggle to get new parents to participate in the tasks, stating that the parents were inexperienced in food preparation, felt uncomfortable and unsure of how to participate in the program, and "don't know what to do." The program leaders decided that people needed to be shown what to do and asked or invited to take ownership of tasks, so they developed a strategy of asking people to "help out":

> One of the things that Mary[23] and I have both found is that we have to assign them jobs because they don't have the confidence to say, "Oh, I'll do that." You have to say to them, "Can you do this?" And a good example of that was, we had green peppers one day for something, or peppers, and I said to the person, "Well you can just cut these up," and they looked at me - they had never cut up a pepper and they had no idea how to do it. So it's a learning, you know, so we have to say – and some of them will just sit there, and it's not because they're lazy, they just don't know what to do. So you have to assign them

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[23] All names have been changed to protect confidentiality.

little things, and then the next week they might say, "Well jeez, can I help out with that again?" … They get a little bit more comfortable and they can take more initiative. (Staff #8, School M)

The main activities of the program were to prepare a snack for after school and a meal for dinner, and to eat together in a relaxed atmosphere with conversation. Then, and "not rushing into it," (Staff #8, School M) some parents cleaned up, some packed up leftovers for the families to take home (usually a substantial amount), and some minded the children during these activities. When asked about their usual activities, the two adult participants who were interviewed said they "helped" the volunteer with the food preparation, confirming the role that parents often take at the beginning of the programs as seeing themselves as "helpers" rather than initiators, and also did table setting and clean-up each week:

> Usually I say to Mary, "What would you like done?" And if I see potatoes there, I'll say, "Do these need to be peeled?" and I'll peel them. … I'll peel carrots. I peeled potatoes today, and if there's dishes, I do dishes. We all work together. We just do what has to be done. (Grandparent # 17, School M)

The Neighbourhood Assistant said that the volunteer leader used recipes, which they photocopied and that they "give them out to whoever wants them." When asked if she thinks people used them, she said "Some of them do, some of them don't. Some of them are more literate than others, and I think that has a lot to do with it" (Staff #8, School M).

Children were sometimes involved in food-related activities (e.g., baking), seasonal activities (e.g., Easter egg decorating), educational games, and table setting and clean-up. At other times they played, did homework, or played games (e.g., cards) with their parents. The menus for the three days that the program was observed were quite extensive, consisting of: (first day) stuffed turkey dinner with mashed potatoes, cranberry sauce, vegetables, juice and coffee; (second day) chili, fried bannock, mixed salad, brownies, milk and juice; and (third day) roasted meat (ham), scalloped potatoes, and salad. There were also snacks: crackers, veggies, dip, fruit

and vegetable slices, and "nest cupcakes" (an Easter theme), which the children participated in creating.

The Neighbourhood Assistant saw the group as a support group, so that if issues not related to the cooking were bothering parents, she took the opportunity to have a group discussion about the issues or to advise them to see a counsellor. She used the program as a springboard to get to know families and have them articulate their needs, which she then tried to help them with. She said she "know(s) for a fact that some of these parents don't have food" (Staff #8, School M). When asked how she knows, she replied,

> Because when you get the connection with the family and you can make them feel that it's not their fault, you know, that you understand, and that they're comfortable enough to open up, sometimes they'll tell you. Sometimes they'll tell you about their friend who doesn't have any food, because they want to help their friend too. (Staff #8, School M)

4.7.2 School E

The program sessions at School E were focused exclusively on parents and took place during a weekday afternoon between 1:00 and 3:00 pm. The participants were a committed core group of about six to eight parents, while others occasionally attended for shorter or longer periods of time. There was some participant turnover but the rate of turnover was very slow.

At School E, participants were taught how to produce healthy and attractive but inexpensive meals for their families, using basic ingredients and making substitutions in recipes where necessary. At the request of the participants, particular attention was paid to how to present fruits and vegetables in ways such that participants' children would want to eat them, and also on how to add more vegetables into recipes so children would be eating them without being particularly aware that they were eating more vegetables.

> There's some veggies that my kids don't eat, but now that I've learned different ways how to make them, I've tried, and my kids love it. And it's healthy for them, which I don't let them know (laughs). (Parent #1/13, School E)

The participants and staff had grown to know each other well, and the program provided a supportive atmosphere where people felt cared for. The first year of the program, two staff were assigned to co-present the program, but their teaching styles were incompatible. The problem was solved the second year by having one staff, the Neighbourhood Assistant, focus on the CFF program for parents, and the other staff provide a cooking program, during school hours, for children.

The Neighbourhood Assistant was very organized and presented three new recipes each week. The recipes were typed up and available for the parents to read while they were being prepared, and to take home. Participants prepared the recipes under the guidance and demonstration, if necessary, of the NA. They then tasted the finished dishes at the program, and often took some of each home for their families to taste. Program descriptions by two different parents, presented below, illustrate the typical routine followed in the program, as well as the obvious enjoyment the parents derived from the minute attention paid to detail and organization:

> So we come, we all look for our cutting boards and everything, which are always sanitized and washed in the dishwasher on hot. So it's always clean, but we always still rinse it, because they were sitting in the cupboard. So just to be on the safe side, we rinse it. We all wash our hands. … We cut, we talk, we chat. … We take turns cooking and chopping and mixing and when everything is done, we sit and eat! We realize how good we were! And then whatever's left over afterward we get a little container to take home to the family. (Parent #1/13, School E)

> … And as one's reading [the recipe out], the others will begin to, if it's chopping or dicing, or pastry cutting, flour measuring. We'll go in order. We know over the last year who does what, but we all pitch in, we all know where the supplies are. Once the food's laid out, we'll get all the utensils, and all the prep, you know, heat the oven if it's the oven thing. It's all of us to be aware of what's going on, you know, it's very structural, we'll, it's very *informal*, but it's *organized*. … And then, let's see, once cooking's done, as it goes along we're cleaning up, because we usually have to reuse some of the items, depending on what the recipe is. And once the cooking's done, we do put all away, clean it up, allow for cook time. … We're almost always able to sit down between/around 2:30 of any given day, and have a little sample of what we're doing. … We'll just play that by ear as it goes through the time. But it rolls pretty nicely. (Parent #10, School E)

The Neighbourhood Assistant picked up supplies from the Food Bank the day before the program, and then supplemented them with food bought at the market, to complete the planned

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menu. Part of the learning exercise each week was discussion and demonstration of how to use the food bank order, since many of the parents would be personally receiving a similar order.

4.7.3 School L

At School L's program (which took place in a community centre), where children attended from 3:00 on, the parents took a very active role in organizing themselves and preparing a snack and dinner. There had been several different staff facilitators over the few years of the program's operation, each with a different style, while a core group of parents had remained. The program was run in a large activity room that had a small kitchen at one end. There was no sense of intrusion into another's space during the program itself, but other programs did use the same facilities at other times. The space did not permit separate ownership of a storage area by any one program, which brought with it the frustration of having equipment and food supplies go missing and cleanliness standards not being upheld. Parents and staff both got into the habit of bringing equipment (e.g., measuring cups, cooking pots, kitchen towels) from home for use during the program. The staff and parents complained about the acoustics in the space – a large reverberating room that echoed and amplified the children's natural tendencies to be noisy. The generally low level of supplies in the community centre comprised what was available to the program; the centre was low on silverware, the knives weren't sharp, and there weren't always essentials such as bleach for the kitchen and soap and paper towels in the kitchen and bathrooms. This lack of sanitation supplies made it more difficult for the program to focus on one of its components, issues of food safety and personal sanitation.

Recruitment and retention of new families was somewhat problematic. A number of factors likely contributed to the situation, including the fact that the program was not at the school, the staff were not part of the school, and the school had lost its inner city school status and funding for additional out-of-classroom staff. As one of the administrators commented:

Once you have an off-site location, the majority of the school people do not see the activity because we have a clientele who's hesitant to join new things. They're not a group of joiners automatically. They're more hesitant in those situations. So what we had is people who had to be very strong, or already knew about it, to go to the community centre. So it had become a group of the people who'd always been there without a lot of new people. (Administrator #13, School L)

During the first year of the program (before the research began) there were reportedly a large number of attendees. During the research period, however, the number of attendees dwindled and the program staff and stakeholders were not able to recruit and retain new members. There would occasionally be a recruitment advertisement at the school (different from the initial offering of the program, which was targeted and by invitation), but these efforts were not sufficiently coordinated with the CFF staff (e.g., a large number of new clients would show up unexpectedly and the staff would not have been warned to plan for them). Most of the new clients would drop out after a week or two; only a couple stayed long-term. The program was eventually closed when the number of steady adult clients dropped to three.

The children's activities component of the program changed over the time span of the program and the research. For the first two years of the program, the community centre provided a "child minder" who was responsible for providing activities for the children. Some of their activities related to food and were integrated with the program (e.g., baking or preparing snacks), while others related to play, such as going to the gym or outside in good weather. Some of the older children sometimes worked alongside their mothers in the kitchen preparing the main meal. Then, however, the community centre administrator decided to terminate the child minder's position and instead to hire two program staff, and to include programming for and carrying out activities with the children as one of their responsibilities. The parents were not happy with the new arrangement and they made it known, reporting that some of their children were now bored at the program and that they found it difficult to concentrate on the program with their children underfoot. They lobbied for the return of the child minder, but did not succeed. Instead, the

administrator stressed to the program staff that they were to be responsible for the children's programming. These staff found it difficult to provide enough educational activities for the children, however, and even the school nurse admitted that with the wide age range of the children, the goal/setup may have been unrealistic.

4.7.4 School F

This school had run some kind of community kitchen program off and on for about 8-10 years, but the most recent incarnation had just started up in the new parents' room during the first part of the research process. This school had the largest program in terms of the number of participants, sometimes reaching up to fifteen or twenty parents (but no children, unless they were toddlers) at a time. It took place in a parents' room in the basement of the school (beside the cafeteria and play areas), and had a kitchen specially built for the use of the parents and the after-school daycare program. The parents had taken ownership of the space (it also had two computer workstations with internet access) and were there often throughout the day and week. The program took place twice a month, and alternated between "Asian" and "Western" cooking, in an attempt to draw in and integrate the two main ethnic groups of the school, Chinese and First Nations. The Chinese multicultural worker arranged her schedule so that she could attend the program, and thus attracted a large number of Chinese mothers, a number of who didn't yet speak English. The Neighbourhood Assistant oversaw the other participating ethnic groups (mostly First Nations and Vietnamese), and often gave them phone calls to remind them of the day for the program. The program was run, for the first study year, by two parent/grandparent volunteers, one of whom was Vietnamese and the other First Nations, each of whom were paid a small honorarium (i.e., $35 per session). The First Nations grandmother acquired another more full-time job part way through the research, and the Vietnamese parent volunteer then ran both sessions each month. The main activity was preparing lunch together and then sitting down and eating together. Sometimes there were left-overs, which some of the participants took home.

There was no formal educational strategy *per se* at this program, but parents talked among themselves and learned from each other.

4.8 Summary of strategies used in the CFF programs

All eight of the CFF programs included in this research provided a social situation where culinary skills could be learned and practiced and new foods could be sampled. Depending on the interests and needs of the clientele, the goals and talents of the staff, and the organizational structure of the programs, they could be more or less educationally-oriented regarding food, nutrition, and safe food handling. The programs also provided a social forum where acquaintances could be made and friendships could be developed. Again, the extent of this happening depended on a number of factors, such as the clients' needs and desires and the skills and orientation of the facilitators. Programs varied as to whether and how they included children, but the underlying focus was on facilitating the best possible nutrition for children. This goal was approached in a number of ways. Aside from the basic concepts of cooking and eating together, each program was specifically tailored according to the above characteristics.

Several strategies were used across all the programs to accomplish the food- and nutrition-related goals. The most common of these were demonstration and direct teaching by staff, active engagement in food preparation activities by all participants, a focus on safe food handling and sanitation, provision of food for participants, and encouragement of participants to apply new skills and learning at home. All programs involved participants in every step of preparing and serving the meals and snacks they created, with many tasks and activities geared towards the development of food-related skills and techniques. Most often, someone led each activity, usually a staff person but sometimes a parent, instructing others and demonstrating as necessary. Parents demonstrating recipes from their own cultures was useful for sharing important food- and nutrition-related information between cultures. Occasionally, staff provided education or information in a more formal way, such as by telling participants information about

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foods they were unfamiliar with or extolling the virtues of certain practices such as reducing salt intake. Participants were invited to eat the food they had prepared as part of the programs' strategies. Eating together at programs facilitated the acceptance of new foods, particularly by children. The strategy of sending food home encouraged families to taste and appreciate new foods, gave legitimacy to parents' attempts to change their families' diets, and provided extra food to families in need. Participants were encouraged, as another strategy, to repeat recipes they had learned at home, and to make healthful changes in their and their families' diets at home.

There was also a common set of strategies across the programs related to psychosocial and school-community integration goals. These included the creation of a comfortable, welcoming setting with the offering of social support from the staff and facilitation of positive and supportive relationships among participants. Several strategies worked towards this, including having everyone sit down and eat together at the programs. Eating together at the programs was also used as a model for families to apply at home. Extensive discussion and inclusion of participants in group decision-making was noted in most of the programs. Programs focussed on strategies to increase levels of literacy to varying degrees. There were many activities geared towards increasing both oral and written literacy related to food. All programs used celebration of participants' cultures as a strategy both to support pride in culture as well as and to facilitate cross-cultural awareness, familiarity and acceptance.

4.9 Challenges and issues in implementing the CFF programs

Challenges experienced in operating CFF programs were voiced mainly by those who were involved in the program implementation – all staff, and those respondents labeled "administrators" but who were not school principals. A few of the challenges were also mentioned as concerns by the occasional parent. The main challenges included those relating to recruitment and retention of participants; staff training, guidance and support; curriculum and

program focus; funding and access to program resources; communication and ethnic variety; and program location. Findings related to each of these challenges is presented below, followed by two short illustrative vignettes.

4.9.1 Recruitment, attendance and retention of participants

Most of the programs were beset, at times, by low or inconsistent attendance. Staff had to put substantial effort into recruitment, reminders and encouragement to attend. Staff and administrators thought that not only were some parents shy and reluctant to get involved with the school, but that many inner city parents juggled many responsibilities that could interfere with their regular attendance at the programs. As well, outside events, such as new requirements for English-language training for social assistance recipients, sometimes conflicted with program times, forcing participants to drop out of the programs. In the initial stages of the programs, recruitment was usually difficult as it had to be done mostly by word-of-mouth, often to potential participants whose understanding of English was limited, or to those who didn't feel familiar with or comfortable in the school. Some programs used multicultural workers to explain the program and encourage parents from their ethnic groups to attend. Recruitment was an on-going difficult issue for most programs, but one program had the opposite problem with having more parents wanting the program than it could accommodate at one time after several years of operation. This school solved the issue of over-subscription by offering three distinct sessions per year, with three different sets of participants. The staff of the other programs, however, noted that on-going effort was required to encourage and retain newcomers. In programs where the majority of the participants were from one ethnic group, especially where they communicated among themselves in their native language, keeping the program welcoming and attractive to parents of other ethnic groups was often a challenge. One multicultural worker commented on this situation: "We want every parent to feel comfortable, even though it seems like the majority

is a *group* [an ethnic group] of parents" (Staff #13, School F). In two of the programs, the

clientele base was long-term and static, which posed another challenge, namely that there was

little room for newcomers, since the kitchen spaces were limited in size, and the close-knit group

might have been difficult for newcomers to fit into.

4.9.2 Staff training, guidance and support

There was no training specifically related to running the CFF programs for the

Neighbourhood Assistants who developed and ran the majority of the programs, although some

of them elected to take a FoodSafe training course on their own. The Neighbourhood Assistants

were members of a local union, and as such, had a variety of in-service opportunities, but these

did not include anything specific to running a program like CFF.[24] There was no person or

position at the school board level to gather the Neighbourhood Assistants together for discussion

or support; they were each dependent on their school's inner city team for this kind of backing.

However, for several years after the CFF program model was developed, the community

nutritionist involved with the program development hosted CFF staff networking meetings

approximately once every second month, initially as part of her nutritionist half-time secondment

to the Vancouver School Board. The focus of these meetings included conversation about the

programs as well as occasional outside speakers who would discuss similar programs or

community initiatives. However, the secondment arrangement was terminated and although the

community nutritionist continued to host these meetings for some time afterwards, toward the

end of the research, the meetings were discontinued, leaving the CFF staff without direct access

to nutritionist support for the programs.

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[24] Once a year, however, the Inner City Schools Project ran a district-wide Inner City
Conference, which all inner city school staff attended. This conference provided the inner city
school staff with an opportunity to explore issues common to the inner city schools and to
network and share information.

Multiple skills and talents were required of CFF staff, in the areas of social skills and group facilitation, teaching and presentation, nutrition, and cooking/food preparation. For programs that required staff hired from outside the schools, finding candidates with this combination of skills who were willing to work part-time was difficult. Staff who were hired from outside the school system to run CFF programs were reliant on their particular school or community centre for on-going program development and support. At one program in which outside staff were hired to facilitate the program, one explained in her interview how she had had to rely on receiving communications and instruction from the mothers in the program about how the program should be run:

> Both Louise and I [both staff] were new to the program, and at the first class, we just didn't know what exactly was going to happen. At the second class, two of the moms gave us a paper talking about what improvements could we do about the program. They said we should use bleach water to clean the tables at the beginning, and also have something for the kids to do. They also suggested that for every single little job in the kitchen, let's say cooking something, you should have two moms to do one job at a time, not just let one person do it on their own. They gave us a paper, a whole list of things that they wanted us to do. (Staff #4, School L)

Another staff member at this program mentioned she had learned about the format of the program from reading the notes left by the previous staff.

Several staff mentioned in their interviews, however, that they enjoyed being able to develop their own ideas about running the program, in conjunction with input from the parents. Most staff said that they felt they had the skills needed to run the programs, with the exception being a staff member of a program that required substantial programming for children, which she did not feel qualified to develop and provide. In terms of material resources for the programs, what existed was the CFF Program Handbook and the program kit. Most staff found the materials in the kit (e.g., cookbooks, games, fruit and vegetable flash cards) to be helpful at the beginning of the program, but found the Handbook to be more oriented towards starting a program than running it. Ultimately, the staff who ran the programs were required to invest a

substantial amount of their own time and energy in creating the programs as well as implementing them without much guidance from their employers or from other sources.

4.9.3 Curriculum and program focus

The staff dealt with a number of challenges relating to program focus and curriculum, or lack of specific curricular direction. At some programs, staff felt that parents weren't interested in learning but only wanted to socialize and have fun preparing a meal together, whereas the staff wanted more of an educational focus. At other programs, however, parents indicated that they wanted a more educational program and that they were tired of a narrower focus on simply having fun together. Staff were challenged in both types of situations to adapt to, or challenge, parent expectations.

One staff commented that the program needed a clearer agenda and articulation of what was expected of the parents, and another complained about unclear program rules and expectations. Aside from the general focus on "healthy eating," there was no set plan for the weekly or biweekly program sessions. At one of the programs, which was facilitated by a volunteer parent, a multicultural support worker mentioned the difficulty of getting the parents to focus on safe food handling or nutrition. Several staff mentioned difficulties with parents who don't fully participate while at the programs, perhaps because the participation requirements are not clear, and one said that the parents in her group had many different needs, indicating a sense of unsureness about which, and how many of these needs could be filled by the program. Most of the staff felt a sense of urgency and some anxiety in terms of assisting program participants deal with adverse circumstances in their lives, especially around healthy eating, food insecurity, and lack of family participation in food activities together, and were challenged to address these issues through the program curriculum.

The lack of a developed educational curriculum for children who attend the programs was a challenge for some of the programs that included children. Children were sometimes without structured activities at the programs and needed constant attention either from staff or their parents. Although a program kit is available with some games and reading materials for children, these are not meant to provide enough activities for a year's worth of programs and they soon become repetitive. When children attend, the programs need adequate staffing to handle planning and implementing activities with both parents and children.

4.9.4 Insecure funding, staffing and access to food

Funding instability was mentioned by most of the staff and by some of the administrators as a long-term problem. Fundraising for the programs was haphazard and uncertain from year to year, with no one in charge or responsible for raising funds for the programs. With no one in a position at the school board to solicit donations for the programs, potential funders were sometimes ignored and current funders were often not kept motivated by being informed about the use and results of their contributions or receiving appreciation for their assistance. Uncertain and insufficient funding caused interruptions in the programs and negatively impacted long-range planning for the programs. Several staff commented that while changing participants' food habits at home is a challenge and requires long-term programming and participation of families, unfortunately, the sustainability of the program was always in jeopardy due to insecure funding, both at the program level and the school/school district level. At the program level, there was no central administrator in charge of raising funds and no long-term strategy for funding the programs. Threatened and actual staff layoffs, both of the Neighbourhood Assistants and other support staff (e.g., multicultural workers, counsellors) within the school system due to government budget cuts to education were also quite disruptive to both everyday functioning and longer-term planning for the programs.

About half of the programs mentioned the need for a child minder for when the parents were cooking, but there were not often sufficient funds to provide for this. Sometimes this was for preschool children, but even when older children attended, there needed to be a second staff person to organize and interact with them. When this was not available, it caused disruption in the programs.

Access to sufficient food of adequate quality to run the programs was another issue related to funds. About half the programs used the food bank as a source of food – generally those that were located closer to the food bank used it more. Although the food bank was committed to providing all the assistance it could to the programs, it was not in control of what it had to offer at any given time. Some staff who didn't use the food bank mentioned difficulties coordinating with the food bank: often what they had ordered (they had to submit menus a few days ahead of time) wasn't available the day they picked up the order. This would leave them scrambling to shop the same day, with limited time. Some staff reported occasionally receiving outdated items or sub-quality items such as damp baking products from the food bank, which made it difficult for them to rely on the food bank, since they could not receive and check their orders until the day of the program. Some staff, however, worked out a beneficial relationship with the food bank and were able to use it consistently as a resource for their programs.

4.9.5 Communication and culture

Many of the program participants were not yet comfortable speaking English. Because of language barriers and other communication problems, the requirements of the programs were not always clear to parents or to children. For example, children would sometimes show up and want to attend without a parent, or parents might decide to leave before clean-up was finished. Staff continually worked to communicate around these types of issues. Many Chinese and Vietnamese participants spoke little or almost no English. Although staff were happy that these parents were

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attending, communication was an issue and a challenge for both sides. Occasionally a multi-cultural worker attended and interpreted for these parents. During the research period, however, some multi-cultural staff positions were eliminated from the school district due to budget cuts, and consequently, some parents stopped attending some programs. Because of their difficulties with English, some parents in the programs relied on each other for instruction and direction. One staff reported that she sometimes found it hard to get the parents' attention as they were so involved talking among themselves.

Most of the programs incorporated two or more cultural groups. This was seen as a positive and desired situation by the staff, but at the same time, it was sometimes difficult to get the different groups to relate to each other and to work together, especially when they were first thrust together. One staff commented that the different cultural groups in her program had different nutritional needs as well.

4.9.6 Space and location

Programs that didn't have a dedicated room for the parents experienced time constraints on use of the space. Those that had to share space faced ubiquitous problems of equipment, utensils and supplies going missing, and issues related to standards of cleanliness being maintained between programs. A couple of staff mentioned not being able to afford to buy needed equipment. Program spaces in very large rooms were quite noisy and non-intimate. The opposite problem was obvious in most of the other rooms – the kitchen areas were quite small. Some programs, seeking more than one stove for baking, used other kitchens in the building as back up (e.g., a staff room), but food had to be carried one or two stories up and down stairs. Everyone put up with these obstacles with good cheer most of the time.

4.10 Vignettes illustrating challenges and issues in implementing the CFF programs

4.10.1 School M

Various issues were apparent in the program at School M, but the Neighourhood Assistant felt that they were being adequately managed. When asked how she felt about running the program and if she was happy with the way things were going, the Neighbourhood Assistant said that she was, but that it was an ongoing learning experience for both herself and the parents and that "it's challenging, but it's rewarding" (Staff #8, School M). One of the challenges was managing recruitment and attendance, since the targeted parents were usually not very connected with the school, and there were issues related to poverty (e.g., lack of telephones, family crises) that required special attention to help parents commit to attending the program on a regular basis: "Getting people to show up, getting people to participate. It's just that their lives are so up and down that we have to work around those things" (Staff #8, School M).

Having a program that keeps children constructively occupied while staff work with their parents was also a challenge at School M, where the program was held upstairs in the staff room. The children wanted to exercise and run in the halls; it took energy to keep them from being disruptive. The Neighbourhood Assistant at School M did not want to simply hire a child minder, because she wanted the parents to interact with their children as part of the program "so that we can help to role model [to the parents], and actually we can learn from them also, and learn a little bit more about the kids" (Staff #8, School M). Modeling how to interact with their children in a public place, with an educational focus, added a significant amount of energy required to facilitate the program.

When asked how many people drop out of the program, the Neighbourhood Assistant said that a few people don't come back after their first or second session, assuming they don't feel "comfortable," but that "we usually can get people to stay." However, when asked about how the program works with fathers, she admitted that not many men attempt to take the

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program. She then gave an example of one man who had tried the program and an explanation of why he didn't remain in the program. In her opinion, he didn't feel he fit in: "I think it was just the group he wasn't comfortable with."

Although the Neighbourhood Assistant had written the application for funds to run the program, at the time of the interview she could not remember who was supplying the funds for the program, and also didn't know where funds would come from (or whether they would come) to continue the program the next year.

Securing and maintaining an adequate physical space to hold the program could be challenging in the very busy school environment. The Neighbourhood Assistant at School M was able to negotiate use of the staff room for the program, and adapted the program in some ways to fit the available time and space. She started the program after the teachers vacated the staff room after lunch, and incorporated maintenance of the room into the program activities:

> We supply the dish soap now for the staff room because we figure that can be our contribution, and we kind of share tea towels and stuff now. And once a week, when we have our program, or every second week, we take all the towels home and wash them and put them back so they're clean. So we kind of – we're gaining the respect of the staff because we're doing that. (Staff #8, School M)

The program acquired a cupboard and its own counter in the staff room, and then the Neighbourhood Assistant moved a filing cabinet into the staff room for storing the program's pots, pans, and mixing bowls. Having a number of children in the staff room during the food preparation time could push the limits of what is workable, and the program utilized other spaces to deal with this, such as the library for videos, going outside on nice afternoons, and having children take part in helpful activities such as delivering flyers in the neighbourhood for up-coming school events. Because the Neighbourhood Assistant worked full time at the school, it was possible for her to negotiate the use of the space in these ways.

The Neighbourhood Assistant kept a journal in which she recorded information about each session, such as "how much we spent, who was there, what we cooked, what we did,

whether we thought it was a success or not. Did we come up with new ideas?" (Staff #8, School M). This information was condensed into a report that she submitted once a term to the organization that handled the CFF funding for five programs. The Neighbourhood Assistant found this record keeping very helpful to look back on for future planning. No one at the school had ever asked her for the specifics of this type of information, although she was ready to offer it. At school staff meetings, she mentioned the program and asked for input from the other staff about any parents they thought might benefit from the program.

The Neighbourhood Assistant at School M was able to manage the challenges of running the CFF program at her school by incorporating the program planning and the management of the issues involved with running this type of program into her everyday activities, not just on the day of the program but all week long. In this way, she managed the relationships between the parents and children who participated in the program and the school staff and administration, and addressed issues such the program's use of the school space that impacted on others in the school environment.

4.10.2 School L

Although there were challenges at School L, involving the parents in activities at this program did not seem to be an issue. The core group of parents were experienced in the kitchen, and most were looking for social enjoyment and sharing recipes with other adults, social and educational experiences for their children, while some were also interested in receiving extra food. The staff who were interviewed, however, were quite focused on trying to facilitate parents in changing their eating habits. A sense of conflict pervaded the program during some of the research period. There were a variety of foci for the conflict: parents' anger about the administration's canceling of a child minder and their perception that there were not enough activities for the children to do at the program; some of the staff's perceptions that they did not

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have adequate training or resources to provide a full-time program for the children; and some of

the staff's perception that the families were not eating healthy diets and were not interested in

trying new foods or changing their diets. One staff member explained how she worked to

incorporate new foods into program menus: for the children, she would incorporate it without

telling them; while with the adults, she would take the time to converse with them about the new

foods and ideas:

> I usually print out the recipe ahead of time. So I usually have a little sentence saying (let's say we have lentil soup today); I would say, "Lentil is low in fat and high in fibre, so it's good for you." Something like that. At the very beginning, at the very top of the recipe, so I'm sure they can read it before they read the recipe. And also maybe during the cooking process I would tell them, "We are making lentil soup today." And then maybe one of the moms says, "*Eew*, I don't like that." I always say, "Lentil is very nutritious. It is a good source of protein and it has low fat and high fibre." So maybe they will want to try it if they know that it is so good for them, because maybe they just have never tried it before and they don't know how good it is. So just to have more conversation and more interaction – I'm trying to have more communications with the moms in that way. If you know them more and they know you well, they are more willing to share information with you. In that way you can share your knowledge and what you know and what you want them to know. It's easier to tell them that way, whereas if you don't know them very well, it's very hard to communicate with them. Because, you know, with nutrition messages, it would be quite odd if you don't know them very well – they would have the feeling that you're lecturing them. You want to do it in a way that they're feeling that you are just sharing information and you are just talking with a friend, and that's the approach that I use, rather than – it's not a lecture about nutrition (laughs). Because, you know, the program's called "Cooking Fun," right? They want to have fun. I just want to have a more relaxing atmosphere. (Staff #4, School L)

Another staff member commented on the frustration she had felt over time in the program in

terms of the readiness of the clients to learn and change, and how the program had, in the end,

changed her:

> When I started out I thought, "How could they be so stupid!" and now I realize that they're not stupid but they've come from probably circumstances that haven't been conducive to getting an education or to being empowered to deal with what life hands you. I don't know. Just not feeling good about themselves. There's a whole range of issues involved, but poverty is the crux of all of it. It's ugly. It's really ugly. (Staff #9, School L)

4.11 Summary of challenges and issues in implementing CFF programs

The state of flux that many of the participants were going through in their lives, the fact that program staff were involved in trying to establish new contact with many of the parents, and language and communication barriers and ethnic differences all contributed to the challenges of running the CFF programs. The fact that the program model was new to the implementers and that there were no protocols or sets of training materials also contributed to challenges in terms of staff preparation, support and guidance, and even the focus for the weekly program. Where children were involved, there was a lack of educational materials as well as the need to keep young children occupied while their parents worked on preparing food. Funds for purchasing food for the programs were sometimes minimal, depending on how many parents and children participated. Some programs used the Food Bank to subsidize their food funds, while others found it too difficult to access or unreliable. Government cuts to education funds created instability in terms of knowing what multi-cultural staff might be available, and the Neighbourhood Assistants' jobs were in danger of being cut during the research period. Funding for the CFF programs itself was also insecure, with most staff not knowing where the funds would come from for the following term, or if there would be funds available, making it difficult to plan for more than one term at a time.

4.12 Discussion

Chapter 4 began by presenting a detailed description of the study participants: their food- and nutrition-related attitudes and behaviours, their self-rated levels of health, and their social connections, gathered by means of the adult participant questionnaire. This was followed by qualitative research findings related to the first research goal: to understand how the CFF program model is implemented in different sites by examining the goals, objectives and expectations held for the programs, the strategies used to accomplish these, and the supports and

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challenges experienced by those who implement the programs. These research findings, taken together, lay the foundation for understanding the interrelations between the program, its staff and administrators, the program participants, and the social context in which the participants live and the programs operate. They act as an example to inform us about the development and implementation of small, community-based health promotion programs for vulnerable populations, and together with the results presented in the following chapter, make it possible to interpret and more deeply understand the perceived impacts of the CFF programs. More specifically, the findings demonstrate the high level of vulnerability of the CFF clientele and elucidate how the goals and strategies of CFF programs compare to other Canadian community kitchens and current principles of adult education, nutrition education and health promotion.

4.12.1 Comparison of CFF responses to the questionnaire with characteristics of the general public

Comparison of the self-rated health and household food security status of CFF participants with population health studies of the general population shows that the CFF program is serving a vulnerable population. Substantially more adult participants of CFF programs self-rated their health as "fair or poor" while substantially fewer adult participants of CFF programs self-rated their health as "excellent" compared to national or municipal populations (please see Table 7). This suggests that the CFF adult participants were, as a whole, less healthy than the Canadian and Vancouver general populations.

Table 7: Self-rated health of general (Canada)* and municipal (Vancouver)* populations of women aged 25-54, and of CFF adult participants

| Self-rated health | Location | | | | | |
| | Canada | | Vancouver | | CFF | |
	n	(%)	n	(%)	n	(%)
Excellent	1,765,064	(25.0)	48,863	(31.0)	4	(4.5)
Very good	2,673,370	(37.9)	54,043	(34.3)	27	(30.7)
Good	1,976,530	(28.0)	41,675	(26.4)	36	(40.9)
Fair or Poor	633,612	(9.0)	13,019	(8.3)	21	(23.9)
Total	7,048,576		512,604		88	

*Data from the Canadian Community Health Survey, 2003 (Statistics Canada, 2003).

CFF participants were also, as a group, much more food insecure than the British Columbia or Vancouver population (Fourster-Coull, Levy Milne & Barr, 2004, pp. 27-30) during the same time period. The proportion of CFF households worried about running out of food was almost six times higher than in the general population, the proportion eating a compromised diet was similarly almost six times higher, and the proportion who were living with hunger (i.e., not getting enough to eat) was four times higher. The one-third of CFF respondents who reported that someone in their household had not had enough to eat sometimes or often during the past twelve months were most likely referring to themselves, since several studies have shown that parents will compromise their own nutrition before letting their children go hungry (McIntyre, Glanville, Raine, Dayle, & Anderson, 2003; McIntyre & Rondeau, 2009). The clientele of most of the collective kitchens reviewed in the literature were also from vulnerable population groups, being either one or a combination of low-income, single mothers, new immigrants, seniors, people with disabilities, the homeless, or the underhoused (Engler-Stringer & Berenbaum, 2005).

It is likely that for those participants who were suffering from hunger on a regular basis, attending a program like CFF that provided a healthy meal without the stigma attached to some other food provision programs was one of several coping strategies regarding food acquisition. The high level of chronic hunger and deprivation in a large proportion of the CFF clientele that

was indicated by the questionnaire responses triangulates with the interview data regarding the staff's and administrators' perceptions of the clientele and their needs.

Despite indications of the high level of vulnerability of CFF participants, a similar proportion of CFF participants reported consuming enough fruits and vegetables to meet Canada's Food Guide recommendations as that reported by other surveys of the Canadian and British Columbian general population during the same time period. This proportion was not high in either case, however.[25] Although it is impossible to compare results of these surveys exactly to each other because of differences in methodology (British Columbia Ministry of Health Planning, 2003), all the surveys found approximately the same proportion of individuals were consuming at least the minimum recommended number of servings of fruits and vegetables on a daily basis. About 40% of CFF adult participants reported that they were consuming at least the recommended five servings of fruits and vegetables a day in 2001-2003, while the 1999 British Columbia Nutrition Survey found that about one-third (35.5%) of British Columbia adults were meeting the minimum recommendations (Fourster-Coull, Levy Milne and Barr, 2004) and the 2004 Canadian Community Health Survey found that one-half (50%) of Canadians were meeting the minimum recommendations (Health Canada, 2007). It is possible that the CFF participants who were meeting the recommended guidelines were either predisposed to healthy eating or were motivated to it by the program, but it is also possible that they were the group of CFF participants who were not food insecure and had more resources to put towards healthy eating. Another survey of a group of community (collective) kitchen programs, found, however, similarly higher levels of fruit and vegetable consumption among participants as among the general population in that province (Alberta) (Fano, Tyminski & Flynn, 2004). These findings might indicate either a predisposition of community kitchen programs participants towards

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[25] Daily consumption of fruits and vegetables is often used as a marker for healthy eating in nutrition research.

healthy eating or an increased propensity for it due to attendance at the programs or a combination of the two. It may, however, also indicate an overestimation of fruit and vegetable consumption when using a less rigorous data collection approach than that used in larger surveys, yielding less accurate data.

4.12.2 Comparison of the goals and objectives of CFF programs and other community kitchens

Comparison of the goals and objectives of the CFF programs to reported goals of other Canadian community-kitchen-type programs suggests that while CFF is similar to the collective kitchens evaluated in the literature in that it aims to support vulnerable families in the areas of food and nutrition and to provide a supportive social and psychological environment while doing so, it differs from the most commonly evaluated community kitchens programs, i.e., collective kitchens, in that the predominant focus of CFF programs is educational rather than directly aimed at supporting food security by providing extra food for families to consume over the month. Although the staff and administrators who developed CFF programs were responding to the food poverty/insecurity context of the inner city landscape, perhaps because the CFF programs were developed and situated within a school context, the rationale for CFF programs was of a more layered nature, with the primary focus being to support healthy eating in the context of food insecurity rather than directly attempting to reduce participants' levels of food insecurity, and with some of the CFF programs actually stating that psychosocial goals were equal or even more important than food-related goals (i.e., that food was used as a strategy to accomplish psychosocial goals). Supporting healthy eating was also a goal of most, if not all, community kitchens reviewed by Engler-Stringer and Berenbaum (2005), but the overall focus of the community kitchens programs was more strongly on the provision of food. In some CFF programs, part of the healthy eating message was conveyed through incorporating a very social and extended-family-like atmosphere where all the families sat down and ate together towards

the end of each program day. This is similar to the communal meal type of community kitchens program (Tarasuk & Reynolds, 1999), but with CFF, although the communal meal was the culmination of the session, it was part of the educational or psychosocial enhancement strategies and served a multi-layered function.

For many participants of the community kitchens programs reviewed in the literature, the social aspects of the programs are an important reason participants gave for being involved (Engler-Stringer & Berenbaum, 2005), although this seemed to be more often voiced as a perceived benefit or reason for continuing rather than as an initial goal or reason for joining the programs. On the other hand, social goals are an integral part of the CFF programs, seen by most of the study respondents as equally important to, or in some cases even overshadowing, the food-related goals. Some authors, particularly those who see community kitchens as an actual or potential community development strategy, recommend more of a focus on social goals and a more critical, emancipatory agenda for the programs (e.g., Fernandez, 1996; Ripat, 1998). The history of community kitchens in the poor people's movement in Peru shows that they can be a vehicle in which poor people can develop the social skills, connectedness, awareness and motivation for political action in terms of their rights to food security (Engler-Stringer, 2005). As Fernandez's (1996) analysis showed, the focus of most of the "how to" manuals for starting and operating collective kitchens is, however, on the "technical" aspects of food production and running a kitchen, with little instruction or focus on taking advantage of the social situation that collective kitchens offer or on how to facilitate relationships and offer counselling within the programs. Fernandez (1996) suggested that the technical focus on food should be reduced in community/collective kitchens while the interactive focus on relationships should be increased and even developed into a critical educational focus.

4.12.3 Comparison of the goals/objectives of CFF and CK programs with determinants of health

In addition to comparing the goals of the CFF programs to those of other Canadian community kitchens, these goals can also be examined more broadly in relation to the key determinants of health identified by Health Canada. Here, CFF and other community kitchens can be seen as addressing four of the key determinants of health: "social support networks," "personal health practices and coping skills," "education and literacy" and "healthy child development" (Public Health Agency of Canada, 2007, p. 1). Although not many evaluations of collective kitchens programs actually use the language of the determinants of health when discussing goals of the programs, the first three of these above-named determinants of health were also identified as consistent with the program objectives in the evaluation of the Calgary Collective Kitchens (Fano, Tyminski & Flynn, 2004). (The Calgary Collective Kitchens programs predate the Population Health Promotion Model [Hamilton & Bhatti, 1996], but the objectives driving the Calgary programs were perceived by the evaluators to be consistent with these determinants of health as outlined in the Population Health Promotion Model.) Development of social support networks, a key determinant of health, is clearly recommended by the CFF Program Handbook in its instruction to use "concern for children" as well as interest in "food, a universal bonding agent," to provide the motivation for parents, most of whom were initially uninvolved with the school, to risk participating in a new and unknown social situation. The goal of this participation is to build bridges at a number of levels, including between individuals; between individuals and the schools (and by association, between their children and the schools); and at the neighbourhood and community levels, as people become more acquainted with and integrated with each other outside of the school environment. Another key determinant of health identified by Health Canada that is targeted in the CFF Program Handbook is "personal health practices and coping skills." Building capacity, as suggested by the

Handbook, refers to building the ability of families to participate in healthy eating. This is done through a variety of strategies in the programs. "Education and literacy," a third key determinant of health identified by Health Canada, is highly reflected in the educational and skill-building focus of CFF programs. "Personal health practices and coping skills" and "health literacy," which defines the type of educational and skill-building focus of the programs, overlap in CFF programs. Finally, "healthy child development" is a fourth key determinant of health noted by Health Canada that is addressed by the CFF Program Handbook's goal of supporting families, since the focus of the programs as a whole is to support children's healthy development through supporting families.

Food security is not among the major social determinants of health listed by the Public Health Agency of Canada (2007) (but is likely covered by the "income and social status" determinant), but has been identified by others as a key determinant of health (McIntyre and Rondeau, 2009; Tarasuk, 2009). Although the goals of the CFF programs as stated in the CFF Program Handbook include improving families' food security, there is no direction or discussion in the Handbook about how to improve families' food security, and little explicit reference as to how the programs would aim to improve food security in the staff's goal statements. (Since the thrust of the program outlined in the Handbook is education and behaviour change, it would seem that education and behaviour change are the vehicles by which the Handbook proposes the improvement in food security.) The CFF programs examined in this study came into existence after the creation of the CFF Program Handbook. This study found that CFF staff, administrators and participants were not as focused on food security *per se*, but on some of the components of food security such as eating a variety of healthy foods. Fano et al. (2004) state that "one might anticipate that these goals [of food security] would be met by addressing those three health determinants [education, personal health practices, and social support networks]" (p. 79).

4.12.4 Comparison of the settings, structure and strategies used in CFF and CK programs

The settings, structure and strategies used in community/collective kitchens are not discussed in detail in the published literature. (The most comprehensive review of community kitchens stated: "In none of the projects was prolonged observation used to study collective kitchen groups. The groups generally were observed for one to two cooking sessions, and in most of the studies, the stage of development for the sampled groups was not mentioned" [Engler-Stringer & Berenbaum, 2005, p. 247]). However, there is enough information in the published literature to show that most collective kitchens are held within community agency settings, involve about 4-5 participants, and often are facilitated by one of the participants. Most collective kitchens also have an administrator who is part of the supporting agency that they can turn to if the need arises (e.g., for conflict resolution among the group). In contrast, this study examines the structure and strategies of the CFF programs in detail, which allows for a comparison of the CFF programs with the published literature on the principles of adult education, nutrition education and health promotion.

4.12.5 Discussion of the CFF programs in terms of factors affecting children's eating patterns

With its focus on assisting parents to provide healthy foods for their children and to motivate their children to eat well, CFF addresses theoretical knowledge that eating patterns that are established in childhood persist into adulthood (Cooke, 2004; Veugelers et al., 2005). The program in particular addresses "learned" factors influencing children's food choices (Cooke, 2004; Cullen et al., 2001; Cullen et al., 2003); those that relate to children's experiences within their families, such as children's exposure to new foods, the availability and accessibility of different foods, and parents' behaviour in relation to their children's eating. Because many of the healthy foods that the program seeks to promote are unfamiliar to both the parents and the children, the program especially employs the technique of "exposure" (Cooke, 2004), where both

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parents and children are encouraged to try new foods, but without pressure, and parents are encouraged to provide additional exposure to these new foods at home. Parents are also encouraged to organize family meals more often, so that children can benefit from seeing others eating new foods and perceiving that eating these foods is now part of the family's routine.

Since parents are important role models for their children's food choices (Cullen et al., 2001; Lee et al., 2001; Patrick & Nicklas, 2005; Veugelers et al., 2005), CFF also addresses parents' knowledge, skills and motivation to eat as well as possible themselves. Parents are encouraged to become actively involved in all aspects of learning at the program and to reproduce what they have learned at home. The programs, through their focus on healthy eating on a low budget, try to convince parents that healthy eating can be possible for them and their families, through their efforts to avoid eating out in fast food restaurants and purchasing ready-made or take-out foods, while creating more nutritious alternatives for themselves with their newly learned skills and techniques. The programs, through the staff and the parents' relationships with each other, attempt to provide continuous supportive encouragement and motivation towards this end.

4.12.6 Comparison of the CFF programs to educational and health promotion principles

It is said that "[L]earners expand their knowledge within the context of what they already know. This is especially true for adult learners. Thus, applied learning opportunities should take into account the variety of life experiences and expertise that adults bring to the new learning experience" (Donohue, 2008, p. 23). This philosophy is closely followed by the implementers of the CFF programs, as they ease participants into the programs, encouraging them to take part at a comfortable pace and to share their ideas and knowledge with each other. CFF follows the important tenet of nutrition education that "instructional methods should be experiential, active, and hands on" (Contento et al., 1995, p. 307). The CFF programs incorporate some aspects of

current principles of nutrition and adult education theory (Contento et al., 1995; Imel, 1998), such as equalizing the power balance within the groups and between the facilitator and the participants as much as possible, maintaining a respectful and supportive atmosphere, and focusing on what participants want to learn. The programs, as developed at each site, are carefully tailored to the clientele, using inside knowledge of local needs and of the setting. As is suggested for adult learners (Imel, 1998), the participants meet in small groups and are actively involved in both the program activities and the menu planning for future sessions. Some of them also act, on occasion, as facilitators and educators in their areas of expertise. They go beyond an individual approach to behaviour change by attempting to build group norms for healthy eating in the participating schools and by providing a supportive environment for parents and children to experience personal growth. Thus the programs, through their structure and format, address several determinants of health (Public Health Agency of Canada, 2007); education and literacy, personal health practices and coping skills, social support, and healthy child development, illustrating how the principles of education and health promotion can be applied in addressing some of the social determinants of health.

4.12.7 Comparison of the challenges faced by CFF and community kitchen programs

Many of the challenges faced by CFF programs, such as obtaining funds, space limitations and constraints, providing child minding, and consistent attendance, are common to the community/collective kitchens evaluated in the literature as well (Engler-Stringer, 2005; Engler-Stringer & Berenbaum, 2005). This is not surprising, since the programs target the same types of participants who live in similar situations. For example, clientele may experience difficulties attending on a regular basis, requiring a substantial amount of work on the part of the staff related to recruitment and retention; there may be difficulties, at least initially, in assisting participants from different ethnic backgrounds in working together; it may be difficult for

newcomers to fit in and feel comfortable; and participants may find it difficult to implement learning related to healthy eating at home due to financial or other barriers. The provision of child care during programs may not be covered by program budgets, and some parents may not be able to attend if the programs are unable to work out a solution to this dilemma. Training and support for staff may be an issue; although several collective kitchens programs described in the literature had well-thought-out training programs (Engler-Stringer, 2005; Marquis, 2004), that were not available to CFF staff in Vancouver. Most participants in community/collective kitchens needed some financial support directed towards the food costs of the programs. Engler-Stringer (2005) mentioned that some of the programs she reviewed were, due to financial constraints and/or reliance on food banks, not always able to secure the healthiest possible food for their participants. Other evaluations mentioned that some programs had difficulties with finances, such as conflict over how to spend their limited food-purchasing funds (Fernandez, 1996; Ripat, 1998). Although CFF had overall structural financial challenges, staff were not constrained by parents' expectations as to what foods they purchased, and although some programs used donations from the Food Bank, they did not have to rely on them. Even in CFF programs that used food bank donations, the focus was still educational, i.e., for parents and staff working together: "How can we produce the healthiest meal possible using this food?" Some challenges in CFF programs were different from those encountered in the literature. These included the lack of training for the staff, who had a more complex role in CFF programs than in the community kitchens described in the literature, and the related need for a more comprehensive curriculum, since the programs were more focused on building capacity over a broad range of food- and nutrition-related knowledge, skills and capacity to change the family's diet and approach to food. Communication and culture were also more of a challenge in the CFF programs, since there were generally larger numbers of participants per program who were

usually drawn from a number of ethnic backgrounds, and many of whom were very limited in their English-language capabilities.

4.12.8 Summary and conclusion

The CFF programs examined in this research provided a "layered" educational approach that addressed numerous issues such as healthy eating on a budget, how to encourage children to eat more fruit and vegetables, how to involve children in food preparation, safe food handling, and psychosocial issues such as social and cultural isolation/integration, in a flexible manner. For food insecure participants and those who were new to Canadian culture, they demonstrated coping strategies and addressed issues of lack of familiarity with local foods. The findings regarding the implementation of CFF programs can inform health promotion researchers about the development and implementation of small community-based health promotion programs for vulnerable populations. They show that the community (in this case, a school community) can provide a program with a comprehensive set of goals related to healthy eating, social support and social integration tailored to the capabilities of both the staff and the program participants, and can develop a set of strategies for implementing those goals. The findings also provide information about common challenges that can force the community to intensify their efforts, perhaps beyond what would be necessary if they were to be able to gain access to more secure and adequate levels of funds to allow them to fully implement their goals.

Chapter 5: Findings: Perceptions of Food- and Nutrition-related, and Psychosocial, Benefits of CFF Programs

> I'm *more* pleased, I'd have to say, because I think I'm getting more out of it than I expected. In Food Bank things, as in getting donations, as in exchanging recipes, as in social interaction, confidence building, esteem building, community building. Though it's very basic, it's a big rock in the pond that starts the ripple effect, and a lot of it is started with the kitchen, because it is *there*, it's *accountable*. It *is* accountable. It draws people in, it's the same/similar bonding thing basis, you know, everybody needs to eat. Everybody is inner city; everybody usually is poverty line or lower, and with kids, it serves a very *real* purpose. (Parent #10, School E)

Chapter 5 presents the findings related to the second part of the first research question: "What are the benefits of the CFF programs as perceived by parents, staff and administrators?" In this chapter I first present findings from the questionnaires completed by the adult program participants. I then present findings related to what parents, staff and administrators saw as benefits to participants related to food and nutrition, followed by findings related to what these groups saw as psychosocial benefits to participants. The responsive evaluation approach used in the study allowed me to spend extensive time with participants observing and talking with them, as well participating in more formal interviews. The result was a wealth of detailed information about how the respondents conceived of the programs and the programs' perceived benefits to participants and their families.

5.1 Questionnaire results

Thirty-three participants completed the questionnaire a second or third time (either six and/or twelve months after they had first completed it). Paired t-test analyses of these individuals' first and second responses[26] to the fruit and vegetables self-efficacy, household food security, social connections and social capital questions showed no significant changes over the time period measured.[27] To try to ascertain whether those who had attended CFF for longer time

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[26] Because only nine participants completed the questionnaire a third time, third responses were omitted from this analysis.

[27] The number of individuals responding to each question ranged from 26-32.

periods showed different results on food- and nutrition-related variables than those who had

attended for a shorter time, a "dose-response" calculation was performed in which independent

sample t-test analyses were conducted for all questionnaire respondents (n=88). For this, two

groups of approximately equal numbers were created comparing questionnaire respondents who

had attended 10 or fewer CFF sessions with respondents who had attended 11 or more sessions at

the last time they completed the questionnaire. However, the results showed no significant

differences between the groups in either daily servings of fruits and vegetables or household food

security status at the last time each person had completed the questionnaire (please see Table 8).

Table 8: Significance of the relationship between the number of times participants attended CFF
and selected food- and nutrition-related variables

	# CFF sessions attended	N	Mean	P value*
Mean daily servings of fruit & vegetables				
	0-10	32	5.0	0.94
	11+	37	5.0	
Mean household food security status**				
	0-10	38	6.7**	0.60
	11+	44	6.9**	

*equal variances not assumed
**calculated on a scale of 3-9, with 3 being the worst possible responses ("often" experienced) to
all three food security questions, and 9 being the best possible responses ("never" experienced)
to all three food security questions.

Questionnaire results for the questions on household food security were also examined by

hand for the 32 people who completed these questions at two or three questionnaire

administrations (each six months apart). Twenty-six of these respondents indicated some form of

food insecurity during at least one of the questionnaire administration periods, and their

responses were further examined to see whether their food security status had changed over the

time frame of the study. As shown in Table 9,[28] the greatest number of these respondents were

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[28] As few people completed the questionnaire three times, respondents' first and last completion
of the questionnaire were used for this analysis.

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stable in their household food security status during the study time frame. Almost one-half of the respondents reported no hunger during either measurement, but six reported a worsened hunger status while only one reported improvement in hunger status during the study time frame. Regarding quality and variety of diet, only 20% of these respondents reported no compromise on this variable over the duration of the study. Although a little over one half of the study respondents retained the same status on this variable during the study, seven experienced a worsening in this regard, while four experienced improvement. Only 11.5% of these study respondents never worried about running out of food over the study time frame. While about half of them remained in a stable situation regarding this variable during the study, almost one-half experienced less worry about running out of food between the two measurements, while only three experienced a worsening in this regard during the study. Thus although these respondents suffered from a high level of food insecurity, there was a notable improvement for some in worrying less about running out of food, but not much improvement in terms of having to compromise the quality and variety of their diets, and for those who were suffering from not having enough food to avoid hunger, virtually no improvement over the study time frame.

Table 9: Stability of CFF participants' household food security status*

Response 2nd time questionnaire completed	Response 1st Time Questionnaire Completed					
	"Never"		"Sometimes"		"Often"	
	n	(%)	n	(%)	n	(%)
Hunger:						
"Never"	11	(45.8)	1	(4.2)	0	(0.0)
"Sometimes"	3	(12.5)	5	(20.8)	0	(0.0)
"Often"	0	(0.0)	3	(12.5)	1	(4.2)
Compromised quality or variety of diet:						
"Never"	5	(20.0)	3	(12.0)	0	(0.0)
"Sometimes"	1	(4.0)	7	(28.0)	1	(4.0)
"Often"	1	(4.0)	5	(20.0)	2	(8.0)
Worry about running out of food:						
"Never"	3	(11.5)	6	(23.1)	0	(0.0)
"Sometimes"	2	(7.7)	4	(15.4)	5	(19.2)
"Often"	1	(3.8)	0	(0.0)	5	(19.2)

*for those who reported compromised food security at some time during the study, and who completed the questionnaire more than once.

5.2 Perceived food and nutrition benefits

Benefits related to food, nutrition and healthy eating were perceived to be either the most important aspect, or one of the two most important aspects (the other being social benefits) of the programs, and were noted by virtually all the interview respondents. Some of these benefits occurred during the programs, while others related to families applying new knowledge, attitudes and skills at home. Please see Table 10 for a list of perceived food- and nutrition-related benefits, details of which are presented separately for parents and for children.

Table 10: Perceived food- and nutrition-related benefits of CFF programs to participants

Perceived food- and nutrition-related benefits to parents
Learning related to preparation of basic, inexpensive, but nutritious snacks and meals
Recipes from different countries and cultures
Focus on nutrition and healthier eating
Safe food handling and basic sanitation
Trying new foods, bringing new foods home for the family to try
Preparing nutritious snacks and meals that their children will eat
Increased food resources

Perceived food and nutrition benefits to children
Nutrition and healthy eating, willingness to try new foods
Food preparation skills and eating together as a family
Safe food handling and basic sanitation

5.2.1 Perceived food and nutrition benefits to parents

Many, if not most, of the parents attended the CFF programs with the ultimate goal of supporting or improving their family's nutrition, and were very focused on helping their children consume a healthy diet. For most of the parents, a first step in achieving this, in relation to the CFF programs, was to learn about new foods and nutrition ideas themselves. Thus, parents learning about new foods was the main focus of most of the programs, and the main strategy for doing this was by preparing and tasting the new foods via learning new recipes.

Passing the food- and nutrition-related benefits of the programs on to their children and families was the next step for parents in trying to support or improve their families' nutrition. What one parent said, "What I learn there, I always go home and I try to do it for my kids" (Parent #1/13, School E), was echoed by many other interview participants. Many parents talked about learning how to serve more fruits and vegetables at home as an example of one of the benefits of the programs. They talked about the sequence of how the process worked: parents becoming familiar with new fruits and vegetables themselves; learning how to prepare fruits and vegetables in ways their children would like and eat (including how to disguise vegetables in recipes); their children requesting more fruits and vegetables at home as a result of attending

CFF programs or trying new foods at home; learning where to access fruits and vegetables more cheaply; and sometimes taking extra fruit and vegetables home from the programs.

Learning to prepare basic, inexpensive but nutritious meals and snacks was mentioned as a perceived benefit of attending CFF programs most often, followed by learning recipes from different countries or cultures. Mentioned less often but still a significant number of times as benefits were learning about nutrition and healthy eating, learning about safe food handling, trying new foods, bringing new foods home for the family to try, preparing nutritious snacks and meals that their children would like, and acquiring extra food at the programs or to take home. Each of these perceived benefits is described in more detail below.

5.2.1.1 Learning related to preparation of inexpensive, but nutritious snacks and meals

Learning related to the preparation of inexpensive but nutritious meals and snacks epitomizes the basic rationale for the programs and was mentioned as a benefit by almost all of the staff and administrators and most of the adult participants. As one parent explained, "Some of the parents need help with how to prepare nutritious meals; … they learn a lot about food preparation" (Parent #18, School M). This was borne out by an observation made at another program: "[A parent] was asked to clean some carrots but she did not know how to, so that was explained to her by the project team member" (Observer #3, School L). A grandparent summed up how the program helps with basic food preparation by saying, "I think it gives a lot of the parents an idea of how to do things at home, and in a cheaper way, because a lot of parents don't have the money" (Grandparent #17, School M). Parents at another school said the program gave them a chance to learn to cook "on a budget" (Parent #1/13, School E) while at the same time having more access to food by cooking more meals more cheaply at home. Parents from several programs said that the program leaders had taught them to cook in different ways that allowed

them to save time and money, that they had learned different ways of making the same dish, and that they had made foods at home that they had learned at the programs.

Even in one program in which the Neighbourhood Assistant was primarily focused on promoting social interaction between different cultural groups, parents mentioned learning food preparation skills as a benefit. Most commonly mentioned by respondents from all the programs was learning new recipes, techniques, and skills. Parents from non-European backgrounds who still prepared traditional meals for their families were very enthusiastic about learning how to prepare healthy, and what they perceived as "Canadian," food for their children. These children were, for the most part, participating in the meal programs at the school, and were asking for "Canadian" foods at home, which the parents often had no idea how to prepare. For many of these parents, following a recipe was a novel experience. They were also unfamiliar with many of the cooking techniques that are part of the Canadian culture. Most of the program staff attempted to teach these participants "healthy" ways to prepare so-called Canadian foods that their children wanted, such as pizza, hamburgers, chips, french fries, muffins, lasagna, etc., using healthy ingredients and cooking methods. The outcome was something both healthier and less costly than the alternative of purchasing many of these types of foods from local fast-food restaurants or grocery stores. As one mother commented (through the interpreter),

> She says she learned a lot. And just because Chinese people normally cook Chinese food, right? And she just wanted to have some other tastes, you know, so she learn to cook for her kids to eat it. (Parent #21, School D, through Interpreter)

Some of the parents from First Nations backgrounds were also unfamiliar with European-style food preparation, although they were used to eating the foods mentioned above in restaurants. They too appreciated the new skills and techniques they learned that enabled them to cut their food costs while increasing the amount of food they could afford to provide and the nutritional value of their meals. Parents living on low incomes benefited from ideas and activities in the programs such as how to use food acquired from the food bank, how to use left-overs in

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creative ways, how focusing on seasonal produce was healthy and less expensive, how to cook

vegetables they might not be familiar with, and how to make substitutions in recipes. One parent

mentioned how she had learned a new way to prepare something she was familiar with, as well

as how to prepare new vegetables:

> I learned quite a bit. I mean there's things I didn't know how to do, like make apple sauce. I didn't know how to make that. It's so simple. … I learned about different veggies that I never knew about, like squash. I never, ever ate that. I might have in a restaurant or something but I wouldn't cook it because I didn't know how to cook it like that. That was nice to learn, that you can cook it any way. And same with those snow peas. I thought you just threw it in a pot and cooked them with the food. I didn't know you had to pull these stringy things off of them or else they're bitter, I heard. See, I didn't know that. (Grandparent #20, School D)

She also described an important technique that was taught in several of the programs,

substituting ingredients in recipes:

> And like substituting different things, like sometimes she [the staff] doesn't have a certain thing, she'll find something to put in its place, and I didn't know you could do this, eh? I thought you just had to have whatever was in that recipe. And she showed us a lot of things like that. (Grandparent #20, School D)

> One of the school principals, echoing the general consensus about the program model

among the principals, commented on his satisfaction with the program's skill development

aspects: "We brought parents into the school, we've got parents involved in cooking, and we've

got simply healthy menus that they're involved with, in the planning and the cooking and

everything involved" (Administrator #8, School M). He saw the program as a "course or a class"

and said it was "very helpful for our kids and parents – they need it a lot." He summed up his

positive feelings about the program by saying,

> I feel *very* good about the program because it's helped the parents, and, of course, the kids. I think it's an informal but structured way of making sure the parents get what they need in terms of helping to cook for their kids. And many of these parents that we're dealing with have never been taught or instructed how to do this and now they've received that instruction. (Administrator #8, School M)

> Parents from all the programs described skills of learning new recipes and about different

foods, such as vegetables they had not known before, different kinds of oils, cooking from

scratch, new cooking techniques and skills, the use of new equipment, substituting ingredients, and how to handle measurements. One parent's comment sums up all these aspects:

> [Have you learned anything at the program?] Yeah. Different cooking. I learned how to cook different things, like, I don't know, like pasta. Different pasta dishes. Different ways, like on a budget. Like learning how to maintain a proper balance like of nutrition things, yeah. It's been pretty good. (Parent #23, School E)

The staff also mentioned many of the same aspects of learning in their interviews, and were sensitive to the special circumstances of living in poverty. They adjusted the programs accordingly, as the following quote from a parent illustrates:

> I'm learning measurements this year. [Do you have measuring cups at home and stuff?] No, so when she's like doing it roughly by the hand I'm like watching and I put my hand in and get in there . . . [So she does it by hand?] Yeah, so kind of like showing me roughly like too, right? Because not everybody has those at home, so she shows me roughly. (Parent #8, School I)

Administrators were less detailed in their discussions, generalizing their comments to participants' learning of new recipes and cooking different foods.

5.2.1.2 Recipes from different countries or cultures

Along with learning to prepare what they thought of as "Canadian" foods, it was a source of much enjoyment for participants to share recipes with each other from their traditional cultures. One program regularly featured First Nations foods such as bannock and baked salmon. During these days, First Nations parents and grandparents would bring their drums and sing together as the foods were being prepared, and the meal would be treated as a celebration. Sometimes the person who was presenting a recipe from her culture at other programs would make it a theme of the day; in one case, a mother had her son bring his guitar and play and sing songs from their culture before they all ate together. Although it might seem that this is mainly a social benefit, many of these recipes from other cultures are quite healthy, incorporating vegetables and using herbs and spices rather than extra salt and fats to bring out the flavour of the foods. In this way, participants were also introduced to new varieties of vegetables, grains

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and meats, and instructed on how to prepare them. The parents were thus a resource for each other, accomplishing exposure to a wider variety of foods than the staff alone could have done.

5.2.1.3 Focus on nutrition and healthier eating

Many parents said that an important benefit of the programs was learning about healthy cooking and healthy eating. Although most parents described this benefit in terms of their children's behaviour change (see below), a few parents also mentioned the benefit to themselves of eating healthy food at the programs. For example, one parent commented,

> I wouldn't cook and put out a big spread of a tray like that of raw vegetables because nobody in my family would eat them, … so it's not usually something I'd do like what we did today. But yet I love it, and it absorbs in my body and I don't even realize it - I've eaten so much of it; I can tell the change in my chemicals, the physiological changes from eating nutrition. (Parent #27, School F)

Another parent said that because of the program she was now eating more fruits and vegetables herself and was trying to introduce more fruits and vegetables into her children's diets, against both financial barriers and her son's dislike of fruits and vegetables. A third parent said she had learned from the program how to maintain a "proper balance of nutrition" and to use low-fat milk and other healthier ways of eating.

Some of the staff were more focused than others on discussing aspects of nutrition and healthy eating, such as using less salt, sugar, fat, pop, and junk food, and more fruits and vegetables, healthier fats, and dairy instead of pop, but only a few parents mentioned these types of details in their interviews. This could be partly because the fluency level in English was low among a large proportion of the parent respondents. It could also be related to the fact that the interview questions were open-ended and so did not trigger or cue specifics such as nutrition-related details. A few parents mentioned details related to healthy eating, such as decreasing fats or eating certain kinds of fats, or learning about different kinds of sugars or different kinds of cheeses. A couple staff mentioned sugar, salt and fats as items they discussed regularly.

Although most of the foods prepared at the programs seemed to be health-focused, there was one program that was more focused on the social and cultural aspects and less focused on modeling healthy eating. One observer commented about this one program:

> In general I noticed that they didn't pay much attention to the health part of the CFF program (fried Bannock, no whole-wheat flour, only a little bit of corn as a vegetable). (Observer #3, School F)

> Many parents, however, at most of the programs, mentioned learning how to prepare and present fruits and vegetables to their children as a benefit of the programs. A few parents and staff mentioned food groups, serving amounts, or balanced meals. For example, one staff mentioned the benefits to the parents of learning about nutrition and balanced meals:

> Trying different recipes, I think that broadens their experience too. And also, while they're doing their cooking, they learn more about balance, nutrition, balanced meals. (Staff #13, School F)

The concepts of nutrition and healthy eating are somewhat abstract and require a certain level of English-language efficiency to discuss. They were therefore not necessarily incorporated into the open-ended interviews by parents, but were framed in their discussions in terms of more concrete examples. One parent mentioned learning about serving sizes as a benefit of the program:

> [What opportunities does the program present to you?] Oh there's a lot of opportunities. It's like we eat nutrition food, we eat more vegetables, more fruits and it's amazing when you see [Neighbourhood Assistant] sometimes, she brought a picture when there's vegetables, and how much we serving for a day. And then after that we already know how much we eat and nutrition food. It's very important. [So she brought a picture with a number of servings?] Yes, yes. [And you learned that here? That's good.] Yeah, it's nice. Yeah, I really enjoy to eat more vegetables and fruit. (Parent #28, School I)

Another parent described how attending the program taught her about preparing balanced meals for her family:

> [Do you do anything different at home, or do you feel happier, or how does it help your family?] I know the food, the balance of food that I will cook for them. Like today there is pork, a little pork and there's some chicken, and then the vegetable. Very important, the vegetables. Sometimes when I cook [for] my daughter and my grandchildren, and the food, it is fish. It is fish. That's the whole. [Okay, so have you learned that at the program about having the balance?] Yeah, balanced food? It is not only pork, or only meat. It is meat with *vegetables*. (Grandparent #9, School F)

When asked whether she thought the program was meeting the goals she set for it, one staff said a qualified "yes," the qualifier being that it takes a long time to facilitate the kind of life changes she is working on for the families. She thinks she has accomplished the short-term aspects of having participants recognize that they can prepare healthy foods that also taste good:

> We look more on a content of fruits and vegetables and protein, and try to reduce carbohydrates and excessive amounts of saturated fats or saturated fats in general, and go to choices that give us more of a healthy balance in our diet. (Staff #1/14, School E)

Administrators' comments centred upon parents learning about nutrition: nutrition skills, nutrition and food groups, planning balanced meals, healthy eating and alternatives to junk foods, and about Canada's Food Guide.

5.2.1.4 Safe food handling and basic sanitation

Parents from several programs mentioned learning safe food handling skills, including washing hands, sanitizing the cooking and eating environments, appropriate refrigeration and thawing procedures, and safe handling and cooking of meats. Most programs had developed routines that everyone followed, that included sanitizing counters, washing and sanitizing cutting boards, and washing hands, before starting food preparation. Several parents mentioned applying newly-learned food handling skills at home. In particular, information and skills about handling meats, such as cooking meat at higher temperatures to prevent E. Coli, and not leaving meats in the sink to thaw were noted by several parents. As one parent remarked,

> Now I *know*, so I'm more aware of it. The same with, like, cooking and how long you can keep the food outside before you have worried about it being contaminated with salmonella or anything. I didn't know that. Now, I know. So you know, I mean, if I cook something and say it's going to be four hours before we sit down to eat, I make sure it's put away in the fridge. I don't leave it out. Or I make sure I cook it *when* I need it, but the thing is all kept in the fridge, like the meats and that, I make sure it *is* in the fridge, not being thawed outside. And I didn't know all that stuff before. (Parent #1/13, School E)

At some of the programs, parents became interested in and pursued safe food handling training programs. One program, however, was commented on by two of the researchers in regards to a perceived lack of safe food handling practices. For example, one observer reported that,

> And what about the hygiene? I saw that they put the raw salmon right into the kitchen sink while in the other sink some one was washing their hands and other things. Soap dripped onto the salmon… (Observer #3, School F)

5.2.1.5 Trying new foods, bringing new foods home for the family to try

Trying new foods at the programs was a valued outcome at all the programs, mentioned by many, if not most, of the parents and staff in their interviews. Again, this objective was held by virtually all the staff and administrators. Parents in low-income situations cannot afford to try new foods or present them to their families in case they are unwilling to eat them, thus losing the nutritional benefits of a meal. The programs provide a service in this regard, as nutritionists and Canada's Food Guide recommend eating a wide variety of foods to support gaining adequate amounts of micronutrients in the diet. Most of the staff were very conscious of this objective of the programs and made sure that the participants were given exposure to new foods and different ways of preparing them (while balancing this, for comfort, with foods with which they were familiar). The staff walked a fine line in balancing participants' needs for comfort and familiarity with presenting them with opportunities to try new healthy foods. One staff explained how her program approached this issue:

> They [the Chinese parents] want to try different kinds, and yet but not too extremely different from their own appetite. So we try different kinds of recipes during the year so they will feel comfortable to still coming in, and it's trying different kinds of food and being with parents of other ethnic groups. (Staff #13, School F)

At some programs, some of the time, however, parents resisted trying new foods and new ways of food preparation. Staff sometimes had to negotiate with the parents, and parents and staff similarly had to negotiate with children to get them to try new foods. This parent explained how she had used to be afraid to try new foods, as her grandson was now:

Whatever we make here, and I'll take it home and if my grandson likes it then I'll cook something like that. And he is fussy, that kid. Like there's certain things he won't eat. There's mushrooms, and onions once in a while. Celery he won't eat. I know he likes carrots but he doesn't like them cooked so I have problems there with him. It's not a problem, it's just that I don't have those things sometimes that he likes. And lately I've been sort of pressuring him to eat different things. He's scared to try something. That's how I used to be too. If somebody had it and they offered it to me *then* I'd try it and if I liked it then I'd get it, or make it, whatever. (Grandparent #20, School D)

5.2.1.6 Preparing nutritious snacks and meals that their children will eat

Many parents mentioned learning to prepare nutritious snacks and meals that their

children would eat and enjoy as an important outcome of having attended the programs. This was

one of the main rationales parents gave for attending the programs, and a benefit that was stated

over and over again by the parents. (This was an important benefit to parents, as well as to

children, since the parents felt responsible for providing their children with good nutrition and

were looking for ways in which to do so.) For example, one parent talked about how she had

learned about healthy snacks at the program and taught her children, and how pleased her

children were:

> First they teach me how to make some snack or something, and, um, which way of the food is good for the kid. So when I go home, I can, I know this knowledge, "Ah, this one is good for you" because I learned it from my cooking class. "And another kind is the junk food - don't eat too much." [So you learned some healthy snacks?] Yeah. And then the kid will, "Mama, why you know, now give me this healthy snack?" "Because I learned from *school*." So that's why I know. Because before, even sometime with the Chinese parents, just "Ah, you eat. Just drink the milk, eat the chocolate cracker or something." They didn't know. And now I know. And then my kids, they feel so proud. "Ah, my Mom stay home, she learned how to cook." (Parent #4, School I)

5.2.1.7 Increased food resources

Several parents mentioned the benefit of being able to access a little more food for their

families. They said that the programs helped with hunger because parents could take leftover

food or ingredients home. Sometimes when they were running out of food they could take some

food home from the programs and the food taken home from the programs was a "big help;" that

"nine times out of ten" there were enough leftovers to take home and the kids looked forward to getting something other than macaroni and cheese at home; and that the programs helped at least once a week, especially when it was near the welfare cheque week and parents were out of funds. One parent commented that the children didn't get enough fresh fruit and vegetables at home and that the program's focus on serving them was important to the children's health. Parents also mentioned longer-range food resources benefits of the programs, such as that the programs helped with hunger because they learned to make foods that were not too expensive; they learned "how to stretch" the few ingredients they had to make a meal; the staff had taught them to use the Food Bank and to use it to prepare budgeted meals; the staff had also taught them how to get bargain produce at nearby markets; and the programs taught them what they could do with the resources/food/limited income they had.

Staff at all the programs mentioned that at least some of their families were living with limited budgets and welcomed the food they were given. In fact, staff at some of the programs offered that they thought the main reason some families attended the programs was to access the food. Several staff members mentioned that program participants sometimes asked them for food to take home, which they said they always gave them. Staff of two programs said they made a point of buying extra food to distribute for their families to take home. At other programs, staff said, and parents also mentioned, that they always tried to have substantial amounts of food left over at the end of the programs for the participants to take home. One staff mentioned that certain participants were always hungry when they arrived, and felt better after they had had something to eat at the program. A typical comment about the staff distributing food was made by this participant:

> She'll help everybody out with whatever she has, that's been there too long or she doesn't want it to expire so she'll help everybody out with that. And that's not just once in a while, it's been there all the time. I guess she goes to a certain stores to get some veggies and apples and oranges and then she'll divide it up for them so

that's good. [So you get to take some food home most of the time?] Yes. (Grandparent #20, School D)

5.2.2 Perceived food and nutrition benefits to children

It opens a lot …. It's very key. People don't realize: little things make the difference to kids from inner city schools. They don't often get a chance maybe to *see* their parents be cooking. I don't know what their home life is like, but I can only assume from what I see in the kids. So it's always good to be exposing them to them to different things. (Parent #10, School E)

Benefits to children related to food, nutrition and healthy eating were mentioned by many parents and by some staff and administrators. They accrued to children who attended programs, but also to children whose parents attended programs and then applied their new learning and/or taught their children new skills at home. The major focus of these benefits was increased healthy eating behaviour by children, which was mostly discussed in the interviews as increasing the variety of healthy foods that children would eat and decreasing their reliance on unhealthy foods and snacks. This was accomplished through a multi-pronged approach that included parent learning and changed behaviour (discussed previously) such that parents provided and presented a larger variety of healthy foods to their children, and also by the children's willingness to try new foods that were available to them. A second benefit was children learning food preparation skills, which parents said motivated the children to taste new foods and incorporate them into their diets, as well as contributing to their longer-term development of independence and skills that would help them eat healthy diets into the future. Children learning food preparation skills and increased family-oriented mealtimes at home were mentioned in conjunction with each other by most respondents who cited them as benefits. A third, more minor focus was children's increased attention to and learning related to safe food handling and basic sanitation, both when they attended CFF programs and at home under the supervision of their parents. Each of these perceived benefits to children is discussed in detail in the following sections.

5.2.2.1 Nutrition and healthy eating, willingness to try new foods

Parents from many of the programs reported that their children were now more aware of, informed about, and motivated to eat more healthy foods. Children were described as eating more fruits and vegetables, requesting fruits and vegetables at home or at school, drinking more milk and fewer soft drinks, and replacing junk food with healthier snacks. One parent described how her children have begun eating more healthily, as a result of her attending the program and introducing them to new foods or tasty ways of presenting foods:

> My kids are eating a lot more fruits and veggies than we did before. (Of course it also depends on the season and it also depends upon the availability.) Now they eat spinach, they eat broccoli which they wouldn't touch before, they eat cauliflower. With fruits even, they were very picky, because mostly they get an apple at school or whatever. So if I have oranges or pears or peaches, they would be, "No, we don't want to eat. Not this, this, this. We won't like it." And now they want to know when I'm getting it because they love it. Now they eat more fruits, they eat more veggies, so they're not hungry all the time. They're not looking for food to eat all the time. … The other thing my kids have, I noticed, are doing more nowadays is they're drinking more milk than they did before. Before it was like they *had* to have juice or pop and they wouldn't drink anything. Now they're drinking more milk. (Parent #1/13, School E)

Another parent, whose children attend a CFF program, mentioned how attending the program connected with the children's eating at home: "If the children have tasted something at the cooking program that they've enjoyed, then if they ask me to make it, then I'll make it. If I have all the ingredients, I don't have a problem making it" (Parent #5, School L). She said her older daughter was now more selective and chose healthier foods more often:

> It's gotten them [her children] to open their eyes and eat better. They're more, for example, my twelve-year-old now is more cautious as to what she eats. If there's fresh fruit and vegetables in the house, she'll ask for that instead of the bag of chips! Which I think is much better than before. So she's learning that good food is not only good for your *body*, but it's good *tasting*. (Parent #5, School L)

Many parents had found new foods that their children would eat, therefore broadening their children's diets. A variation on this outcome that some children experienced, notably those whose parents were from non-western, non-English speaking ethnic groups, was the introduction of "western" foods and recipes into the home. Most of the children had experienced western food

at school meal programs, and either preferred it at times to their traditional foods, or were having trouble accustoming themselves to it. In either case, parents learned more about preparing this type of food in healthy ways and were able to encourage their children to adopt healthier eating habits as a result.

5.2.2.2 Food preparation skills and eating together as a family

Whether children's diets improved did not depend on the children attending the programs, since many of the parents who attended without their children implemented changes at home that affected their children's eating habits and diets. A number of parents said that since they had joined the programs, they had done food preparation activities with their children at home that they wouldn't have done before. Their children had developed knowledge and skills related to food preparation and the use of the kitchen and were now doing more food preparation activities at home. One parent described demonstrating what she learned at the program to her two daughters each week when she got home. She said that her daughters were interested and learned by watching her repeat what she had just learned herself:

> I come home and I can say, "Well, this is what we made today." And I make it, and they [her children] watch. … So when I get home, I'm, like, I have to pull it all out and look at everything [the raw ingredients for re-making the recipe at home], and they watch me, right? So it's a learning thing too, learning how to cook. (Parent #8, School I)

Several parents mentioned involving their children in food preparation as a means to get them to try the new foods they prepared at home with them. They said their children were willing to try new recipes and new foods, including those from other countries and cultures, because they had participated in preparing them. Children were particularly interested in new and healthy foods when they had had fun preparing them. For example, one parent said,

> Every Tuesday I get to learn something new when I come to the class. And then when I go home, I want to try it myself. So the kids get to learn it, and if there's something they can help me with I certainly call them in. I say, "Let's do it!" Like the other day when we did the gnocci. I got the oldest one to peel potatoes, I got the youngest one to mash the potatoes when they were cold. And then the middle one and myself, we got in there and

we mixed and we did it. It didn't turn out the same, but they knew what was in it. They helped, and so they had fun doing it, and so they ate! Normally they wouldn't have touched it! (Parent #1/13, School E)

Some parents said that for their children, seeing other children eating and enjoying a larger variety of healthy foods motivated them to do the same. A mother of children who attended a CFF program described how being part of the process of preparing the food has helped her children to be open to trying new foods, and being with other children who are trying these foods has helped her children to be willing to also try them:

> If you prepare it *with* the children and they help you to cook and to prepare, to chop, to do all that, I think they have more sense of what nutrition is and more desire to try new things, which are more nutritious. A lot of, you know, vegetables that they haven't tried before. Not to force them but to ask them to try. … Trying, or at least looking at others eating, and so all that, you know, eating together is very important, they learn to eat some other things. (Parent #12, School L)

Another parent from the same program described the benefits of cooking at home with her daughter after learning new recipes at the program:

> And then a lot of times, like I say, I will bring the recipe home. Whatever, we might do two or three that day, I'll bring one of them home to *do* at home. So often I'll do something for her [her daughter], a dessert thing at home which she can participate in, and then, you know, that's a bonding thing, plus it's a food thing and, it's character building all the way around. (Parent #10, School E)

Other parents, particularly from programs which included food preparation activities for children, mentioned that their children had become more adept in the kitchen and that they now participated in food preparation at home on a regular basis. One parent said that now she has her children help her out in the kitchen:

> And I even get my oldest one, and if I can tolerate her, I get the youngest one to help me out in the kitchen, cooking or baking or something. If I can *tolerate* her [laughs]. Because she's got quite the sticky fingers and likes to get *into* things [laughs]. (Parent #5, School L)

Another mentioned how much her daughter has learned at the program, and how she combines her daughter's learning at the program with teaching her how to cook at home:

> When [my daughter] helps me in the cooking class, she learns how to cut, to clean and do everything to prepare. She does salads good. She knows how to make scrambled eggs. Now she wants me to teach her how to make pancakes, which is pretty simple. I've got her to do meat pies and scalloped potatoes and things like that. (Parent #14, School L)

A grandparent described how her grandson cooks at home with recipes he gets from the program staff:

> Some of those little things, like those recipes that [staff] has, some of them are nice and little that even [her grandson, who lives with her] can do it himself. He's got a little cookbook and all that. If he wants something he can – I usually help him though. He made some peanut butter cookies one day and did they ever turn out good! I just told him how to do it. (Grandparent #20 School D)

> Benefits for some children include family members eating more meals together at home.

One parent described the sequence of home activities with food that has evolved since she joined the program. She now involves her children in cooking activities with her at home, and because they have been involved in preparing the food, they are willing (and pleased) to eat it. This has led to them organizing themselves to eat meals together: "Plus when we sit down for a meal, we are actually sitting down for a meal, all of us at the same time, at the table" (Parent #1/13, School E). Having families eat more meals together was a goal for staff of several of the programs. One of them acknowledged the time it takes for families to reorganize their time and activities to achieve this long-range behaviour change that supports families and is known to help children developmentally:

> It is a slow process. I think that some of them had that [cooking at home and eating meals together as a family] even before joining the program, though they were not really into cooking that much. But some others, I think that they took the children at home and put them in front of the TV while they do something else, and so it was a whole change, mentality, really, change for them. (Staff #1/14, School E)

5.2.2.3 Safe food handling and basic sanitation skills and behaviours

Most of the programs focus a considerable amount of attention on safe food handling and basic sanitation skills. The two programs that incorporated children fully, in particular, emphasized hand washing and other sanitary behaviours with them, such as not "double-

dipping" vegetables into a dip, not touching one's mouth while preparing food, etc. The message about hand washing did get across, as evidenced by this observer's comment:

> Mickey, of whom we questioned last time whether he washed his hands or not, now entered the room, dropped his bag and rushed to the kitchen to wash his hands. Anastasia and Angie also washed their hands in the kitchen. Valerie and Kristie said they washed their hands really well in the bathroom, but Alanna asked them to wash their hands again in the kitchen, so everyone could see it. (Observer #4, School L)

Some of the parents from parent-only programs mentioned teaching their children newly learned safe food handling behaviours at home. Staff at programs with children also mentioned the benefits to children regarding learning about sanitation, particularly if it's fun to do so:

> We talk about cleanliness. The best one was when we did that thing with the hands where you put that stuff on to see where the germs were. And I tell you, we had these two kids, and they must have spent I don't know how much time in the washroom washing their hands, and they kept coming back and there was still germs on it. And it got to the point they were coming out of the bathroom with their hands up like a doctor, and they wouldn't touch the handle. You know, trying to say, "Our hands are germ free." But it was a learning experience and they had a lot of fun doing it. (Staff #8, School M)

5.2.3   Summary of perceived food and nutrition benefits

Study respondents reported that families had expanded their repertoire of activities relating to healthy food and nutrition both at the programs and at home. Many parents reported that their families were eating healthier meals and snacks at home. Children who attended programs were said by their parents to be more aware of nutrition and desirous of healthy eating at home. New information and skills learned by parents at parent-only programs were often taught to their children later at home, providing opportunities for children to both learn and to participate in family activities with their parents and siblings. Many parents reported children's enthusiasm for new recipes they were preparing at home. Some families began spending more time cooking together and were eating more meals together at home.

The CFF programs were perceived as having healthy eating benefits to participating parents and to their children, whether the children participated directly in the programs or not.

The pathway to the healthy eating benefits varied among participants, depending on which aspects of the programs affected them. For example, for some, motivation and encouragement was the most important factor in their producing more home-made and healthier meals, while for others, nutrition knowledge and skills were more important factors in producing a similar outcome. For participants not familiar with western cooking, the ability to produce healthier and less expensive versions of western foods than those available in the supermarkets or corner stores contributed to healthier eating as well as cost savings. The programs also contributed to healthy eating by establishing social norms within the participating families that provided motivation for children to bypass unhealthy foods at home and make healthier food choices. When parents volunteered or programs participated in wider school events, these healthier eating norms were disseminated more widely.

5.3 Perceived psychosocial benefits

> I've come to know the people, I've come to know my community, I've come to know my environment. … Now in school I know who the teachers are, I know the Principal, I know who the support staff are, and the same with the community centre. (Parent #1/13, School E)

> Every time we met here, no dull moment! We're very happy! (Parent #9, School F)

Many perceived psychosocial benefits of attending CFF programs were mentioned and discussed by parents, staff and administrators in their interviews, with every interview respondent reporting some of these types of benefits. I have divided them into three groups: social, psychological, and skill building (please see Table 11), and present them separately for parents and children in the following sections. For adult participants, the presentation is separated into three sections following the three subheadings in Table 11. For children, however, the presentation of all the perceived psychosocial benefits is combined into one section, since

overall, there was less detailed discussion of the perceived psychosocial benefits for children

(perhaps because fewer children than adults actually attended CFF programs).

Table 11: Perceived psychosocial benefits of CFF programs to adult participants

Perceived social benefits
Meeting new people, making new friends, developing social networks
Socializing with staff and other program participants
Integrating with other cultures
Increased tolerance for and patience with others
Building community, being part of a community, sense of belonging
Deepened or expanded relationships with school, community centre, community
Accessing other resources
Perceived psychological benefits
Relief from isolation, loneliness, and boredom
Relief from frustration, personal problems
Enjoyment, happiness, fun
Perceived skill-building benefits
Learning and sense of accomplishment
Learning team work
Learning/practicing English, literacy skills

5.3.1 Perceived social benefits to parents

Social benefits to parents who attended CFF were mentioned often by all three categories

of respondents. Developing new relationships was commonly noted: for example, as in "meeting

and getting to know new people," "learning about people," "making new friends," and

"developing new social networks." As one parent said, "Is fun! And I know another parents. So

now we so friendly!" (Parent #4, School H). A researcher noted, about the relationships in one of

the programs she observed, "The relationships were of obvious importance as well as the food

preparation. … People were asking each other how they were, and there seemed to be a very

empathetic feeling in the room" (Observer #2, School E). Some parents commented that since

getting to know their neighbours better, they had become friends, socializing in their own

neighbourhoods, with their children playing with their neighbours' children. They also were then

more able to rely on their neighbours for instrumental social support, such as exchanging child

care responsibilities. One parent verbalized a common feeling among the parents and staff

regarding this benefit. She talked about how the program provided her with a "circle of friends"

who can help each other in ways compatible with each of their skills and talents:

> I consider [the program] a source of, I don't know what the word would be, but like "a circle of friends" socializing kind of, where you get to know people, you get to know their qualities, you get to know their kids, you get to know what they are capable of doing or what they aren't. At the same time, they get to know about you, and chances are their disabilities may be your abilities, where you can combine the two, and help each other out. (Parent #1/13, School E)

A parent described how other parents in her program supported her through difficult times in her

life:

> Parents in the program help and support each other by talking things out, or, if somebody's got somebody to talk to something personal about. They'll say, "Well, can I talk to you for a minute please?" I find they're pretty good with each other, and everybody's really cooperative with other's feelings and stuff. I've had quite a few traumas in the last two years of my life, and everybody's been pretty good to me, and helped me through it, because I couldn't go through it alone, right? I've had nothing but deaths and all kinds of things happen to me in the last year or two, and my daughter got assaulted in the summer, and they were all very supportive of me, very supportive of me. (Parent #23, School E)

And a grandparent at another one of the programs noted how the parents were able to become

comfortable enough with each other to bring up their personal problems for discussion:

> They learn to meet each other and talk, and talk about maybe home life, or what they cook at home, or what their life is like. They communicate. We talk about things, and sometimes they might have a little problem at home, and so we talk about it and stuff like that, you know. I just tell them to hang in there. I don't say it like that, but you know. [Do you think just by listening to their problems that they feel better just by talking to everybody?] I think they do. I think they feel better just by talking about it. That helps a lot sometimes. (Grandparent #17, School M)

While socializing with the other program participants was important to most of the

parents interviewed, some also mentioned socializing with the staff as an important component

of the programs. Staff who enjoyed socializing with the participants were able to act as "ice-

breakers" and those programs enjoyed closer relationships between the participants than where

the staff were less socially involved. A few parents felt the social aspects of the programs were

the most important to them, such as one mother who stated that attending the program had not

affected her family's diet much (she said they already ate well), but that she had made a lot of new friends at the program: "I made friends with Mary [staff] and Grandma and a lot of parents" (Parent #18, School M). She said she felt she could trust the people in the program and that if she needed help and asked, she would be helped by someone in the program.

An important aspect of getting to know others in Vancouver's inner city is integrating with other cultures. Many parents and most staff and administrators thought that the provision of an opportunity for people of different cultures to get to know each other in a safe, non-threatening atmosphere was very beneficial to the parents, their children, and the school-community as a whole. This parent expressed her appreciation of the opportunity to meet and get to know people from other cultures at the program:

> [What I like about the program is] communicating with other . . . I guess what I like about it is, because you get different kinds of parents here. Like you get the Asian, you got the First Nations and you got the East Indians, you get the Polish, and then learning to communicate with them. Because the opportunity too, is learning to know them. (Parent #8, School I)

Another parent expressed the idea as seeing cultural barriers dissolve when the program participants are working together:

> And I see the cultural barriers coming down because they're not really different than anybody else. They're like women leaving the home, putting their small children at school. There is a dialect, or the language is a bit different but the energy that goes into it, like all of a sudden you're chopping or you're doing something and somebody else is doing something. You just feel the energy and you just shed what, you know, sort of the grief of the day. (Parent #27, School F)

One of the staff noted that the program had changed her and made her more tolerant of others: "It really has got a grip on me, this program, it's done something to me. It's made me much more empathetic and much less judgmental, you know" (Staff #9, School L). A parent also mentioned becoming more patient and tolerant with other moms, and even with the school system as a whole:

> Oh, I've become, myself, become more confident, and more patient and tolerant, knowing where the moms are coming from, 'cause I've been there too. It gives them a

little bit, gives me a security, also gives them an opening, and a door opens for both of us. … I have a little bit more understanding of the process of the school. So I just, I'm a little bit more tolerant and patient. And I don't, I've learned not to expect everything *today*, but, and go with the flow. (Parent #10, School E)

Some participants described the programs as community-building and mentioned the development of feelings of belonging and being more a part of the community: "It gives them a chance to meet women, get out and do something productive. Yeah. Community building" (Parent #10, School E). The same parent described how the program was grounding for her because she could count on it, it was always there at the same time each week, and she also described it as grounding for her daughter for the same reason: "It's *there*, and we can *count* on it. And the women *count* on it, they *do*" (Parent #10, School E). Being part of the program gave her a grounding in the school-community and a sense of belonging to the community:

> You have a *diverse* background, so you have Italian background, First Nations background, and South American, East Indian type thing, so you have a diverse background. That itself is just good for everyone to get together, you know. So it's community building. … It just gives them a good chance to connect for sure. It is community building that way. I think they know they are not alone. I hear them *saying* that. (Parent #10, School E)

For many participants, attending the programs resulted in a deepened or expanded relationship with the school, the community centre, or the community in general. For the programs held in schools, parents, staff and administrators all commented that the programs were very successful in helping the parents feel more comfortable in the school and get to know the school staff. A Neighbourhood Assistant was asked what she thought the parents' reasons for attending the program were. She responded, "The food, I think a lot is the camaraderie, the sense of belonging" (Staff #8, School M). She illustrated this by saying she had heard one parent say to her friend, "I'm going to the cooking group. It's *my* cooking group" (Staff #8, School M). She further commented: "I think there's certain parents that feel more comfortable in the school because of it. They feel they have a place, … And then you see them in the hallway and actually, they're starting to say 'Hi' to each other" (Staff #8, School M). Similarly, the community centre

programmer, who administers and oversees another program, felt that the goals of promoting

wellness for the target families had been met over the three years of the program "to some

extent" because the families had become more integrated with the community through

participating in community centre events and programs:

> The reason why I would say that is, that we have families that are returning, which means that we are providing them with a support outside their inner circle. And that's one of our goals of the program is to have them feel more comfortable within a larger geographical circle, if you could call it that, within the community. And so we've really increased their comfort zone at the community centre as well; they really have developed a sense of belonging at the centre, and I think that program was what made that successful, that sense of belonging. (Administrator #4, School L)

Another administrator voiced a similar attitude towards the program:

> It's a good way to be able to invite parents in to be more comfortable in the school environment. Food's a big draw, and parents in these kinds of neighbourhoods [inner city] are often reluctant to be participants in the school. Often their other involvement with the school has been negative, so they're here because their child's having learning difficulties or discipline issues. So to come and get a sense of the school from a different point of view is very helpful. (Administrator #3, School E).

Social benefits to the community involved more community members knowing each other and

potentially supporting each other and acting together to improve their schools and communities.

In many cases, people from different cultures got to know each other at the programs, and this

potentially improved the tolerance level and safety of the communities. As one Principal

mentioned, the CFF program was one of a number of programs to bring parents into the schools,

aimed at strengthening the capacity of the community and making stronger community

partnerships. He said that these programs encouraged conversation, problem-solving and support

regarding topics of interest to the parents, including not only education but also language, culture

and employment, problems of immigrants, poverty, housing and medical care (Administrator

#11, School I.) As one parent said to illustrate how much more involved and integrated she was

with other parents and the school after having attended CFF, before joining the program she had

only said "Hello" to other parents:

That was it – "Hello" and "How are you?" and "Goodbye." Now we meet together every morning. We sit, we have coffee for half an hour. We talk, we discuss issues that are of concern. Currently the topic is the school cut-backs, so that's what we talk about. "How can we deal with it?" "What can we do about it?" "How do we go about it?" …. (Parent #1/13, School E)

For many parents of Asian heritage, becoming a part of their children's education is a new and different approach that they are not used to. For parents who speak little or no English, knowing how to approach the school can be difficult. A multicultural worker commented,

To our Chinese parents, I think it is a really good way for them to come into the school, being more involved in what's happening in school. Because culturally, or traditionally, Chinese used to stay away. The parents used to stay away from school because most of them think school is just for their kids' education. … With the Community Kitchen [CFF] going on inside the school, it makes them feel more comfortable coming in to do something that, especially cooking, is for most of the moms are something they are good at, they know what to do. And coming in, getting together with other parents, they know each other more, they can communicate within themselves, and also they get more information about the school at the same time. (Staff #13, School F)

Most of the staff and a few of the parents mentioned that once parents became more familiar with and integrated into the schools, they began to attend or volunteer at other school events and functions, helping the schools out and functioning as an integral part of the school. For example, at School M, parents from the CFF program attended other events such as Literacy Week events: "I think once they get in and they realize that they're not alone, and they can go and they don't have to sit by themselves because they recognize other parents, and they're accepted for who they are, I think it makes a big difference" (Staff #8, School M), and some parents from the CFF program even baked for and ran the concession stand at the Spring Fair. For the program held in a community centre, the staff and administrator likewise commented that an important outcome (and previously, a program goal) had been that the families participating in CFF had come to use the community centre almost "as a second home," availing themselves of the many services and programs it offered. The Chinese multicultural staff worker at another program discussed the sequence from parents joining CFF and other school programs such as "Family Literacy" to attending Parent Advisory Committee (PAC) meetings and Parent-Teacher

conferences. She said that as the parents gain more comfort and self confidence they begin to be

active rather than passive members, asking questions and giving their opinions:

> If they're not involved, they are not active, they will just be like a receiver. But if they are involved in, more like a giver, or like a partner, they are more like partners with the school in their child's education. … Once they are in the PAC meeting actively, maybe they are making some changes, they raise their concerns. It's really changing the school in a way. … If the school is willing to take the step to have the parents involved, you can see a lot of other changes going on. You can see the effect of it. (Staff #13, School F)

Finally, some parents mentioned that through attending CFF programs they had come to

learn about other resources that were available to them. This included not only other sources of

food, but things like free passes to community centre or sports programs, free internet access and

computer courses, free clothing, and other programs that could be of help to them. This was

because of the networking, discussion, and mutual aid aspects of the programs:

> And I found free studying, free schooling, free food. Oh my goodness, this country is so good. We have none like that in the Philippines. Free schooling, free food, and sometimes yeah, it's happened one time that I got free clothes for winter. Oh, it's very good. (Grandparent #9, School F)

Other parents, such as the following, commented on the intangible resources that are gained from

participation in the programs in terms of the world of friends and relationships that it creates:

> You're getting to know people, you're getting to make friends, you're going to make friends not only for you but also for your kids, which will make them open up in a circle, environmentally. And then there will be things, you know, that you didn't know, or you know that they didn't know, and you can share that. You know, the resources that you can share amongst yourselves. (Parent #1/13, School E)

5.3.2   Perceived psychological benefits to parents

Psychological benefits included relief from loneliness and boredom; social support and

relief from feeling frustrated by personal problems; and experiencing enjoyment, happiness, and

having fun. Parents from some of the programs commented that attending the program helped to

relieve loneliness: "If I didn't come, just stay home, I feel as lonely" (Parent #4, School H), and

boredom: "I hear them [other mothers] saying, 'My kids are in school anyways, and I would be

doing laundry. I would be *bored*'" (Parent #10, School E). Parents, staff and administrators all

mentioned that the programs brought people in the community together so that they were not

isolated. Several of the participants mentioned the benefits of getting out of the house and

forgetting their own problems while doing something enjoyable with others:

> That's one place that's not bad. And I could be in a real ugly mood, and as soon as I get
> there everything goes away. (Grandparent #20, School D)

> [What's the most enjoyable part about the program?] I guess you forget about your own
> problems for a while when you're, you know, up to your elbows in water. (Parent #27,
> School F)

The participants and staff thought of enjoyment as an important beneficial outcome of

attending the programs. One grandparent expressed her appreciation of the opportunity to get

together with others:

> I like coming because it gets me out and it gives me something to do and I like to meet
> the people. I like the children, you know, and all sorts of reasons. I like cooking here and
> I don't know, I just like *being* here. (Grandparent #17, School M)

Every parent/grandparent who was interviewed mentioned how much she enjoyed the

program and for most programs, parents/grandparents also mentioned how much they enjoyed

and appreciated the staff. Many had developed a teasing, joking relationship with the staff, which

gave them a lot of pleasure and feelings of being on an equal footing. Parents said, in particular,

that they enjoyed themselves at the programs; enjoyed working with other moms and with staff;

made jokes at the programs and teased each other; enjoyed the cooking and the food, the friendly

environment, friendly people, and the staff's humour; and that the fun was the best part about the

programs. One staff mentioned that she thought the parents had used to come for the food, but

now came because they like to get together, to have fun and have a social life. Another parent

said it was her relaxing time and it was fun to eat together with the other families. A typical

comment was: "If we're cooking, we, we're *happy* to do that. We cook up everything in order.

Everybody's *enjoying*, you know!" (Parent #2, School H). And finally, one parent expressed, in

an eloquent way, what all the parents indicated in their interviews: "It's fun. It's *fun*! *Oh*! *It's fun*! We missed the "*fun*" part! We all have fun with it, that's a key thing, or we wouldn't keep coming back!" (Parent #10, School E).

5.3.3 Perceived skill-building benefits to parents

The third aspect of social benefits to parents related to feelings of accomplishment from what they did and learned in the programs and, for some, an acknowledgement of additional skills they had learned that were not directly related to food and cooking. Many parents expressed a feeling of accomplishment from what they had learned about food preparation in the programs. For example, one mother said: "I get the knowledge and the satisfaction of knowing that I've learned something new … budgeting, cooking within a budget, healthy cooking" (Parent #1/13, School E). Some parents commented on how happy their families were when they produced new dishes at home that they had learned at the programs. Their families supported feelings of pride in themselves for their learning. For example, one mother commented,

> And if I learn, I cook in my place, and my husband [sounding very pleased] "Oh, we have a *different* food today!" [Respondent laughs.] You know. It's *fun*! Yeah! … I did it, I do it one time in my place, and my husband, *"Oh, that was so good*!*"* And even my kids, "Oh, Mummy, can you cook some more like that?" Because they like potatoes. "Oh, this is different today, Mummy, tonight. This is especial? Whose birthday?" [Laughs. Because Philippines, you know, the same. All the same stuff cooking. (Parent #2, School H)

Other parents mentioned learning to work with others as a team as one of the things they had accomplished at the programs: "[We] learn about team work. You share the things, you share the work" (Parent #3, School H). Many parents built up a variety of skills related to language and communication: learning or practicing English with staff and other participants, learning to read recipes, and expanding vocabulary. Most of the participants who were learning English mentioned that the programs gave them a good opportunity to practice speaking English and to learn new vocabulary, particularly words related to foods. Some of the staff, and

particularly at one program, were quite focused on teaching related English vocabulary, and held it as one of the key goals of the programs. For some parents, the skills learned at the programs translated into perceived increased employment opportunities. For example, one parent mentioned that the program gives people an opportunity related to acquiring employment in the food industry: "It could give you an opportunity if you wanted to go be a chef somewhere, or you wanted to go to a cooking school, because they're looking for a lot of people who know how to do that now" (Parent #18, School M).

5.3.4   Perceived psychosocial benefits to children

Psychosocial benefits to children were discussed by some interviewees, but less frequently and in less detail than discussions of the food-and-nutrition-related benefits that they perceived for children. When they did describe psychosocial benefits for children, parents and most staff identified similar benefits to those they identified for parents, encompassing both personal and social areas. Some staff and most administrators focused particularly, however, on the benefits children accrued by having their parents more involved with the school.

Some children were said to have benefited from a sense of accomplishment due to learning knowledge and skills related to food preparation. For some, this learning took place at the programs; for others, it occurred at home; and for some of those who learned at the programs, it was reinforced and extended at home. Participants also commented that children who participated in food preparation, food-related household chores, and/or eating together with their families as a result of the programs, whether they attended it themselves or not, benefited from the increased family cohesion and sense of responsibility and competence that participating in these activities produced. Children were also said to derive pleasure from doing these activities at home.

Some parents commented on the opportunity attending the programs gave their children regarding social relationships. They said their children met new people, made new friends, developed broader social networks and learned about other cultures, either directly through participation in the programs, or as an indirect benefit of their parents increasing their own social networks and expanding their children's networks as a result. For example, one parent mentioned that her daughter "gets invited to birthday parties and stuff" (Parent #18, School M) as a result of attending the program. A grandmother commented: "It teaches the kids to get along. It teaches them a little bit about cooking, and they learn to communicate with each other without fighting. And I think that the kids like it just as much as we do" (Grandparent #17, School M). Another parent explained how her children (who were First Nations) had become comfortable enough at the program to talk with children from different ethnic backgrounds:

> [Has your attending the program had any influence on your children's social relationships? Have they met any kids, more kids, because you've met more parents?] Yeah, they're out there more. They have friends that aren't First Nations, which is nice, right? I would say yeah, they've learned how to communicate. Like, you know, they're not as shy. [Is that because you're communicating? Do you think they take it from you?] Yeah, I would say that. They get out there and try and talk and they're trying. Because when they were small we used to do it [attend CFF] after school, and we used to go till 4:00. So all the other parents, we used to cook it and we'd all sit around and eat, and they'd come in and you're trying to communicate with other parents. It's what they see so that's, yeah. So I think they've learned by watching that it's okay to try and talk with different other people, right? (Parent #8, School I)

Although a few parents reported that some of their children became bored at the program at School L after several years, particularly when there were few planned activities to occupy them while their parents were preparing the dinner, for the most part, parents and staff reported that the children liked to be at the programs, both programs that children attended regularly, and those that they attended occasionally or in a more limited fashion. The children especially seemed to enjoy eating together with other children, and the parents were happy about the positive influence the children had on each other in regards to eating enthusiastically and trying new foods. One parent noted how the children encouraged each other in this regard: "Trying, or

at least looking at others eating; eating together is very important: they learn to eat some other things" (Parent #12, School L). Some parents said that their children felt proud to see their parents at the school learning something new, while several parents noted that the skills the children were developing in the programs that they attended would help them later in their lives in a variety of ways.

Most school administrators and a few staff discussed the programs from the perspective that parents' involvement at their children's schools benefits the children's education over-all. School administrators, focussed on the larger picture and aware of the Inner City Schools Project's goal of involving parents in the inner city schools, spoke about the benefits to children of having their parents present in the school, developing a relationship with the school. One principal discussed how the goal of the educational system is to create a "seamless education" from early childhood right through to high school, and that the way to do it is to have a strong "link between the school and the community, focusing on the family" and that what is most important is that "they're learning that learning is life-long, that the school is a centre of learning in the community" (Administrator #6, School D). A common theme among administrators was that seeing their parents at school made the children feel more secure, supported their valuing of learning, and assisted children with developing a feeling of integration between their home and school lives. As one Principal noted, it is very important for children to see their parents valuing education and the school: "I think the children themselves, when they see their parents being in school, it's a huge boost to see their parents value education, support the school, gaining knowledge" (Administrator #9, School H).

Some staff and administrators also mentioned the fact that benefits accrue to children's long-term educational development when their parents show an interest in and become involved with the school. They noted that when parents are present in the schools, they develop relationships with teachers and principals. If problems then arise relating to the children's school

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progress, or parents simply need to understand and support their children in their educational process, the parents are more likely to approach the appropriate staff person to receive assistance. Parents, likewise, mentioned the fact that they have become more comfortable with the school staff and administration and that whereas they might only have approached teachers once a season at the parent-teacher conference, now they feel freer to discuss any concerns they have with their children's teachers as they arise.

One staff said she felt that parents in her program had developed more respect for the teachers at the school when they became aware of how hard the teachers work and how dedicated they are to the children. She said that the parents' appreciation for their children's teachers communicates a message to their children that they and the schools are working together for the children's benefit. Another staff said that she felt it was good for the children to see their mothers happy while they were at the program; it contributed to children's positive perception of the school.

Several school principals noted the benefits to children's education of having the parents involved in the school:

> Long and short, anytime a parent shows interest by coming to the school or getting involved, the child benefits because they feel the parents are interested in what's going on at school. … It makes parents more aware of what's going on in the school, and some parents become involved and then hopefully will get more involved in their own child's education. (Administrator #5, School F)

As one principal explained, the CFF program has benefits on many levels:

> Any time we get kids and parents working on a project together, that can have an impact on their home life, positive impact on their home life. … It's actually a win-win situation for everybody because we get parents into the school. The more they're here, the more conversant they are with us in the school, the more comfortable they are, and there's a lot more positive spin-off from [it than] just the cooking. We get the chance to talk to the parents about what they're doing, and get to know them better, and their kids, and they get to know us better as well. (Administrator #8, School M)

A Chinese multicultural worker who was involved with one of the CFF programs was able to explain in detail the process of how non-English speaking parents begin to get involved

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with the school and the benefits this provides to their children. She said that before the parents become involved, they are "silent in planning, policy making, raising their concerns" (Staff #13. School F); in other words, they do not participate. Even if they have interpreters available, they do not know how to interact with the school. Once they gain experience in being in the school and begin to understand and "feel more comfortable, and have more self-confidence" (Staff #13, School F), they will begin to attend Parent Advisory Meetings and Parent-Teacher conferences, and will start speaking up, asking questions such as "How can I help? What can I do? How is my child doing?" They start to volunteer assistance to the school, maybe also attend morning coffee hour, and talk with others about what they can to. They are part of making changes and raising their concerns, which actually changes the school. The school benefits from knowing what they think and the parents "are more like partners with the school in their child's education" (Staff #13, School F). There are many benefits to the children that grow out of this parent involvement: "role modeling, kids feel proud, kids have a greater sense of belonging to the school" (Staff #13, School F). She said that the kids then have a different kind of "knowing" that their parents really care – for example, the parents can ask the children meaningful questions and make meaningful, relevant comments about what is happening at school. The children also gain strength and courage because they see their parents trying to communicate with their schools. The children, being ESL, are struggling with the same language problems, and seeing their parents making the effort to communicate encourages the children to keep trying: "Even though they are struggling, they will try" (Staff #13, School F).

5.3.5   Summary of perceived psychosocial benefits

Psychosocial benefits described by respondents occurred in the areas of social relationships and social and emotional support, personal development, integration into the school and community, and recreation. The three groups of respondents all mentioned psychosocial

benefits, but differed in their emphases. Parents focussed more on discussing recreational aspects such as enjoyment and fun, and social integration aspects, such as meeting new people and developing friendships, some of them cross-cultural, citing these as benefits for both themselves and their children. They also mentioned many aspects of social and emotional support, including feeling a reduction of loneliness and isolation, feeling happy, feeling supported by staff, and having a sense of belonging, inclusion, acceptance and bonding with the group. Administrators mentioned school and community integration aspects of the programs more often. They cited the great value of bringing parents into the schools, and of parents feeling more comfortable, trusting and valued in the school and with school staff, which they stated benefited the children. They also noted that because of attending CFF, parents were feeling more comfortable with each other, were building cross-cultural relationships, and were developing access to more resources. Staff echoed the sentiments of both groups above, and added an additional aspect of personal development, noting that over time, parents who attended CFF developed self-confidence through their participation and team work. Parents mentioned that their children developed competence and independence in relation to their food preparation abilities, and also benefited socially in terms of problem solving in their relationships, occurrences which they saw as developmentally positive. Both administrators and staff mentioned that parents' increased self-confidence and sense of belonging assisted them in branching out to take on other roles in the school and community, such as attending Parent Advisory Committee meetings and volunteering at school events. In conclusion, the study findings indicate that participants, staff and administrators all perceived both food- and nutrition-related and psychosocial benefits for participants who attended CFF programs and their families.

5.4 Discussion

Chapter 5 presented the food- and nutrition-related and psychosocial benefits of the CFF programs as perceived by participants, staff and administrators, and the self-assessed program benefits reported by participants on a questionnaire. These perceived benefits will first be discussed in relation to perceived benefits of other community kitchens evaluated in the literature. This will be followed by a discussion of the perceived benefits of CFF programs in terms of health promotion theory.

5.4.1   Comparison of perceived benefits of CFF and other community kitchens programs

The focus of the CFF programs is a combination of educational and social with some nutritional support, and the perceived benefits follow along the same lines. They are generally similar in these respects to those shown in other evaluations of community kitchen programs (Crawford & Kalina, 1997; Engler-Stringer, 2005; Engler-Stringer & Berenbaum 2005; 2006; 2007; Fano, Tyminski & Flynn, 2004; Fernandez, 1996; Marquis, Thomson & Murray, 2001; Ripat, 1998; Tarasuk, 2001; Tarasuk & Reynolds, 1999). Most of the community kitchens reviewed in the literature, however, belonged to the subset of community kitchens identified as collective kitchens, where small groups of participants get together once or twice a month to cook several main dishes for their families. This food, taken home and frozen, is meant to last over several days. Although in this regard CFF programs differed from the main group of kitchens evaluated in the literature, the findings regarding the perceived benefits of CFF programs are more similar than not to those of the published collective kitchens evaluations. This is because the published evaluations of collective kitchens found that in general, unless the kitchens were substantially subsidized financially, participants felt the food security-related benefits of the programs were less than they had anticipated, while, on the other hand, the educational and social benefits were greater than anticipated (Engler-Stringer, 2005). For

example, as noted below, comments from parents, from both the published evaluations and from CFF programs, about learning at the programs and then going home to recreate what they have learned at home, either with or for their children, are almost identical: "I find that if I learn something here, I do it at home – and I even pass it on to my children" (Engler-Stringer & Berenbaum, 2006, p. 181); "What I learn there, I always go home and I try to do it for my kids" (CFF Parent #1/13, School E). Similarly, regarding the effects on their children's diets of parents having attended the collective kitchens programs, Engler-Stringer & Berenbaum (2006) found that, just as in CFF programs, participants believed that their children were eating more vegetables and consuming a wider variety of foods as a result of their parents having attended the programs. The participants in Engler-Stringer and Berenbaum's (2006) study also reported very similar learning and changes made at home to those in CFF programs in the areas of learning to substitute in recipes, to add more vegetables to main dishes, to consume a larger variety of foods, particularly vegetables, to cook more meals from scratch, and to reduce their intake of fat.

Similar to the findings of evaluations of most other community kitchens, although all CFF participants were exposed to new foods and a greater variety of foods at the programs than most of them would been exposed to at home, and most reported trying or retrying some of these foods at home again, most of those who completed the questionnaire more than one time did not report a change in their food security status over time in the program it, while in interviews, resolving issues of hunger and worry about running out of food were rarely offered by the parents/ grandparents as part of either the expectations of, or the perceived benefits of attending CFF programs. Although the food insecure CFF participants did not seem to perceive the CFF programs as resolving their food insecurity, the study results do suggest that some CFF participants had achieved a degree of improvement in aspects of living related to coping with food insecurity, such as preparing more meals at home (cost saving), providing healthier choices for their families (increased quality and variety), and accessing additional sources of food

(quantity), through attending the programs. Some parents also mentioned that the quality of food their children were choosing to eat had improved because of the programs, either because children had been motivated at the programs or because of changes in their attitudes and behaviours inspired by their parents. The CFF participants were a heterogeneous group in terms of their food and nutrition knowledge and skills. There was a subset of participants who benefited from the educational approach in terms of learning how to plan their meals and to shop in such a way that they were able to manage their families' meals in a less stressful and more healthful manner, but by no means did all the group need this or respond in this way. As with previous studies of community kitchens programs, it is likely that several aspects of the CFF programs, such as the instruction and practice in preparing low-cost meals, learning how to make acceptable meals with food from donations, and skills (for some) in household management, contributed towards coping with and managing food insecurity, but didn't go so far as to produce food security (McIntyre & Rondeau, 2009).

Social and psychological benefits of the CFF programs were also similar in most respects to those found in the literature on community kitchens. Participants in all the published evaluations, as did CFF participants, cited social and psychological benefits extensively. Attending both CFF and other community kitchens programs was said to contribute to reduced social isolation, increased social support and increased connections within communities, and to provide an enjoyable experience outside the home (Crawford & Kalina, 1997; Engler-Stringer, 2005; Fano, Tyminski & Flynn, 2004; Fernandez, 1996; Marquis, Thomson & Murray, 2001; Ripat, 1998; Tarasuk & Reynolds, 1999).

There were some differences, however, in the types and degree of educational and social benefits perceived by CFF program participants, staff and administrators and by clientele, staff and administrators of the community kitchens evaluations in the literature. Because the CFF programs are provided at no cost to participants, staff are able to concentrate on exposing

participants to new foods and recipes. Thus one of the most common benefits perceived by CFF participants was learning new recipes and learning about new foods. Some collective kitchens find themselves, however, limited in the amount of exposure to new foods that they can provide by the fact that the participants are paying some or all of the costs, or even if they are not, they are depending on the quantity of food produced. They may think of the collective kitchen as part of their household food budgets, to be spent as frugally as possible because of their food insecure situations. Although CFF participants may be as or more food insecure, the CFF programs do not present themselves as part of participants' monthly food procurement strategy. This is not to say that some participants don't use the programs in this way, but that the staff, who either decide the menus or oversee the decision-making around the menus, are able to keep the focus on a longer-range objective, education, which includes exposure to new foods and recipes as part of its strategy. Another difference between CFF and the collective kitchens programs evaluated in the literature is that while collective kitchens usually have a facilitator, the role of the facilitator does not usually include as much of an educational focus as the role of the facilitator or staff of most of the CFF programs does. One implication of these differences is that CFF programs are likely more educational and include exposure to a wider variety of new foods than do most collective kitchens programs.

The CFF program model was initially developed in response to the institutionalization of subsidized lunch programs in Vancouver's inner city schools. Studies of feeding programs and charitable food assistance have found that families for whom they are intended feel they are stigmatizing and demeaning (McIntyre, Travers, & Dayle, 1999). Some participants in the collective kitchens that Engler-Stringer and Berenbaum (2007) examined for their relationship to food security noted that one of the benefits they perceived from the programs was being able to make less use of food banks (p. 81), which they had found to be demeaning. For CFF participants, the access they gained to additional food was not seen as charity but as part of an

educational program. None of the interview participants mentioned, however, being able to reduce their dependence on the food bank.

CFF programs are able to provide additional psychosocial benefits above and beyond those perceived by members of the community kitchens reviewed in the literature, related to CFF's situatedness within the school system. Perceived psychosocial benefits that were unique to CFF programs included parents' feelings of increased comfort and familiarity with their children's school (or with the community centre if the programs were held there), and more ease in communicating with their children's teachers about school work and associated issues (where the programs were in schools). Some parents also became involved in volunteering in the schools and in organized school parent groups. All these activities supported parents' feelings of belonging to the school community (Hagerty, Williams & Oe, 2002; McLaren, 2009). Staff and administrators believed that for children, seeing their parents happily engaged with the school in learning provided positive role modeling for lifelong enjoyment of learning, and imparted value to the school, in the children's eyes, and to their own learning endeavours. Children seeing their parents participating at school was also seen as reducing the social and cultural barriers that children from cultural and ethnic minorities face regarding the integration of their home and school lives. Staff at some schools took advantage of parents from different ethnic backgrounds' willingness to work together by combining disparate groups in their programs, realizing that parents from different cultural backgrounds could enrich each other's lives and broaden the school environment as a whole by sharing knowledge with each other, and also that the different groups shared vulnerabilities and life circumstances with each other that by working together they might have a better chance to overcome.

For new immigrants and refugees who attended the CFF programs and who were learning English and adjusting to a new cultural milieu, there was an additional educational aspect related to learning both the English language and the culture and customs of their new homeland,

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important to them for becoming more socially integrated (Morrice, 2007). Studies of lifelong learning opportunities for adults have identified similar psychological and social benefits for participants from engaging in learning activities (Hammond, 2004; Narushima, 2008).

Is it possible to practice "healthy eating" in the context of food insecurity? Not according to a recent pronouncement by Health Canada: "Food security is essential for healthy eating – without consistent economic access to sufficient nutritious food, healthy eating cannot be achieved, increasing the risk of poor health" (Health Canada, 2007, p. i). Tarasuk qualifies this idea a little by saying that "chronic food insecurity must pose a serious barrier to healthy eating" (2009, p. 215). For some CFF families, it can be assumed that food insecurity is chronic, since the CFF questionnaire found no change in their food security status over time in the program. For these families, in terms of food security, CFF can function as a "Level One" community food security program (Community Nutritionists Council of BC, 2004) – programs which distribute food in "emergency" situations but do nothing to change the underlying dynamics of the causes of food insecurity, as well as a transition/participation "Level Two" program. More is needed for these families, however, in terms of adding "Level Three" types of responses (e.g., government, policy, employment). All three levels of food security responses are necessary in today's socio-economic climate. From a critical perspective, education is also needed to bring people to consciousness about the social and economic aspects of food insecurity (Travers, 1997): "As long as nutrition educators place primary emphasis on changing individuals without consideration of their social context, the potential exists for victim blaming" (Travers, 1997, p. 59).

Although it is clear in the literature that household food insecurity is correlated with inadequate household income, it is not clear that increasing families' income in the absence of improving aspects of other determinants of health will automatically improve their nutrition. For example, Power (2005, p. S37) suggests that without changes to improve low-income families'

lives *and* improvement in the level of nutrition in the general population (changes in norms, availability, accessibility, etc.), it will be difficult to improve low-income Canadians' nutrition. CFF is a program that positively addresses changes in norms and potentially addresses children's accessibility to healthy food at home if parents are able to access the needed supplies, but minimally addresses availability issues related to poverty and inadequate income to purchase healthy foods.

5.4.2 Perceived health promotion benefits

As noted in Chapter 2, creating supportive environments, strengthening social networks and enhancing health literacy are presently the three highest priority areas for strategic action in health promotion (Mittelmark et al., 2008b), aimed towards the ultimate health promotion goals of supporting empowerment, autonomy and people's control over the determinants of their health. The creation of a supportive environment for parents within the inner city schools is part of the mandate of Vancouver's Inner City Schools Project, with the ultimate rationale of enhancing the health and learning outcomes of inner city students. CFF programs are one of the strategies for enacting this mandate. They are themselves supportive environments for learning and for social integration. Many CFF study respondents perceived that the social context of the programs was equally important as the educational component and that the two were inseparable in that they worked together to produce the program benefits. The intent of the CFF programs is to build an environment that supports "healthy lifestyles" (Frohlich & Potvin, 1999; Frohlich, Corin & Potvin, 2001; Lyons & Langille, 2000). CFF programs support an expanded concept of lifestyles – that a healthy lifestyle depends not only on personal skills, attitudes, and behaviours, but also on the social contexts in which people live and the relationships they have within these contexts (i.e., the environment).

Participants in the CFF programs were intentionally exposed to a wider number and variety of new people than those in a typical collective kitchen program, providing increased opportunities for building social networks. The staff also made efforts to facilitate the creation of supportive relationships with the participants and among the participants themselves. The situatedness of most of the CFF programs in schools provided opportunities for parents to become part of the fabric of their children's schools. The opportunity to interact socially with a broader segment of the culture is critical to new immigrants and the socially excluded (Morrice, 2007). It acquaints them with the social interaction norms of other cultural groups, which can assist them in moving to social inclusion. If and when parents begin to attend school Parent Advisory Committee meetings and other school events, which attending CFF programs moves them towards, they get a better idea of the totality of what the school can offer their children. These offerings are sometimes more intangible than the classroom teaching that occurs, since education also involves becoming a part of a social context, important in helping children establish themselves in the mainstream culture. What is also important is for parents and their children to be part of the same social context. This is facilitated by parents and children developing closer relationships with their neighbours, providing them the opportunity to live in a more socially-cohesive neighbourhood (Teasdale & Silver, 2009).

Enhancing health literacy is a new area of focus in health promotion that has not been discussed in previous evaluations of community kitchens. Health literacy is a concept that is still in the process of development. Recently, the formulation of the ideas contained in the term health literacy has expanded from a focus on skills and attributes needed for navigating the health care (illness care) system to a broader focus on skills and attributes needed to enact disease prevention and health promotion actions for achieving and maintaining health (Nutbeam, 2008). St. Leger and Nutbeam (2000) developed a model for organizing education and health goals, with learning outcomes, for health literacy. The four broad categories of learning

outcomes in this model are "lifelong learning," "competencies and behaviours," "specific cognate knowledge and skills," and "self attributes" (St. Leger & Nutbeam, 2000, pp. 46-47). Nutbeam's more recently conceived "conceptual model of *health literacy as an asset*" (2008, p. 2076) is a useful tool for understanding the perceived benefits of the CFF programs within the framework of the earlier model developed by St. Leger and Nutbeam. In the conceptual model of health literacy as an asset for health, Nutbeam (2008) incorporates the last three of the learning outcomes from the previous model into three new outcome categories labeled "developed knowledge and capability" (i.e., development of relevant personal knowledge and capability), "skills in negotiation and self management" (i.e., interpersonal skills) and "skills in social organization and advocacy" (i.e., social skills) (Nutbeam, 2008, p. 2076). These three learning outcomes related to health literacy as an asset are called *aspects* of health literacy in this discussion of perceived benefits of CFF programs. The newly-conceptualized aspects of health literacy have been expanded to include more explicit reference to the higher *levels* of health literacy, the interactive and critical levels,[29] as Nutbeam now advocates for recognition of the potential scope for applying health literacy skills towards social action for emancipatory change (2008). These three *aspects* of health literacy as an asset and the three *levels* of health literacy can be used in interpreting the perceived benefits of the CFF programs (please see Table 12).

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[29] The three levels of health literacy are "basic/functional," "communicative/interactive," and "critical" (Nutbeam, 2000a, pp. 263-4). Functional health literacy involves skills needed "to be able to function effectively in everyday situations (Nutbeam, 2008, p. 2075);" communicative/ interactive health literacy involves "more advanced cognitive and literacy skills which can be used to actively participate in everyday activities and to apply new information to changing circumstances (p. 2075)," and critical health literacy skills involve "the most advanced cognitive skills which can be applied to critically analyze information, and to use this information to exert greater control over life events and situations (p. 2075)."

Table 12: Aspects and levels of health literacy: Examples of perceived benefits (health education/promotion outcomes) of attending "Cooking Fun for Families" (CFF) Programs*

Levels of health literacy**	Aspects of health literacy*** (health education outcomes)		
	Developed knowledge and capability	Skills in negotiation and self-management	Skills in social organization and advocacy
Functional	Basic healthy food choice and food preparation knowledge and skills	Development or reinforcement of a positive attitude towards learning	Parents learning to organize and plan (to take responsibility) for CFF weekly sessions with staff
Communicative / interactive	Learning knowledge, recipes and skills from different countries and cultures	Feelings of self-efficacy, self-confidence and motivation to provide healthy low-cost meals to families	Parents becoming part of social networks to give and receive various forms of social support
Critical	Learning how to get the most benefit from what is accessible (e.g., how to use food from the food bank)	Parents encouraging and motivating their children to make healthy food choices	Parents' willingness to advocate for children's educational needs with schools

*Table 12 includes one example of a perceived benefit for each level and aspect of health literacy related to attending CFF programs. More examples are found in the discussion below.
**Levels of literacy (Freebody and Luke, 1990, as cited in Nutbeam, 2000a)
***Aspects of health literacy (Nutbeam, 2008)

In the area of food and nutrition-related learning, there were skills and competencies developed in the first and second aspects, but not the third (social organization and advocacy). The development of the *aspect* of personal knowledge and capability at the first *level* of health literacy, basic or functional health literacy, is supported by the opportunities for CFF participants to learn, if they need to, basic knowledge and skills for making food choices and preparing and serving healthy foods. Some related specifics at this level that participants may benefit from working towards, according to their needs, are reading and understanding recipes and food labels; reading, measuring and substituting in recipes; safe food handling; nutrition knowledge;

and cost-saving techniques such as preparing meals from basic ingredients. The development of personal knowledge and capability at the next *level* of health literacy, communicative/interactive health literacy, can also be related to perceived food- and nutrition-related benefits of CFF programs. These would include learning knowledge, recipes and skills from different countries and cultures, and maintaining a behavioural focus on nutrition and healthier eating. The development of personal knowledge and capability at the third *level* of health literacy, critical health literacy, involving "more advanced cognitive skills, which, together with social skills, can be applied to critically analyze information, and to use this information to exert greater control over life events and situations" (Nutbeam, 2000a, p. 264), is realized as a capability regarding food and nutrition by parents learning how to make use of food from the food bank, how to stretch their food dollars, and how to get the most benefit from what they have accessible to them; in other words, by increased capability to manage and cope with limited financial resources.

Turning to the second *aspect* or building block of health literacy, skills in negotiation and self-management, at the second, communicative/interactive health literacy *level* would include developing feelings of self-efficacy, self-confidence and motivation for implementing what one has been learning; support for a positive attitude towards lifelong learning; activities related to the programs that parents do with their families, such as bringing new foods home for their families to try and serving their families healthy foods as much as possible; and motivation and commitment to teach one's children food and nutrition-related skills, to make food a communal part of everyday home life, and to motivate and encourage one's children to make healthy food choices. Critical health literacy for this aspect is realized as skills in self-negotiation and self-management through parents and children being willing to learn new nutrition information and to try new healthy foods, and by parents, having acquired more knowledge and understanding, now applying their skills in encouraging and motivating their children to eat healthy foods.

The social and psychological perceived benefits of CFF programs occurred within the skills in "negotiation and self-management" and "social organization and advocacy" *aspects* of health literacy (Nutbeam, 2000a, 2008), rather than within the development of personal knowledge and capability. Basic or functional skills in negotiation and self-management include a positive attitude towards learning; a sense of accomplishment; relief from isolation, loneliness, boredom, frustration and personal problems; and enjoyment, happiness and fun, contributing to a sense of well-being. For some participants, they also include learning and practicing English language skills. At the communicative/interactive *level*, the negotiation and self-management *aspects* of participants' health literacy is enhanced by engaging with others in the programs, which facilitates the development of social support and social integration among participants, including with people from different cultures and backgrounds; feelings of belonging to the group and the school and community; a sense of pride in one's culture; and knowledge about other cultures. The third *aspect* of health literacy, skills in social organization and advocacy is evident at all three *levels* of health literacy in CFF programs. At the functional level, participants organizing, along with staff, the sequence of weekly program activities, and planning for future sessions, constitutes participating in learning and practicing basic social organizational skills. Communicative/ interactive health literacy is facilitated by participants' willingness and ability to become part of social support networks and to give and receive social support, by developing relationships with people from other cultures, and by gaining access to other resources. Critical health literacy skills in social organization and advocacy include, for some, new relationships with their children's teachers and better understanding of the school system and how to help their children and advocate for their educational needs; learning to work with a team and increased tolerance for and patience with others; deepened relationships with schools, community centres, and the community; and building community, being part of a community, having a place in the community, and a sense of responsibility, desire and willingness to actively engage with one's

school and community. This level of health literacy is often described as community empowerment in the literature (Tones, 2002), and was recently described by Nutbeam as "enabling individuals to exert greater control over their health and the range of personal, social and environmental determinants of health" (Nutbeam, 2008, p. 2074). The perceived psychosocial benefits of CFF programs qualify the programs as being health promoting (Cohen, Gottlieb, & Underwood, 2000; Heaney & Israel, 1997), in the sense of promoting positive health and well-being. The positive health movement extends the meaning of health to include, for example, "diverse aspects of flourishing, such as leading a meaningful and purposeful life as well as having quality ties to others" (Ryff & Singer, 2000, p. 30).

The idea that "any communication practice that enables a person to function effectively in their local social and cultural contexts and participate in decisions that affect them must also be understood as literacy" (Nason & Whitty, 2004, p. 3) supports the use of Nutbeam's (2008) conceptual model of *health literacy as an asset* for planning and evaluating health promotion programs. CFF provides its adult participants with an opportunity for informal lifelong learning, important for increased literacy and health literacy for those beyond public school age (Morrice, 2007; Narushima, 2008). Paying attention to a cross-cultural understanding of health literacy, as suggested by Aboriginal writers Antone (2004) and Battiste (1984) (as cited in Ronson & Rootman, 2009), the types of health literacy supported by CFF programs truly "are more reflective of culture and context than of formal instruction" (Battiste, 2004, as cited in Ronson & Rootman, 2009, p. 174). Culture is front and centre and is celebrated in CFF programs, where preparing food and eating together is a holistic event. The First Nations participants, who included singing and drumming along with food preparation and eating, showed that our relationship with food is meant to feed the mental, emotional and spiritual sides of people, as well as the physical.

Children who attended CFF programs in any capacity were exposed to a wider variety of healthy foods than they would otherwise have been. For children whose parents involved them in food preparation at home, as a number of CFF participants reported they were doing, there are long-range potential benefits as children learn to take control over their food-related activities and behaviour, giving them more choices. The research literature regarding school-based interventions to improve children's food choices and dietary behaviours (usually focused on increasing children's fruit and vegetable intakes) shows that it is very difficult to improve children's dietary behaviour with school-based programs that target only children, even if they follow current principles of nutrition education. These principles include exposure and active involvement with food preparation as well as strategies that address cognitive and affective domains (see, for example, the "Cookshop Program" [Liquori, Koch, Contento, & Castle, 1998]). Some of the programs have a parent inclusion component, but CFF takes the parent inclusion focus much farther, to where it becomes the main strategy for improving children's diets. The parent inclusion component in most of the school-based programs reviewed in the literature mainly involves reading written materials. Relying on written materials (i.e., knowledge) to motivate and facilitate behaviour change has limitations generally. and may be even less effective with low-income families that often have low levels of literacy, or low levels of literacy in English (Travers, 2001). Participation in CFF does not require a high literacy level, as do many interventions aimed at increasing the population's level of healthy eating. CFF can be delivered to people with little or no English (others – friends – interpret for them when needed) and to people who speak English but do not read it at a high level of competence, or even at all. It is also possible for people who do not have (e.g., cannot afford) tools such as measuring spoons and cups to learn how to reproduce recipes by attending CFF programs. This is accomplished through the very personalized demonstration and explanation strategies used in the programs. The school-based interventions for children also do not usually achieve enough

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facilitated repeated exposure for children to become accepting of new foods – it can take up to 10 or more times of trying a food before children express a preference for it (Cooke, 2004; Nicklas et al., 2001). It is likely that only parents have enough time, motivation and perseverance to present new foods repeatedly until children accept them. Low-income parents may also need material support to keep offering new foods during the time period when children reject them, and CFF provides some of this.

5.4.3   Summary and Conclusions

Cooking Fun for Families offers an environment where families can get to know each other and build friendships, trust, relationships with, and security in their schools and communities, while at the same time increasing their exposure to new healthy foods and their knowledge, skills and abilities, and motivation to eat in a healthy manner. These characteristics of CFF programs identify it as being a health promotion program that implements the current priority actions of health promotion. The program provides a supportive environment, encourages and enables increasing social networks, and contributes to the development of health literacy related to healthy eating. From a nutrition perspective, CFF can be seen as a dual-focus transitional food security program that provides a necessary supportive social context for its food-related activities, making participation in the program a holistic and meaningful experience for impoverished inner city families. It is a move away from disempowering charity-based programs, but at the same time, it isn't able to resolve issues of poverty and food insecurity that its clientele are living with.

CFF programs are a combination of health education and health promotion. The health promotion aspects of the programs reflect a variety of phases of health promotion – behaviour change, inclusion of environmental (social) influences, community development relating to the school environment (Dwyer, 1997), and, to a limited extent, intersectorality, interdisciplinarity,

and interorganizationality (Green & Kreuter, 1991). They do the latter by weaving together institutions involved in education (schools), recreational programming (community centres), and health (health department/ nutritionists), while appealing to a variety of community organizations to provide the funding. They contribute to personal autonomy by providing a venue where participants can choose the focus and depth of their involvement, contribute labour, learn, socialize, build support networks, plan and facilitate at program sessions, branch out into the school and community, and partake of the food. For the most part, there is little pressure to achieve any goal imposed from outside oneself, and every effort is made by the programs to provide a positive, accepting and nurturing atmosphere. Although some program leaders encourage changing food and nutrition behaviour at home more than others, there is no requirement for this. The parents understand that by developing healthy eating habits now, their children will be enabled to live healthier and more productive lives. The programs' focus on well-being is manifested as concern with participants' whole lives and the provision of an environment where respect and mutual concern are nourished.

The CFF programs thus were perceived to have short-term and potential longer-term social and educational benefits. They did not, however, show political or economic impacts for participating families. Some participants formed groups that perhaps began to move towards social action, but this was not an explicit or implicit goal of the programs. Although some staff, in particular, showed awareness of the social causes and inherent unfairness of nutritional inequities, there was no guidance for or overt action towards positioning the programs to provide either a critical perspective on nutrition education or political action towards social justice goals (Travers, 1997). Engler-Stringer and Berenbaum (2006) similarly found a lack of political perspective regarding nutritional inequities in the collective kitchen programs they studied in English-speaking Canada, and while they did find a political perspective embedded into the collective kitchens model and movement in Quebec, it did not seem to lead to positive social

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gains. The goals stated in the CFF Program Handbook and by the CFF program constituents were focussed on benefits to individuals and families, mostly in the area of healthy eating, that could conceivably be achieved without addressing the larger social system within which the participants were embedded, but this would depend on the participants having access to sufficient resources with which to purchase adequate amounts and quality of food, which some of them did not. Nevertheless, small groups in which the participants developed trust in each other had the potential of becoming politically active, especially within their schools, but also potentially beyond the schools into the wider community. This would be called community empowerment (Laverack, 2004), and remained at the level of a potentiality for CFF programs, but was noted as a benefit in some community (collective) kitchens evaluations (Engler-Stringer & Berenbaum, 2005; Ripatt, 1998). Empowerment and community empowerment develop along a continuum, from "personal action, small mutual groups, community organizations, partnerships, [to] social and political action" (Laverack, 2004, p. 48). CFF programs are at the beginning end of the continuum, but hold the potential for developing community action over the long term.

Chapter 6: Integration and Conclusions

The main goal of health promotion is to promote empowerment, autonomy and people's control over the determinants of their health. With vulnerable citizens this may need to include development of a sense of efficacy and support for developing the motivation to take action, along with relevant needed skills and competencies. Small community-based health promotion programs may be optimally positioned to provide the personalized, tailored support needed to accomplish these goals. This study examined one such program to ascertain what types of health promotion benefits it was perceived as providing for its clients, and to gain understanding of the program structure and processes that enabled it to accomplish these ends. The study adds to theoretical and practical knowledge about small community-based health promotion programs for vulnerable groups. Although the program, Cooking Fun for Families (CFF), was focused on food and nutrition activities and functioned in a context of participant vulnerability and food insecurity, it addressed these issues within the broad framework of health promotion and is examined within that framework in this study. Using the Cooking Fun for Families program for illustration, the study raises and attempts to answer several questions pertaining to small community-based health promotion programs for vulnerable population groups, as illustrated by the program examined in this study: What are the unique values of these types of programs for these vulnerable groups? How can programs like CFF be interpreted within a health promotion framework and health promotion theory? What is especially different and valuable about this program having arisen and been implemented in a school setting? And what kinds of limitations are inherent in these types of programs? In this chapter, I will address each of these questions in turn, review the study strengths and limitations, and present the implications of the study findings for research, policy and practice.

6.1 Review and integration of the perceived benefits/value of the CFF programs

The main perceived benefits of the CFF programs clustered into the two main theoretical areas of the study, food- and nutrition-related and psychosocial benefits. The two types of perceived benefits were interrelated and supported each other. To show the interrelationships among the perceived benefits of the CFF programs suggested by the study findings, they are presented schematically in Figure 2. Figure 2 includes several constructs relevant to understanding the study findings, including positive health/ psychological well-being as one of the main perceived outcomes, healthy-eating literacy skills and competencies and healthy eating behaviours, and constructs related to psychological states and social interactions.

Analysis of the perceived benefits of the CFF programs, as presented in Figure 2, suggests that one of the most important changes brought about by the programs for many of the adult participants was an increase in psychosocial well-being or positive health. Positive health is a state of well-being that supports both mental and physical health: "The core hypothesis of positive health … is that the experience of well-being contributes to the effective functioning of multiple biological systems, which may help keep the organism from succumbing to disease, or, when illness or adversity occurs, may help promote rapid recovery" (Ryff, Singer & Dienberg Love, 2004, p. 1383). The notion of positive health or psychological well-being, supported by the World Health Organization's definition of health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (Czeresnia & Soares, 2008, p. 134), has been related to six contributing factors: self acceptance, positive relations with others, autonomy, environmental mastery, personal growth and purpose in life (Ryff, Singer & Dienberg Love, 2004, as cited in Lundberg, 2008, p. 249). The constructs of being able to cope with stressful situations, a strong social support system, and integration into the community, associated with positive health (as defined by Bowling, 1991, as cited in Locker and Gibson, 2006, p. 168), are reflected in the goals and perceived benefits noted in this study.
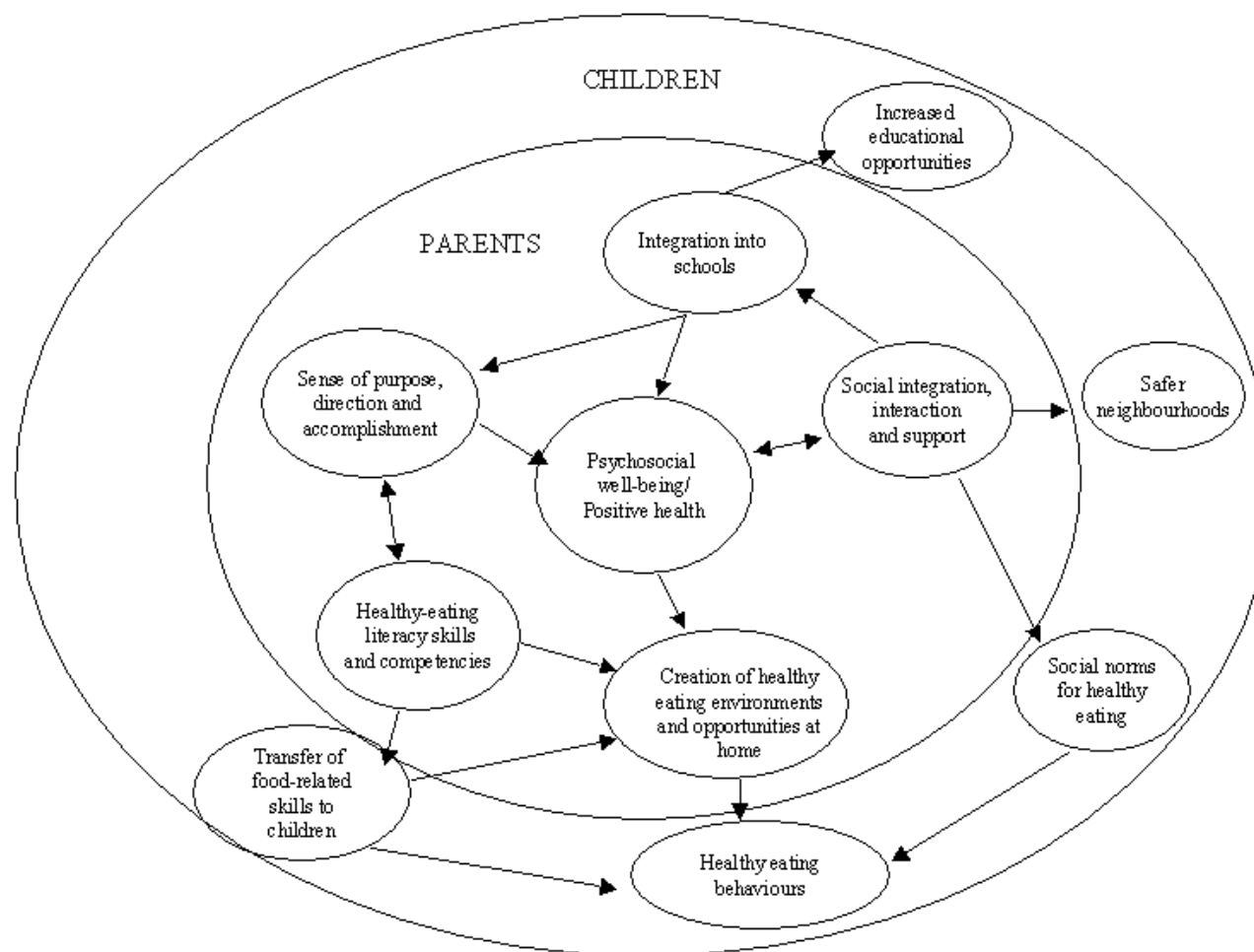
Figure 2: Perceived Benefits to Parents who attended CFF, and Perceived Benefits to their Children

Figure 2 suggests that the development of psychological states and social interactions, such as a sense of purpose, direction and accomplishment, and social integration, interaction, and mutual support, contributed to psychosocial well-being/ positive health for adult CFF participants. The development of a sense of purpose, direction and accomplishment also supported and was supported by the development and acquisition of healthy-eating literacy skills and competencies and healthy eating behaviours. For adults, the development of healthy-eating literacy skills and competencies facilitated the transfer of similar skills to children. The combination of psychosocial well-being/ positive health and healthy-eating literacy skills and competencies influenced the eating environment at home by producing more healthy eating opportunities at home. The transfer of food-related skills to children also had a feedback effect of increasing the creation of healthy eating environments and opportunities at home. The program was perceived as positively influencing the attitudes of children who attended, through the fostering of positive social norms, towards trying new, healthy foods, and requesting them at home. For children who did not attend, many parents said that as they began to more fully involve their children in food preparation activities at home, their children were positively influenced in trying and consuming healthy foods. A spin-off perceived psychosocial benefit for adults was increased integration into their children's schools. For adults, the increased integration into the schools provided opportunities for more social integration, interaction and support, further sense of accomplishment, purpose and direction related to a variety of new roles and responsibilities, and increased psychological well-being/ positive health. This also supported increased educational opportunities for children. The social integration was perceived to ultimately contribute to safer, more tightly-knit neighbourhoods.

6.2 Interpreting CFF from a health promotion perspective

To understand the meaning of the CFF program from a health promotion perspective, it is necessary to articulate the framework of health promotion theory within which the program is being examined. As reviewed in Chapters 1 & 2, health promotion theory outlines both the targets of health promotion and the appropriate methods for reaching those targets. The aims and goals of health promotion include capacity-building, empowerment, and the use of a participatory approach to engage and activate people, especially vulnerable people, towards having a sense of agency – the conviction that they are able to take action that will positively affect their lives. The ultimate aim of health promotion is to reduce health inequities in society, tackling particularly those inequities that arise from social injustices such as discriminating practices based on race, gender and culture (Mittelmark, Kickbusch, Rootman, Scriven & Tones, 2008a, p. 226). The current priority areas in health promotion in working towards its broad goals are to enhance health literacy, create supportive environments and strengthen social networks (Mittelmark, Kickbusch, Rootman, Scriven & Tones, 2008b). These aims differentiate health promotion from the related field of disease prevention, since they are not aimed at preventing or ameliorating a specific disease state, but rather at strengthening and reinforcing the broader factors that support health generally and that speak to the notion of positive health and well-being.

An organizing framework currently employed for examining the impact of health promotion programs by linking health promotion actions to various levels of health promotion and health outcomes is the Outcome Model for Health Promotion (Nutbeam, 2000a, p. 262) (see Figure 1, p. 7). The next sections examine the CFF program in terms of each level of health promotion actions and outcomes in the Outcome Model for Health Promotion.

6.2.1   Health promotion actions

The structure and approach, actions and activities of CFF programs, detailed in Chapter 4, can be examined in relation to the health promotion *actions* noted in the Outcome Model for Health Promotion. CFF activities were primarily education and social mobilization (in terms of increasing social networks and supporting social relationships). Part of the educational approach was the creation of a supportive environment for parents within the school and the program (an intermediate health outcome that leads more directly to health and social outcomes in the model, but that was also facilitative of the educational outcomes). The rationale and structure of the CFF programs reflect the clientele's needs. The programs advocate for healthy eating in a poor population in which every purchase of food needs to contribute to health. They concentrate on educating and motivating parents to provide healthy foods to their families and are a forum for discussion and feedback regarding strategies for accomplishing these goals. The program model is built on research that suggests that parents are highly influential in determining their children's food choices. However, the programs are not didactic, but provide a place where parents are encouraged and supported to act on their families' behalf. Health promotion theory suggests that active participation in areas of interest and motivation can lead to involvement in problem-solving, decision-making, gaining personal competencies, gaining self-efficacy and self-confidence, and building a healthy and satisfying lifestyle. The active learning approach taken by adult education and nutrition education programs for vulnerable populations meshes with the health promotion literature on "participation," which shows that active participation is more empowering than a passive attitude of receiving. For example, VanderPlaat (1998) argued that "the emancipatory 'moment,' or critical fulcrum in empowerment oriented interventions, lies in the emphasis on group participation and mutual support [and argues that] it is here that one finds

the legitimate starting point for the construction of an emancipatory approach to social intervention" (VanderPlaat, 1998, p. 72).

Education, producing a variety of types of literacies, can work towards ameliorating a lack of resources and opportunities. The overarching goal of health education is emancipatory and empowering (Nutbeam, 2000a). Equalizing opportunities for healthy eating for vulnerable families, such as participants of CFF programs, means providing programs that incorporate strategies that work for them, such as activities that do not depend on the ability to speak or read English, or for others who lack purchasing power, activities that teach how to measure without tools, how to substitute in recipes, and how to put together a meal with what is on hand. For some participants, the programs must also include encouragement and motivation to make the effort to try to eat as well as possible in the difficult circumstances they are in. Since the behavioural objective of healthy eating is, as are many determinants of health, embedded in a complex network of supporting and detracting factors, factors that facilitate the desired behaviour, such as the social and psychological factors found in CFF, should be included as an integral part of these types of programs.

While the strategies that were discussed in Chapter 4 were based on nutrition education and adult education principles, they are also health promotion activities. Specific features of the structure, approach, actions and activities of CFF programs helped to achieve its perceived benefits: the small, intimate, inclusive, engaging, sensitive and non-threatening nature of the CFF programs supported the development of attributes of positive health, such as a sense of belonging and a sense of purpose and accomplishment.

The integration of psychological and social factors with the healthy-eating literacy skills and competencies that attending the program develops, illustrated in Figure 2, supports a broad conceptualization of education and its integration with social mobilization. Without the cognitive, social and emotional levels of engagement achieved by the program, the development

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of the skills and competencies would be disconnected and meaningless. It is possible that a more directly focused program could accomplish more in terms of education, but what would be traded off would be sensitivity to parents' vulnerability other, psychosocial needs. A comment made by one of the staff illustrates awareness of this issue. She pointed out that it would seem intrusive if she were to just "educate" the parents, i.e., tell them what to do; that what was needed, as a strategy, was to be talking to them as a friend. For that to happen, she needed to know them, to have developed a relaxed, trusting relationship with them, which took time and sensitivity.

It is possible and likely that the kinds of activities needed to build the type of learning environment needed for this type of vulnerable population are best accomplished through a very client-oriented, tailored, flexible type of intervention. A ground-up program will naturally include health promotion strategies. This small school/community-based health promotion program, implemented at the ground level with very little oversight of or direction to the implementers, is an example of how the health promotion tenets of increasing health literacy, supportive environments and social networks are naturally reflected in a program developed by within-organization staff, in ways that they think best, with sensitivity to and in conjunction with the clientele it targets. The type of support this provides can't be mandated ahead of time as to how to do it or what exactly to do, because it is based on understanding the changing needs of the clientele and working with the clientele to meet them.

6.2.2 Health promotion outcomes

In the Outcome Model for Health Promotion, health promotion *actions* are linked to *health promotion outcomes* (such as educational outcomes, as distinguishable from intermediate health outcomes that would be the end result of the application of the educational outocmes). The health promotion perceived benefits/outcomes of the CFF programs were presented in Chapter 5.

Of the three types of health promotion outcomes in the Outcome Model, those that were identified as perceived benefits of CFF programs included health literacy and, to a lesser extent, social action and influence (in terms of the development of increased social networks and social support and the creation of healthy-eating norms among participating families). The three current foci of health promotion (directives to increase health literacy, expand social networks and provide supportive environments), as strategies and directions, worked together to produce the perceived benefits (health promotion outcomes) in CFF programs. First and foremost, CFF programs support the development of literacy, notably health/ healthy-eating literacy. The current focus within the educational system on supporting the development of personal capacity through "lifelong learning" highlights the importance of literacy as a resource for health, well-being and life opportunities. Life-long learning capacity and opportunities are especially critical for people belonging to vulnerable populations if they are going to be able to better their situations and achieve equitable levels of health and well-being. Literacy skills are now considered necessary for the process of empowerment to take place: "Literacy education contributes to the development of self knowledge and critical thinking skills. In turn, this development empowers individuals and communities" (Ontario Ministry of Education, as cited in Ronson and Rootman, 2004, p. 167). Support for literacy is the overriding goal of Vancouver's Inner City Schools Project, and CFF programs support this goal.

Participants developed a variety of health literacy skills and competencies relating to healthy eating through attending the programs. The positive health attributes were integrated with the healthy-eating literacy aspects of the programs and cannot be separated from them. Some of the skills and states are components of health literacy in that they can be applied to behaviour change facilitating healthy food choices/ healthy eating, while others, such as social support and increased feelings of happiness can have both an indirect effect on health and well-being through their supporting roles in facilitating health literacy, as well as a direct supporting

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relationship to health and well-being. Healthy lifestyles, in turn, facilitate health and quality of life. Psychosocial outcomes of health education and health promotion programs can also influence health and quality of life directly, independently of health literacy.

6.2.3   Anticipated intermediate and long term benefits

While the naturalistic context and short-term nature of the CFF programs does not allow for measurement of longer term outcomes of the program, the Outcome Model for Health Promotion suggests that the types of health promotion outcomes demonstrated in this study are linked to higher level, intermediate health outcomes, confirmed by evidence gained from health promotion research. Healthy lifestyles and healthy environments, both intermediate health outcomes or modifiable determinants of health in the Outcome Model, are now seen as co-occuring (Frohlich & Potvin, 1999; Frohlich, Corin, & Potvin, 2001; Lyons & Langille, 2000). In this study, social environments, identifiable as patterns of social support and the creation of new social norms, support the enhancement of lifestyle elements; in this case, healthy eating. In fact, the physical, psychological and social elements of the current multifaceted construction of lifestyle as identified by Lyons and Langille (2000), including "effective coping, lifelong learning, safety and security precautions, social activity and volunteering, and a sense of purpose and meaning, spirituality and hope" (p. 13), reflect the directions that attending CFF programs are perceived to produce for the program clientele, as presented in Chapter 5.

An increase in psycho-social well-being or positive health is among the ultimate outcomes in the Model. It is likely that this ultimate perceived outcome in this study was achieved by working through several levels in the model, from a focus on education (lifelong learning) to the acquisition of health literacy skills and competencies within a supportive social environment, to a positive change in collective lifestyle.

In summary, aside from the immediate psychosocial benefits experienced by participants, the social aspects of the CFF programs could potentially positively impact families in the longer term, as they become more connected with each other and with institutions in their communities. These connections could open doors to more information, and social and emotional support, and remove some of the barriers to social interaction and participation that are part of the social climate of inner city settings. These social and personal benefits could be understood as aspects of empowerment, defined by Labonte (1999, p. e2) as "personal, group and social aspects of power and capacity ranging from leadership, resources, and strengthened networks, to critical thinking, trusting relations, and increased group participation." Literature about community kitchens also mentions empowerment as a possibility – "[they] appear to be working toward personal empowerment and small group development, endeavoring to promote greater self-sufficiency and, in some cases, to foster a climate of mutual support among participants" (Tarasuk, 2001, p. 492). Of interest and relevance are the evaluations of Health Canada's Community Action Program for Children (CAP-C) programs in Atlantic Canada. VanderPlaat, Samson, and Raven (2001) found the most salient feature of the programs to be the autonomy and opportunities for action and interaction that they presented to participants. What happens "between the lines" in the programs – the group participation and social support, is the real strength of the programs (Vanderplaat, 1998). Her conclusion was that "a truly emancipatory politics of intervention might be judged appropriately by the extent to which it is capable of creating a communicative space for the articulation of needs and interests by those who might otherwise be excluded from the public domain" (VanderPlaat, 1998, p. 87). CFF programs function at a similar level, by creating a communicative space.

6.3 What is especially different and valuable about this program having arisen and been implemented in a school setting?

The fact that the CFF programs arose in, and most of them take place in schools is an integral aspect of the programs; the program could not exist as it is with the perceived benefits it generates if it did not operate within the school system. The school has been noted as an important setting for health promotion because some groups, particluarly children, are most easily accessed through this setting. In another way, though, the school is an important venue for this type of health promotion program in that having parents visibly involved in the school supports the health and well-being of the children. It supports education and literacy for children by giving the children a sense of continuity between the home and the school, inspiring them to value learning, and assisting the school to communicate with parents, furthering their attempts to work together with families to create supportive environments for their children's learning. Holding the CFF program in schools also sends a positive message to the community about the availability and accessibility of the schools in support of life-long learning, helping to realize inner city school principals' vision of their schools as learning communities "involving the kids and the adults and extending beyond the walls of the school" (Principal, School D), helping build capacity, independence, and the trust that strengthens the kinds of connections parents and students need with their schools.

The CFF program exists because of an important tenet of health promotion theory: partnerships. The program operates in an economic climate marked by substantial funding cuts to education and other social services (McBride, 2005). Partnerships between the schools and other agencies fill in gaps in funds and knowledge. The schools are unable to provide funds for purchase of the foods needed for the program; thus partnering between the schools and groups and organizations whose mission includes providing funds for this type of program is valuable. The schools are also unable to provide direction on the food-related content of the program

because they lack the needed expertise in nutrition; thus partnerships between health organizations and the schools are important. In conclusion, the fact that the program is embedded within the school system, particularly the inner city school system, with its great variety of resources that can be targeted where needed, its large contingent of politically aware, concerned and committed staff and administrators, and its symbolic meaning as a supremely important player in inner city families' lives and the future of their children, makes the complex interactions generated through the program possible.

6.4 Limitations of the CFF program model in relation to health promotion theory

Although there were many perceived benefits of the CFF programs in relation to aspects and levels of health literacy, the programs were unable to provide food- and nutrition-related perceived benefits within the third *aspect* of health literacy, skills in social organization and advocacy. This suggests that although CFF programs develop people's knowledge and capabilities related to food and nutrition, as well as developing some interpersonal skills and self-management, they do not address organization and advocacy in terms of food and nutrition. Similarly, CFF programs do not have perceived benefits related to all aspects of the Outcome Model for Health Promotion. They do not include advocacy-related actions, address policy and organizational practice, or have a direct relationship to health services. They cannot, therefore, address problems of, for example, food insecurity at a more fundamental policy level. The components of the Outcome Model for Health Promotion at which CFF does operate are an important part of health promotion strategies, but for full effectiveness and ultimate social change towards health equity, they must be combined with strategies at the advocacy and policy levels.

Recently, authors have distinguished between overcoming food insecurity and coping with food insecurity (McIntyre, 2004; McIntyre & Rondeau, 2009). Participation/transition

programs such as CFF may assist participants to cope with some aspects of food security by increasing the variety and quality of food they consume. The programs develop more of a sense of autonomy around food and food-related issues for the parents, such as how to encourage their children to make the healthier choices (partially done by incorporating their children as partners in the food selection and production milieu), and more food-related healthy-eating literacy for children. They promote more familiarity with food and with a wider variety of foods, and more skills and competencies, leading to increased food choices.

6.5 Study strengths and limitations

Limitations of qualitative studies, such as their inability to provide standardized, easy-to-replicate data, apply to this study. Because of the qualitative approach taken, participants' perceptions and impressions were elicited as opposed to perhaps more "objective" measures, such as an appraisal of knowledge and skills, size and quality of social networks, or calculation of people's food intakes. Because a significant percentage of the program participants did not speak English sufficiently to communicate verbally directly with me and had to communicate through a translator, a layer of uncertainty and possibly loss of data was added. The vulnerability of the study participants required that the research team spend several weeks with each group "getting to know them" before they were comfortable enough to participate in the study. This, as well as the fact that many of the participants had been in their programs for more than one term at the time the research was conducted, precluded the gathering of pre- and post-intervention data to measure change. Since the programs were on-going, while at the same time they were of a drop-in nature, it would have been logistically and theoretically impossible to collect standard pre- and post-test data.

The study possessed several strengths that balance the above limitations. It was characterized by immersion in the setting, extensive data collection, and triangulation due to the

employment of numerous data collection methods and instruments and a number of participant researchers. I was an experienced researcher in the setting, which facilitated entry into and understanding of the research field. The exploratory nature of the study generated a wealth of descriptive data that could not have been obtained otherwise, and facilitated the recognition of differences as well as commonalities of opinion and experience in response to the programs. The study was able to access a vulnerable multi-ethnic community population and give voice to their ideas and perceptions. The use of a translator/interpreter pleased and engaged the program participants and positively predisposed them towards the study, facilitating communication with otherwise difficult-to-reach program participants.

6.6 Strategic directions

The implications of this study for future directions can be divided into three areas, which relate to research, policy and practice.

6.6.1 Strategic directions for future research

The detailed findings of this study point to a number of areas in which valuable research could be conducted that would potentially assist vulnerable families with healthy eating and other health promotion outcomes such as positive health and social integration. More research is needed to examine how educational programs can work with parents to support and influence healthy eating patterns for vulnerable children and their families. Following up on the present research, more research is needed regarding how to assist vulnerable children and families to consume healthy diets. Further explication of the skills and competencies, along with their accompanying factors, needed to secure healthy-eating literacy for vulnerable inner city families would be useful, as would further research on how to assist families whose diets are transition (by choice or by necessity) to ensure the changes are towards healthy diets.

Research is also needed on how health promotion can assist vulnerable inner city families to move towards advocacy for policy solutions to the structural problems that keep them below the poverty line and enmeshed in food insecurity.

6.6.2   Strategic directions for policy

Much work remains to be done in terms of integrating parents into the school system as viable, functioning partners in their children's education. The findings of this research build on other research that suggests that integrating parents into school systems is potentially one of the most important future policy directions for education. More opportunities for this kind of educational and community-building program focused on family support and healthy eating could be provided within inner city school systems, with more positions such as the Neighbourhood Assistant positions in this study. Neighbourhood Assistants should be provided with sufficient funds to run these types of programs and with guidance, training and support, and a theoretical framework describing the scope and possibilities of the programs. Similarly, community centres in inner city neighbourhoods could provide comparable opportunities for education regarding awareness, skills and competencies for healthy eating and that include a similarly wide range of approach and format for supporting psychological and social support and integration.

Policies should be developed and implemented to reduce the high level of food insecurity in large inner city areas. Provincial governments should take the lead on implementing these policies, which should include providing social assistance and disability assistance rates that bring inner city families at least up to the poverty line; increased educational, training and retraining opportunities for unemployed family providers; and a combined wage and taxation system that provides all who are employed with adequate resources with which to live healthy lives.

Programs that work towards supporting vulnerable families, such as the Vancouver School Board's Inner City Schools Project, should be assured of funding continuation, and funding should be adequate to support the large variety of services that are essential to equalizing opportunities for health in inner city schools filled with vulnerable children and their families.

6.6.3   Strategic directions for practice

Building on this research, provision should be made to provide a more family-like eating situation for meals that are consumed at schools. More adults need to be involved during school meals to model family-like meals and to support and encourage children's healthy food choices, and involving family members in this role would likely have the most positive impact. At the same time, opportunities for physical activity should be increased and integrated throughout the school day, to support healthful physical and mental growth and stress management and reduction. Adults and parents from a variety of cultures should be involved in the above changes in ways that facilitate cultural integration and responsiveness to the needs of children from many cultures.

To build viable, safe and constructive communities within the multi-ethnic and poor inner city population, there should be continuation and expansion of programs wherein families from different cultures get together and get to know each other while sharing in interesting, meaningful activities, and where families from different cultures are exposed to different cultures' types of healthy food options. Advocacy activities should continue to press for solutions to the food insecurity and poverty that plague many vulnerable inner city families.

In terms of the development of similar programs, to assist staff in presenting this type of ground-up program, the following aspects of programs could be given attention: a set of program protocols and standards; an educational curriculum for participating children; a staff job description and training protocol; identification of sources of support for staff, including

nutrition information and psycho-social resources; and development of a collective kitchen program that would serve as a follow-up program, enabling participants to graduate to a supportive nutrition-related program that was less intensively facilitated and therefore less expensive to provide.

Similarly, administrative functions that would be useful for these types of programs include: someone to coordinate fundraising and liaising with the community for other resources for the programs and for participants, communication with potential participants, overseeing and supporting staff, communication and recruitment of outside support staff such as counsellors and multi-cultural workers, establishing program standards, and overseeing other development work on the programs.

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Appendix A: UBC Certificates of Approval

The University of British Columbia
Office of Research Services and Administration
Behavioural Research Ethics Board

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	NUMBER
Levy Milne, R.	Family & Nutr Sci	B01-0173

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT
Public Schools ,

CO-INVESTIGATORS:
Milligan, Carol, Health Care/Epidemiology

SPONSORING AGENCIES
Social Sciences & Humanities Research Council

TITLE:
Evaluation of the "Cooking Fun for Families" Program: Skill and Community Building Program for Inner-City Parents and Their Children

APPROVAL DATE	TERM (YEARS)	AMENDMENT:	AMENDMENT APPROVED:
APR 1 2 2001	1		

CERTIFICATION:

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval of the Behavioural Research Ethics Board by one of:
Dr. Paul Hewitt, Chair
Dr. R. D. Spratley, Director, Research Services

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures

The University of British Columbia
Office of Research Services and Administration
Behavioural Research Ethics Board

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	NUMBER
Levy Milne, R.	Family & Nutr Sci	**B01-0173**

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT
Public Schools , UBC Campus,

CO-INVESTIGATORS:
Milligan, Carol, Health Care/Epidemiology

SPONSORING AGENCIES
Social Sciences & Humanities Research Council

TITLE:
Evaluation of the 'Cooking Fun for Families' Program: Skill and Community Building Program for Inner-City Parents and Their Children

APPROVAL RENEWED DATE	TERM (YEARS)	AMENDMENT:	AMENDMENT APPROVED:
APR 2 4 2002	1		

CERTIFICATION:

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval of the Behavioural Research Ethics Board by:
Dr. James Frankish, Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures

The University of British Columbia
Office of Research Services and Administration
Behavioural Research Ethics Board

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	NUMBER
Levy Milne, R.	Family & Nutr Sci	B01-0173

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT

Public Schools , UBC Campus,

CO-INVESTIGATORS:

Milligan, Carol, Health Care/Epidemiology

SPONSORING AGENCIES

Social Sciences & Humanities Research Council

TITLE:

Evaluation of the "Cooking Fun for Families" Program: Skill and Community Building Program for Inner-City Parents and Their Children

APPROVAL RENEWED DATE	TERM (YEARS)	
MAY -2 2003	1	

CERTIFICATION:

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval of the Behavioural Research Ethics Board by one of the following:
Dr. James Frankish, Chair,
Dr. Cay Holbrook, Associate Chair,
Dr. Joe Belanger, Associate Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures

Vancouver School Board
School District No. 39 (Vancouver)

DISTRICT LEARNING SERVICES
1580 West Broadway
Vancouver, B.C.   V6J 5K8
Telephone: (604) 713-5000
Fax: (604) 713-5244

2000 October 11

TO WHOM IT MAY CONCERN!

Re: **Approval for the "Evaluation of the Cooking Fun for Families Program" Research Project**

On behalf of the Vancouver School Board, I am pleased to provide approval in principle for the research project "Evaluation of the Cooking Fun for Families Program".

It would indeed be mutually beneficial to obtain an assessment of the impact this nutrition education program has made on parents and children in inner city schools. It would also be helpful to ascertain if the original objectives of increasing families' nutrition and well-being; enhancing food security; addressing social support and isolation; and facilitating school bonding, have been met.

The Vancouver School Board would appreciate it if the results of the study could be shared upon its completion.

My very best wishes for the success of the project.

Sincerely,

Valerie Overgaard, PhD
Associate Superintendent, Learning Services

3rd Floor—520 West 6th Avenue   Telephone   (604) 714-3760
Vancouver, BC Canada V5Z 3X5   Facsimile   (604) 874-4562

June 12, 2001

Vancouver/Richmond Health Board

Working Together for Better Health

Dr. Ryna Levy Milne
Room 230, Food, Nutrition and Health Building
University of British Columbia
2205 East Mall
Vancouver, BC V6T 1Z4

Re: Evaluation of the "Cooking Fun for Families" Program: A Skill- and Community-Building Program for Inner-City Parents and their Children

Dear Dr. Milne,

Thank you for your submission concerning the above-named research proposal.

I am pleased to advise you that your proposal, as outlined, meets V/RHB standards for ethics, relevance, feasibility and validity.

I have included a copy of our confidentiality statement and a confidentiality agreement. I would like you to read the policy, sign the agreement and return the original to me by mail.

I would appreciate receiving a copy of the results of your study when it is complete. In the event that you prepare a manuscript to submit for publication we would appreciate the opportunity to look the paper over prior to submission. Finally, this approval is for the project as described in the materials you have sent us. If you make any substantive changes in your research protocol, please contact me.

I would like to take this opportunity to wish you a very productive and personally rewarding research experience at the V/RHB. I have been designated as your contact person in connection with this project so, if you have any questions or difficulties in conducting your research at the V/RHB feel free to contact me directly.

Yours truly,

Ron Peters
Director of Research & Policy Analysis

cc: Barbara Crocker

C:\program files\eudora\attach\01 Crocker Approval.doc

THE UNIVERSITY OF BRITISH COLUMBIA

Food, Nutrition and Health
Faculty of Agricultural Sciences
2205 East Mall
Vancouver, B.C. Canada V6T 1Z4

Ryna Levy Milne, PhD, RDN
Assistant Professor of Nutrition
Tel: (604) 822-6869
Fax: (604) 822-5143

"Cooking Fun for Families" Program
Research Evaluation

"Cooking Fun for Families" is a nutrition education and health promotion program for families. The program was developed from 1994-1997 with parents, students, teachers and other school staff. People involved in the program learn from each other about healthy foods and new recipes. They have fun cooking and learning together. Children enjoy being in the program with their parents and learning about food and nutrition.

This research project will look at the goals that staff, parents and children have for the program, and see if they are being met. It will also ask questions about family food security. You are invited to become involved in the research. You can do this by sharing your opinions and thoughts about the program with the research staff.

All information related to the research will be confidential. Names of schools or people will not be used in any documents or reports about the research. You will be completely free to refuse to participate in any or all of the research activities without jeopardizing your position as a participant in the "Cooking Fun for Families" program.

Research results will be used to improve the program, to show program funders the benefits of the program so they will continue to pay for the program, and to let other schools in other cities know about the program.

We hope that you enjoy the program and that you will take part in the research.

Dr. Ryna Levy Milne, Principal Investigator
Dr. Jim Frankish, Dr. Gwen Chapman, and Dr. Chris Lovato, Co-Investigators
Barbara Crocker, Community Nutritionist
Dawne Milligan, Research Coordinator, Ph.D. Student

Letter of initial contact

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英屬哥倫比亞大學

食物學, 營養學, 和健康學
農業科學系
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Ryna Levy Milne, 哲學博士, RDN
營養學之教授助理
電話: (604) 822-6869
傳真: (604) 822-5143

"家庭之烹飪樂趣"節目
研究評估

"家庭之烹飪樂趣"是給每個家庭的一門營養學, 教育和健康學宣傳的節目。自從 1994 至 1997, 這項節目被家長, 學生, 教師, 以及其他學校的教職人員們一起發展出來。人之所以參與這項節目, 除了可以彼此學習對方的健康食品及新食譜外, 更可以聚首一堂去學習和去發掘出烹飪的樂趣。小朋友亦有機會可與家長一起去欣賞這項節目而從中學習到有關於食物和營養的信息。

這項問卷研究計劃的目標是要看出這節目能否符合職員, 家長和小朋友的需要。這項研究將會發問有關於家庭裏的合標準食物。您將會被邀請去參與這項研究。而這是您能力做得到的——就是將您認為有關這項節目的個人意見和想法去告訴問卷研究員。

所有問卷研究資料是絕對保密的。學校名稱和您的姓名是不會印在任何文件或有關研究報告資料上。作為一位"家庭之烹飪樂趣"節目之參與者, 您是絕對完全有自由去拒絕參與任何其中項目或所有研究的項目而沒有危及或影響您的決定。

研究得來的結果將會去改善這項節目, 亦敍述它的益處給這項節目的贊助商。因此仍能得到他們繼續去贊助支持這項節目。最後更將這項節目推廣到其他城市的學校去。

我們期望您能讚賞這項節目和期望您亦能參與這項問卷研究計劃的一份

衷心感謝,

Ryna Levy Milne 醫生, 調查負責人
Jim Frankish 醫生, Gwen Chapman 醫生, 和 Chris Lovato 醫生, 合作調查組
Barbara Crocker, 社區之營養師.
Dawne Milligan, 研究協調人, 哲學博士

ĐẠI HỌC VIỆN B. C.

Thực Phẩm, Dinh Dưỡng và Sức Khỏe
Ngành Nông Lâm Súc
2205 East Mall
Vancouver, B.C. Canada V6T 1Z4

Bác Sĩ Ryna Levy Milne, PhD, RDN
Phú Tá Giáo Sự về Dinh Dưỡng
Tel: (604) 822-6869
Fax: (604) 822-5143

Bình Phẩm về Chương Trình
"Nấu Ăn chung Gia Đình"

"Chương Trình Nấu Ăn chung Gia Đình" là chương trình giáo dục cộng đồng về dinh dưỡng và giữ gìn sức khỏe. Bắt đầu thực hành từ năm 1994 đến năm 1997 (đợt đầu), với sự hợp tác chung của học sinh, phụ huynh, giáo viên và nhân viên làm việc tại trường. Nhóm viên đến dự chương trình có dịp học hỏi thêm từ người này qua người kia về cách nấu nhiều món ăn, có dinh dưỡng và khác lạ. Làm việc chung, nấu ăn chung, học hỏi ở nhau. Ngoài ra, học sinh có phu huynh đến dự còn có dịp làm việc chung với cha mẹ, tập phụ trong bếp, và thưởng thức khẩu vị mới từ nhiều món.

Phần giải đáp câu hỏi có mục đích để biết thêm chương trình có đem lại gì tốt cho nhóm viên không? Và sau nhiều buổi dự nhóm, có học được cách giữ thực phẩm sao cho đúng điều kiện dinh dưỡng và vệ sinh. Vì vậy, quí vị được mời tham dự vào phần tham khảo góp ý. Và nhân viên làm việc sẽ ghi nhận ý kiến quí vị để tìm cách làm chương trình hoàn hảo thêm.

Bạn nên nhớ những gì chia sẽ đều được giữ mật. Chúng tôi không nêu ra tên người góp ý thêm. Bạn không nhất thiết phải dự phần tham khảo và có quyền từ chối, mà vẫn được tiếp tục làm nhóm viên "Chương Trình Nấu Ăn".

Mục đích chung chỉ để phát triển chương trình ngày một tốt đẹp, và cho cơ quan tài trợ chương trình xác nhận là chương trình rất hữu hiệu, và nên tiếp tục tài trợ, cùng lúc đem chương trình phổ thông ra các trường thành phố khác.

Hy vọng bạn vui lòng hợp tác và giúp được chúng tôi tiến hành công việc điều tra tốt đẹp.

Thành thật cảm ơn sự hợp tác của quí vị,

Bác sĩ Ryna Levy Milne, phụ trách điều tra
Bác sĩ Jim Frankish, Bác sĩ Gwen Chapman, và Bác sĩ Chris Lovato, cộng sự ban điều tra
Cô Barbara Crocker, chuyên viên dinh dưỡng cộng đồng
Cô Dawne Milligan, đặc trách nghiên cứu, sinh viên Cao Học ngành Triết Lý Học

THE UNIVERSITY OF BRITISH COLUMBIA

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Informed Consent Form for Families

Evaluation of the "Cooking Fun for Families" Program

Dr. Ryna Levy Milne
Assistant Professor,
Agricultural Sciences, Food,
Nutrition and Health,
University of British Columbia
Phone: (604) 822-6869

Dawne Milligan
Research Assistant, and Ph.D Student,
Individual Interdisciplinary Studies Graduate
Program,
University of British Columbia
Phone: (604) 822-6637

Purpose of the Research

The purpose of the research is (1) to identify potential benefits of the "Cooking Fun for Families" programs for parents, children, schools and communities and (2) to identify factors assisting or limiting the implementation of the program.

Study Procedures

All families involved in the "Cooking Fun for Families" program will be invited to participate in the research. Parents will be invited to share their thoughts about the program with the research staff through interviews, discussion, or questionnaires. Children will also be invited to share their thoughts about the program in the same manner. All information collected by the research staff will be done as part of, and during the time of the program. Each adult study participant will contribute approximately one hour to the evaluation activities, and each child participant will contribute approximately 15 minutes. All evaluation data will be collected in the program area, i.e., the school's kitchen or activity area.

Confidentiality

All information resulting from this research study will be kept strictly confidential. All documents will be identified only by a code number, and will be kept in a locked filing cabinet at the university. All computer files for analyzing the data will use the codes only. Names of schools or of individuals connected with the study will not be released in any documents or reports, or in any other way.

Contact Information

I understand that if I have any questions or desire further information with respect to this study, I may contact Dr. Ryna Levy Milne (822-6869) or Dawne Milligan (822-6637), Research Coordinator.
I understand that if I have any concerns about my treatment or rights as a research participant, I may contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley, at 822-8598.

Consent Form: May, 2002
Page 1 of 2

Established in April 1990 to provide a UBC focus for multidisciplinary research, education and consultation in health promotion

Consent to Participate

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time without jeopardy to my participation in the "Cooking Fun for Families" program. I have received a copy of this consent form for my own records.

Consent Form for Parents

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time without jeopardy to my participation in the "Cooking Fun for Families" program.

I have received a copy of this consent form for my own records.

I consent to participate in this study.

_____

Please print name in full

_____

Signature   Date

大衛可佩比些人浮

健康推廣調查協會
畢業生研究系
2206 East Mall, Rm. 324
Vancouver, B.C. Canada V6T 1Z3
Tel: (604) 822-2258
FAX: (604) 822-9210
WWW: http://www.ihpr.ubc.ca

通知同意書表格給與各家庭
評估關於"家庭之烹飪樂趣"節目

Ryna Levy Milne 醫生
大學教授助理,
農業科學,食物學,
營養學和健康學,
英屬哥倫比亞大學
電話: (604) 822-6869

Dawne Milligan
研究助理,和哲學博士,
各學科間的個別研究畢業生課程,
英屬哥倫比亞大學
電話: (604) 822-6637

問卷調查之目的

這項問卷調查之目的是 (1) 給與各家長,小朋友,學校和社區去確認這項"家庭之烹飪樂趣"節目是存有可能性的益處和 (2) 確認這因素能幫助或有些限制地去履行這項節目。

察閱問卷的程序

所有家庭介入了這項"家庭之烹飪樂趣"節目將被邀請參與問卷調查.問卷調查員將採用見面,討論,或問卷去邀請家長們分享他們對於這項節目的意見。小朋友亦是採用相同之方法去邀請他們各自分享意見.調查員將在節目的期限內將所有資料完全收集好.每位成年人參與者大約花一小時去評估這活動,而每位小朋友參與者大約花十五分鐘.所有評估的資料將被收集在這項節目範圍內.例如:學校廚房或活動地區。

嚴格地保密

問卷調查部門會將得來的所有資料結果會嚴格地保密.所有文件只用密碼代替才能被認可,更被鎖在大學院的文件檔案櫃內.而且所有電腦檔案想去分析這些資料,亦必須只有用密碼才可行.參與的學校名稱或個人將不會公佈在任何文件或報告,或其他途徑上,

<u>聯絡資料</u>

我明白,假如我有任何問題或想得到更詳盡資料關於這問卷調查,我可以直接聯絡 Ryna Levy Milne 醫生 (822-6869) 或 Dawne Milligan (822-6637) 研究協調人。我明白,假如我有任何關於我的對待或權利作為一位問卷調查參與者,我可以直接聯絡在大學院之調查服務董事, Richard Spratley 醫生, 電 822-8598。

<u>同意去參與</u>

我明白我參與這項研究是完全地出於自願,而且我可以從這項研究隨時地去拒絕或退出而沒有危及或影響我參與這項名為"家庭之意飪樂趣"節目。同時我亦收到一份這項同意書表格作為我自己的紀錄檔案。

<u>給家長的同意書表格</u>

我明白我參與這項研究是完全地出於自願,而且我可以從這項研究隨時地去拒絕或退出而沒有危及或影響我參與這項名為"家庭之意飪樂趣"節目。

我有收到一份這項同意書表格作為我自己的紀錄檔案。

我同意去參與這項研究.

_____

請用正骨豐寫全名

_____

簽名   日期

ĐẠI HỌC VIỆN B. C.

Học Viện chuyên về Y Khoa
trong Bách Khoa Viện
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Đơn Ký Thảo Thuận Tham Gia Hội Thảo
Bình Phẩm "Chương Trình Nấu Ăn chung Gia Đình" Cộng Đồng

Bác sĩ Ryna Levy Milne
Phụ tá giáo sư nghiên cứu,
Ngành Canh Nông, Thực Phẩm,
Dinh Dưỡng và Sức Khỏe
Đại Học Viện B.C.
Phone: (604) 822-6869

Cô Dawne Milligan
Phụ tá đặc trách nghiên cứu, cũng
là sinh viên Cao Học về Triết
Chương trình Giáo Huấn Cá nhân
Các Ngành Cao Học,
Đại Học Viện B.C.
Phone: (604) 822-6637

Mục Đích Nghiên Cứu

Mục đích điều tra để xác định công dụng của chương trình này khi làm việc chung với phụ huynh, học sinh, nhân viên trường học với sự hợp tác của cộng đồng phụ cận để nhận thức được những điểm nào có khiếm khuyết, bất lợi.

Tiến Trình Điều Tra

Những nhóm viên tham gia "Chương Trình Nấu Ăn" đều có điều kiện dự hội thảo. Phụ huynh được mời dự phần vào buổi vấn đáp, mời góp ý thêm cảm tưởng của mình khi đến dự "Chương Trình Nấu Ăn". Chúng tôi cũng hỏi trẻ con góp ý thêm, khi gặp dịp. Chúng tôi ghi nhận lại ý kiến quý báu của quí vị ngay trong giờ dự nhóm, hay đôi khi hẹn gặp một, hai vị ngoài giờ dự nhóm. Chúng tôi chỉ xin hỏi thăm quí vị trong khoảng một giờ đồng hồ, và hỏi trẻ con khoảng 15 phút. Chúng tôi cố gắng hỏi thăm quí vị ngay giờ dự nhóm trong phòng hoạt động chung, như phòng phụ huynh, hay bếp nấu ăn.

Giữ Mật

Tất cả những gì nói ra đều được giữ mật. Hồ sơ lưu trữ tài liệu được đặt vào ngăn lưu trữ, dùng số mật mã riêng biệt, cất trong Đại Học. Tất cả tài liệu ghi nhận được, sẽ dùng mật mã trên để giúp việc ghi chép số tỷ lệ trong thống kê. Xin nói rõ là chúng tôi chỉ ghi lại ý kiến quí vị, mà không bao giờ ghi tên người giải đáp vào hồ sơ lưu, cũng như bài báo cáo nào hết.

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Số Điện Thoại Liên Lạc

Nếu có gì thắc mắc, xin yêu cầu quí vị vui lòng liên lạc trực tiếp Bác Sĩ Ryna Levy Milne số # (604-822-6869), hay Cô Dawne Milligan số # (604-822-6637), điều động viên chương trình. Tôi hiểu nếu có vấn đề gì muốn hỏi thêm về tham khảo trên, tôi có thể liên lạc giám đốc Ban Sưu Tập Tài Liệu, Đại-Học-Viện Tỉnh B.C., tên là Bác Sĩ Richard Spratley, số # (604-822-8598).

Bằng Lòng Tham Gia

Tôi biết là tham gia vào hội thảo nói về chương trình hoàn toàn do tôi tự nguyện, và cũng biết là tôi được toàn quyền từ chối tham gia, hay không muốn tiếp tục tham gia vào phần tham khảo, mà vẫn không mất quyền đến dự "nhóm nấu ăn" nói trên. Tôi được phát một bản sao đơn thỏa thuận tham gia của tôi, để tôi lưu giữ riêng.

Đơn Thỏa Thuận Đưa Phụ Huynh Ký

Tôi biết là bằng lòng tham gia vào tham khảo nói trên, hoàn toàn do ý thích của tôi, và tôi được quyền từ chối, hay không muốn tiếp tục tham gia, mà không mất quyền đến dự nhóm nấu ăn, nếu tôi đổi ý.

Tôi có nhận được bản sao (copy) của đơn thỏa thuận tham gia tham khảo hay phỏng vấn này.

Tôi bằng lòng tham gia vào tham khảo này.

_____

Xin viết lại tên họ bằng chữ in. Cảm ơn.

_____

Chữ ký   Ngày tháng

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Appendix F: Consent Form for Staff and Administrators

THE UNIVERSITY OF BRITISH COLUMBIA

UBC

Faculty of Agricultural Sciences
Food, Nutrition and Health
2205 East Mall
Vancouver, BC Canada
V6T 1Z4

Tel: 604-822-2502
Fax: 604-822-5143

Informed Consent Form – Staff and Administrators

Evaluation of the "Cooking Fun for Families" Program:
A Skill- and Community-Building Program for Inner-city Parents and their Children

Dr. Ryna Levy Milne
Assistant Professor,
Agricultural Sciences, Food,
Nutrition and Health,
University of British Columbia
Phone: 822-6869

Dawne Milligan
Research Assistant, and Ph.D Student,
Individual Interdisciplinary Studies Graduate
Program,
University of British Columbia
Phone: 822-6637

Purpose of the Research
The purpose of the research is (1) to identify potential benefits of the "Cooking Fun for Families"
programs for parents, children, schools and communities and (2) to identify factors assisting or limiting
the implementation of the program.

Study Procedures
All staff and families involved in the "Cooking Fun for Families" program will be invited to participate
in the research. Staff will be invited to share their thoughts about the program with the research team
through interviews, discussion, or questionnaires. All information collected by the research team will
be done during staff working hours and staff will have received approval from school Principals to
participate in the program evaluation as part of their work duties. Each staff study participant will
contribute approximately one hour to the evaluation activities. Evaluation data will be collected in the
program area, i.e., the school's kitchen or activity area, or in participating staffs' office areas.

Confidentiality
All information resulting from this research study will be kept strictly confidential. All documents will
be identified only by a code number, and will be kept in a locked filing cabinet at the university. All
computer files for analyzing the data will use the codes only. Names of schools or of individuals
connected with the study will not be released in any documents or reports, or in any other way.

Contact Information
I understand that if I have any questions or desire further information with respect to this study, I may
contact Dr. Ryna Levy Milne (822-6869) or Dawne Milligan (822-6637), Research Coordinator.
I understand that if I have any concerns about my treatment or rights as a research participant, I may
contact the Director of Research Services at the University of British Columbia, at 822-8598.

CFF Staff Consent form 2003
programs for ecosystem, community and human health   Page 1 of 2
Agroecology • Food, Nutrition and Health • Global Resource Systems • Home Economics • Landscape Architecture
www.agsci.ubc.ca

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Consent to Participate

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time without jeopardy to my staff position in the "Cooking Fun for Families" program. I have received a copy of this consent form for my own records.

Consent Form for Program Staff

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time without jeopardy to my staff position in the "Cooking Fun for Families" program.

I have received a copy of this consent form for my own records.

I consent to participate in this study.

_____

Please print name in full

_____

Signature   Date

Appendix G: Data Collection Framework

"Cooking Fun for Families" Data Collection Framework

Methods	Questions for Staff and Administration	Questions for Program Participants (Parents, Children)
Basic or "core" questions • The same questions for all sites • An in-person survey with short interview questions to clarify if needed	*Goal:* *To study the process and implementation of the program.* *Topics:* • Setting and participant profile • Origins and history of the program • Number and brief description of participants • Description of staff - roles, job descriptions, time spent on program • Administration - roles and responsibilities • Budget and program costs • Program goals and objectives • Monitoring and evaluation data collected	*Goal:* *To study the impact of the program on parents and children.* *Topics:* • Nutrition • Food safety • Hunger and food security • Self-rated health • Social support • Social integration • Self-efficacy • Sense of belonging • Relationship to the school • Satisfaction with the program
Case studies and Interviews • Participant observation and • more intensive interviews	Goal: To study the staff's experience with the program – • What worked well • What didn't work • Perceived benefits of the program • Barriers to success • Recommendations	Goal: To study the participants' experience with the program – • To gain more detailed information about the above topics • Perceived benefits of the program • Barriers to success • Recommendations

Cooking Fun for Families
Program Description

School: **Program Location:**

Program Name: Cooking Fun for Families

Day of Week program offered:
Number of Participants: Parents: Children: Total:

Start Date: Finish Date:

Staffing:

Program Goal:

Recipes/Menus used:

Children's Activities:

Parent's Activities:

What's Working:

Issues/Challenges:

Parent's Feedback:

Appendix I: Parent Interview Schedule

1.   Why do you like attending the CFF/CK program? What do you enjoy about the program?

2.   What opportunities does the program present to you?

3.   How do you think the program benefits your family? Your children?

4.   Has the program affected your family's food habits? Describe/explain.

5.   What have you learned at the program?

6.   What do you usually do at the program? Describe a typical program session (one day at the program).

7.   What opportunities does the program present to the parents as a group?

8.   How does the program support community-building for your neighbourhood and school?

9.   How has attending the program influenced your relationships with the other parents?

10.   Has your attending the program had any influence on your children's social relationships? Describe/explain.

11.   How has attending the program influenced your relationships with the school and community?

12.   How do parents in the program support or help each other?

13.   How long have you been attending the program?

14.   How did you first hear about the program?

15.   Why did you decide to join the program when you first started attending? What were your hopes and expectations of the program?

16.   How satisfied are you with the program?

17.   How do you think the program could be improved?

18.   Other questions …

19.   Is there anything else you'd like to say about what we've talked about today?

Staff Interview Guide

Areas to be improved: overlap in some areas - participants versus parents, children. How does the program fit into the school or community? More specific questions. Hone the questions, make sure all areas are covered. Word the questions so that they flow better. Make sure there are no overlaps, even if I have to change the categories.

Six areas adapted from McConney, Rudd & Ayres (2002) (page 132):
1. Program training and follow-up support
2. Administrative support, (including level/adequacy of resources, security of program support, school staff reactions to the program) and program fit
3. Parent and community reactions to the program
4. Implementation of the program model
5. Perceived program effects &/or impacts
6. Critical rating

I Program training and follow-up support
Have you seen the CFF program facilitators' guidebook?
Do you have the CFF program kit?
How did you find out about the program?
Did you choose to develop the program at your site, or were you told you had to?
Did you come into the position by taking it over from someone else? If so, how did that work? Problems? Benefits?
Do you feel you have adequate knowledge to run the program?
Whose idea was it that you run the program?
How do you feel about running the program?

2 Administrative support, (including level/adequacy of resources, security of program support,) and program fit, and school staff reactions to the program
Funding
Who supplies the funds for your program?
Do you have a direct relationship with the funder(s)? If not, who do you go through?
Who do you think should fund the program?
How much is spent on the program per year at your site?
How much do you spend per week on groceries? On other costs? Describe.
How much food do you get from the Food Bank each week?
Has this changed lately?
What kind of relationship do you have with the Food Bank? Describe. Issues? Solutions?
Accountability
Are there any accountability requirements for you (to the funder, the administration) for you as program staff?
Who are you accountable to for the program?
How do they evaluate the worth of the program?
Do you discuss the program with them? Do they discuss their evaluation of the program with you?
Teachers and administration
How do you think teachers and administration feel towards the program?

How often do they visit the program? Describe.

Do you think the program assists communication between parents and school staff? How so? Describe.

Support for running the program

Do you discuss the program with anyone else in the school or community centre?

Who do you turn to if you have issues to discuss regarding the program?

What kind of support does this person(s) give you?

Overall, do you feel you have enough support in running the program? Explain/describe.

3   Parent and community reactions to the program

How well integrated is the program into the school or community centre? Describe.

4   Implementation of the program model

Focus, goals, objectives of the program

What is(are) the main focus (or goal) of the program?

What are the secondary goals?

Do you have a particular health message you are trying to get across? If so, what is the message?

Strategies for accomplishing goals/ objectives

What do you do in particular to get your main message(s) across?

How successful do you think you are in getting it (them) across?

What makes you think this? (evidence)

Program leadership, planning and information

Is leadership of your program shared, or solely yours?

How does this work? (Describe)

How is it working? (Evaluate)

Do participants take responsibility for any aspects of running the program? Describe? Are they remunerated? How?

Describe how you plan for the program (whole year? Season? Week?)

Do you have an information session about the program? If so, what do you cover?

Successes and challenges

How do you know if a session has been successful?

How do you know if there have been problems with a session?

What kinds of problems do you have or see on a regular basis?

How do you handle participants who don't speak much or any English?

Food and storage

Where and how do you get the ingredients needed each week?

Do you keep ingredients over?

Do you have storage space? Describe.

Do you send food home with parents? Describe.

Do you work from printed recipes? Are parents able to read them? Children? How do you present new recipes?

Participants

Are there any children involved in the program? If so, ages (or grades). Activities?

How many participants do you have regularly? Total? Parents? Children?

Do you have fluctuations in attendance? Why do you think so?

Do you have any fathers attending? Regularly? Or do they drop out?

How many people drop out of the program? Do they tell you why, or do you know why? Explain.

5   Perceived program effects &/or impacts
Hopes, expectations, and perceived benefits
What would you like participants to get out of the program?
How possible do you think this is?
What do you think are the participants goals/ reasons for attending?
What do you think is the most important benefit that participants get from the program? Other benefits?
Do you think participants are learning anything? What?
Children
Do you think children benefit from the program? In what ways? What makes you think this?
<u>At home</u>
In conversation with parents - how much do they seem to be doing new food and nutrition-related activities at home because of what they've done in the program?
Do you think any of the families are suffering hunger at home? What makes you think so?
Do you think the program can help with this problem? How?
Do you think the program is helping? Why or why not (is it or not helping?)
<u>Fathers in the program</u>
How do you think the program works for fathers?
Are they socially isolated in the program? Why? or why not?

6   Critical rating
All things considered, how easy or difficult (scale 1-10) is it to have the program at this site?
Compared to your ideal for the program, how much do you think participants get out of the program (scale 1-10)?
For each of the above, describe discrepancies and give perceived reasons of circumstances or limiting factors.
In what areas does the program need improvement? Describe and give suggestions for improvement.
How could the program be improved?
What difference would the improvements make? To whom?
Have you made any major changes to the program over the past year?
Describe and tell why? Have you noticed benefits from the changes? What?
Have you made any minor changes to the program over the past year?
Describe and tell why? Have you noticed benefits from these changes? What?

Appendix K: Administrator Interview Schedule

Administrator Interview Guide

1. Please describe briefly how the program is organized at your school (i.e., how funds, staffing, and planning are handled.)

2. What do you see as the impact or benefits of the program (on the school as a whole, on program participants?)

3. What are your goals for the program in your school?

4. To what extent do you think these goals are being met?

5. What are some of the challenges involved in having the program at your school?

6. Comments or questions?

"Cooking Fun for Families / Community Kitchens" Questionnaire

Food, Nutrition and Health - Faculty of Agricultural Sciences, and
Institute of Health Promotion Research
University of British Columbia

We would like to ask you some questions about the "Cooking Fun for Families/
Community Kitchen" program. We will use your answers and others to describe the
program and its effects. All answers will be confidential – your name will not be in any
papers or reports. The information may help to get funding for the program in future years
and to start programs like this in other places.
Thank you for taking part in our study.

1.   The first questions are about the foods you usually eat or drink. Think
     about all the foods you eat, both meals and snacks, at home and away
     from home.

a)   How often do you usually drink fruit juices such as orange, grapefruit or tomato?
     (for example, once a day, three times a week, twice a month.)

     _____

b)   Not counting juice, how often do you usually eat fruit?

     _____

c)   How often do you usually eat green salad?

     _____

d)   How often do you usually eat potatoes, not including french fries, fried potatoes, or
     potato chips?

     _____

e)   How often do you usually eat carrots?

     _____

f)   Not counting carrots, potatoes, or salad, how many <u>servings</u> of other vegetables do
     you usually eat?

     _____

1

2.   Please check one box for each of the following questions:

	Yes	No	I don't Know
a) Do you think you could give your family fruits and vegetables even if they were expensive?	❑	❑	❑
b) Do you think you could give your family fruits and vegetables even if it took more time to plan and prepare them?	❑	❑	❑
c) Do you think you could give your family fruits and vegetables even if not everyone in your family would eat them?	❑	❑	❑
d) Do you think you could give your family fruits and vegetables even if you had to learn new ways to prepare them?	❑	❑	❑

3. The next questions are about food and nutrition in your home. Please note that the first 3 questions are asking about the past 12 months, while the next 3 questions are asking about the past 3 months. (Please check only one box for each question.)

a) In the past 12 months ...

	Often	Sometimes	Never	I don't know
i) How often did you or anyone in your household worry that there would not be enough to eat because of a lack of money?	❑	❑	❑	❑
ii) How often did you or anyone in your household not have enough food to eat because of a lack of money?	❑	❑	❑	❑
iii) How often did you or anyone in your household not eat the quality or variety of foods that you wanted to eat because of a lack of money?	❑	❑	❑	❑

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b) In the past 3 months ...

	Often	Sometimes	Never	I don't know
i) How often did you or anyone in your household worry that there would not be enough to eat because of a lack of money?	❑	❑	❑	❑
ii) How often did you or anyone in your household not have enough food to eat because of a lack of money?	❑	❑	❑	❑
iii) How often did you or anyone in your household not eat the quality or variety of foods that you wanted to eat because of a lack of money?	❑	❑	❑	❑

4. The next question is about your family's eating patterns.

During <u>the past week,</u> how many times did your family eat a meal together? (Please check only <u>one</u> box.)

❑ we didn't eat together
❑ about once a week
❑ a few times a week
❑ every second day
❑ every day
❑ I don't know

3

5. The next questions are about the school, community and other parents you have met in the "Cooking Fun for Families/ Community Kitchen" program.

Which of the following kinds of programs have you or your children (a) learned about, and (b) attended, because you were in the "Cooking Fun for Families" or "Community Kitchen" program?

	Learned About	Attended
a) ESL or English class	❑	❑
b) Food programs	❑	❑
c) Parenting class	❑	❑
d) Arts, crafts, or sewing classes for parents	❑	❑
e) Activities for children	❑	❑

6. The next questions ask how you feel about other people in the "Cooking Fun for Families / Community Kitchen" program. (Please check only one box for each statement.)

	Yes	No	Don't know
a) There are people from this program who care about me.	❑	❑	❑
b) There is a parent in this program who would help me out if I was sick.	❑	❑	❑
c) There is a parent from this program who would look after my child if I was sick.	❑	❑	❑
d) There is a parent from this program who would give or lend me food if I needed it.	❑	❑	❑

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7. **This next set of statements has to do with how you feel about the people around you. (Please mark only <u>one</u> box.)**

	Disagree	Agree	Don't Know
a) Most people can be trusted.	❑	❑	❑
b) Most adults in my child's school can be trusted.	❑	❑	❑
c) Most children in my child's school can be trusted.	❑	❑	❑
d) People in my child's school are willing to help you if needed.	❑	❑	❑
e) My child's school is a pretty safe place.	❑	❑	❑

8. **Now we would like to ask you about your child's school in relation to yourself.**

a) **Do you attend parent-teacher conferences at your children's school(s)?**

    ❑ Yes
    ❑ No
    ❑ I don't know

b) **How often do you attend PAC meetings?**

    ❑ never
    ❑ 1-3 times per year
    ❑ 4-6 times per year
    ❑ 7-10 times per year

c) **Do you have a friend (another parent or grandparent) in your child's school?**

    ❑ Yes
    ❑ No
    ❑ I don't know

5

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10. The next question is about your health. (Please check only <u>one</u> box.)
    In general, would you say your health is ...

    ☐   Excellent
    ☐   Very Good
    ☐   Good
    ☐   Fair
    ☐   Poor

11. When did you first attend "Cooking Fun for Families / Community Kitchen?"

    ☐ Year _____
    ☐ Month _____
    ☐ I don't know

12. Approximately how many times have you attended the program?

    _____

13. What language(s) do you usually speak at home?

    _____

    _____

14.   Please list your children's ages.

    _____

Thank you very much for answering these questions.

"家庭之烹飪樂趣 / 社區家庭式之烹飪" 問卷

食物學, 營養學和健康學 - 農業科學系, 和
健康推廣調查協會
英屬哥倫比亞大學

我們想請問你一些問題是關於這個節目"家庭之烹飪樂趣/社區家庭
式之烹飪"。我們將會採用你的回答及其他的提議去敘述這個節目和
它的效果。所有的問卷答案將會是保密的-你的姓名將不會出現在任何紙
張或報告書內。這些問卷資料能幫助我們在不久之將來獲得基金贊助這項節
目,和去開辦類似這項節目在其他不同的地方。
多謝你參與我們這項問卷研究計劃。

1. 首先前幾條問題是關於你經常食和飲的食物。細想一下所有你食
   的食物,包括正餐和小食,在家中和在外食的。

   a) 你通常多久才會飲水果果汁,例如橙汁,葡萄柚汁或者番茄汁?(例如,一日
   一次,一星期三次,一個月兩次。)

   _____

   b) 不計算果汁在內,你通常多久才會吃水果?

   _____

   c) 你通常多久才會吃青菜沙拉?

   _____

   d) 你通常多久才會吃馬鈴薯,不包括炸馬鈴薯條,油炸(油煎)馬鈴薯,或者炸馬
   鈴薯片?

   _____

   e) 你通常多久才會吃胡蘿蔔?

   _____

   f) 不計算胡蘿蔔,馬鈴薯,或者沙拉在內,有幾多<u>份量</u>的其他蔬菜你會經常吃?

   _____

1

2.　請在下列的每個問題格仔內(✔)揀選一個答案：—

	會	不會	我不知道
a) 你認爲你會不會給你的家人水果和蔬菜,甚至乎它們是最昂貴呢?	❑	❑	❑
b) 你認爲你會不會給你的家人水果和蔬菜,甚至乎它們需要很多時間來計畫和預備呢?	❑	❑	❑
c) 你認爲你會不會給你的家人水果和蔬菜,甚至乎在你的家庭內,沒有一個人會吃它們呢?	❑	❑	❑
d) 你認爲你會不會給你的家人水果和蔬菜,甚至乎你必須學習新的方法去烹煮它們呢?	❑	❑	❑

3.　以下的問題是關於在你家中的食物和營養.請注意首三個問題是問過去的十二個月,當後三個問題是問過去的三個月。(請在下列的每個問題格仔內(✔)只揀選一個答案。)

a)過去的十二個月內…

	經常	有時	從未有	我不知道
i) 你或者和任何一位家庭成員有多久才會憂慮家中沒有足夠的食物吃,是因爲缺乏金錢呢?	❑	❑	❑	❑
ii) 你或者和任何一位家庭成員有多久沒有足夠食物吃,是因爲缺乏金錢呢?	❑	❑	❑	❑
iii) 你或者和任何一位家庭成員有多久是你想吃而沒有吃到好質量的或各種不同的食物,是因爲缺乏金錢呢?	❑	❑	❑	❑

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b)過去的三個月內…

	經常	有時	從未有	我不知道
i) 你或者和任何一位家庭成員有多久才會憂慮家中沒有足夠的食物吃,是因為缺乏金錢呢?	❑	❑	❑	❑
ii) 你或者和任何一位家庭成員有多久沒有足夠食物吃,是因為缺乏金錢呢?	❑	❑	❑	❑
iii) 你或者和任何一位家庭成員有多久是你想吃而沒有吃到好質量的或各種不同的食物,是因為缺乏金錢呢?	❑	❑	❑	❑

4. 以下的問題是關於你自己家庭中吃的樣式。

在過去的一星期內,有幾多次你一家人在一起吃一餐飯?(請(✔)只選擇<u>一個</u>答案。)

❑ 我們沒有一起吃

❑ 大約一星期一次

❑ 一星期數次

❑ 每隔一日

❑ 每日

❑ 我不知道

3

5.　以下的問題是關於學校,社區和其他家長你曾經在"家庭之烹飪
樂趣/社區家庭式之烹飪"班內遇見。

以下的不同節目,你或者你的小朋友是否(a)學習關於,和(b)參
加,是因為你參與這"家庭之烹飪樂趣/社區家庭式之烹飪"班?

	學習關於	參加
a) 新移民班(ESL)或者英文班	❑	❑
b) 食物班	❑	❑
c) 教育子女班	❑	❑
d) 藝術,手藝,或者縫紉班給各家長	❑	❑
e) 小朋友活動	❑	❑

6.　以下的問題是請問你對於其他人在這"家庭之烹飪樂趣/社區家
庭式之烹飪"班有何感覺。(請在每題敍述格仔內(✔)只揀選一
個答案。)

	有	沒有	不知道
a) 在這項節目內的人關心我。	❑	❑	❑
b) 在這項節目內,如我生病,有位家長會幫我。	❑	❑	❑
c) 在這項節目內,如我生病,有位家長會幫我 照顧我的孩子。	❑	❑	❑
d) 在這項節目內,如我需要食物,有位家長會 給我或借給我。	❑	❑	❑

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7. 以下系列的敘述是必須回答,你對你身邊周圍的人有何感覺。(請(✔)只標示一個答案在格仔內。)

	不同意	同意	不知道
a) 大部份的人是可以信任的。	❑	❑	❑
b) 大部份的成年人在我孩子的學校裡是可以信任的。	❑	❑	❑
c) 大部份的小朋友在我孩子的學校裡是可以信任的。	❑	❑	❑
d) 如你需要幫忙,在我孩子學校裡的人是會樂意幫助你的。	❑	❑	❑
e) 我孩子的學校是一個既美麗又安全的地方。	❑	❑	❑

8. 現在我們想請問你關於你和你孩子的學校的關係。

a) 你是否有出席你孩子學校的家長和教師會議呢?

❑ 有
❑ 沒有
❑ 我不知道

b) 你有多久才出席 "家長代表組" 集會呢?

❑ 從未有
❑ 每年一至三次
❑ 每年四至六次
❑ 每年七至十次

c) 你是否有位朋友(其他父母或者祖父母)在你孩子的學校呢?

❑ 有
❑ 沒有
❑ 我不知道

5

10. 以下的問題是關於你的健康。(請(✔)只揀選一個答案在格仔內。)
    一般說來,你說你的健康是⋯

        ❑ 極好

        ❑ 十分好

        ❑ 好

        ❑ 平常

        ❑ 健康不佳

11. 你第一次出席這個"家庭之烹飪樂趣/社區家庭式之烹飪"班是
    何時呢?

        ❑ 年_____

        ❑ 月_____

        ❑ 我不知道

12. 大概有多少次你出席這個節目呢?

    _____

13. 在家中,你經常會說什麼語言呢?

    _____

    _____

14. 請列出你小朋友的年齡。

    _____

十分多謝你回答這些問題。

6

Name: _____

School: _____

A. Please indicate <u>how important</u> each of the following is to you, for your parents &/or children in "Cooking Fun for Families", or your "Community Kitchen" program, by circling the appropriate number from 1 (low) – 5 (high), where 1 = not important at all; 2 = a little important; 3 = moderately important; 4 = quite important; and 5 = extremely highly important.

		LOW	IMPORTANCE			HIGH
a)	learning how to prepare nutritious dishes	1	2	3	4	5
b)	learning how to prepare inexpensive dishes	1	2	3	4	5
c)	strengthening family relationships	1	2	3	4	5
d)	building families' food security	1	2	3	4	5
e)	integrating families into the school	1	2	3	4	5
f)	integrating families cross-culturally	1	2	3	4	5
g)	participants taking food home	1	2	3	4	5
h)	increasing families' intake of fruits and vegetables	1	2	3	4	5
i)	decreasing families' intake of fats	1	2	3	4	5
j)	learning food safety skills	1	2	3	4	5
k)	breaking down isolation of families	1	2	3	4	5
l)	parents and children interacting together	1	2	3	4	5
m)	building parents' coping abilities	1	2	3	4	5
n)	learning how to budget and shop wisely	1	2	3	4	5
o)	participants enjoying a recreational program	1	2	3	4	5

B. For the same list, please <u>rank in order of importance</u> to you as a program leader, with 1 = most important, to 15 = least important.

RANK (1 = most important, 2 = next most important, etc.)

a) ____ learning how to prepare nutritious dishes
b) ____ learning how to prepare inexpensive dishes
c) ____ strengthening family relationships
d) ____ building families' food security
e) ____ integrating families into the school
f) ____ integrating families cross-culturally
g) ____ participants taking food home
h) ____ increasing families' intake of fruits and vegetables
i) ____ decreasing families' intake of fats
j) ____ learning food safety skills
k) ____ breaking down isolation of families
l) ____ parents and children interacting together
m) ____ building parents' coping abilities
n) ____ learning how to budget and shop wisely
o) ____ participants enjoying a recreational program

Appendix N: Implementation Questions Template

Implementation Questions Template

SETTING

Describe the location of the program (e.g., size of room, features, location in facility).			
Has the program always been in this location and with this set of physical resources?			
If not, describe the previous locations and resources.			

PARTICIPANTS

Who are the target group(s) for the program?			
How many people presently participate in the program?			
What is the age range of the participants?			
How long do people remain in the program?			
What is the ethnic mix of the participants?			
Is the program conducted in English, or another language(s)? Describe.			
What is the annual turnover rate of the school population?			

DEMOGRAPHICS

What is the SES of the census area(s) that the school serves?			
What is the unemployment rate?			
What proportion of families in the area are receiving social assistance?			
Is the school associated with the program receiving inner-city funding?			
If so, how much, and for how long?			
How many extra staff are associated with the school? (Give roles/titles)			

ACTIVITIES

Describe the normal sequence of events at a typical program session.			
What activities do the staff normally do?			
What activities do the parents normally do?			
If there are children present, what activities do they do?			
Are there any food-related activities in which parents participate with their children? Describe.			

GOALS AND OBJECTIVES

What are the goals and objectives of the program at this site?			
To you, what is the most important objective of the program?			
Are there any written records of the program (meetings, goal statements, etc.)?			
If so, try to get copies.			

STRATEGIES

What strategies are the program staff using to try to meet their goals and objectives?			
What strategies are you using to try to accomplish your most important objective?			

Appendix N: Implementation Questions Template (cont'd)

SITE-SPECIFIC PROGRAM HISTORY

When was the program first offered at this site?			
How many times (meaning a set of classes) has the program been offered at this site?			
List the dates.			
Who was responsible for first getting the program running?			
How has the program evolved/changed?			
How many participants have passed through the program? (parents, children)			
How many staff changes have there been? Describe.			
How many administrator changes have there been? Describe.			

RECRUITMENT

What are the criteria for selecting program participants?			
How is information about the program disseminated to potential participants?			
How are participants usually recruited into the program?			
Are any prospective program participants refused? If yes, explain.			

STAFFING AND ADMINISTRATION

List all personnel presently involved with the program (their job titles, not their names)			
Is there any training for the staff specific to the program?			
If so, who delivers it, who attends it, how often is it given?			
What is the turnover rate for program staff and associated personnel?			
What are the problems associated with recruitment and maintenance of staff for the program?			
How much time do people in each staff role devote to responsibilities connected with the program?			
Do any staff donate unpaid time to the program? Explain.			
How is the program administered, and by whom?			
Has the administrative staffing of the program remained stable, or have there been changes? Explain.			
What are the responsibilities of the administration re: the program?			

Appendix N: Implementation Questions Template (cont'd)

BUDGET AND FUNDING: WHAT HAS BEEN THE TOTAL COST OF IMPLEMENTING THIS PROGRAM? WHAT ARE THE MAJOR COST ITEMS?

Re: Structural changes (e.g., new kitchens, renovations)

What structural changes have been made at the site to accommodate the program?			
When were these changes made?			
What did the changes cost?			
From what sources were the funds obtained?			
Were there any accountability requirements attached?			

Re: Equipment

What equipment has been purchased for the program?			
What has been the cost?			
From what sources were the funds obtained?			

Re: Ongoing program activities

What is the cost of operating the program per term? Per year? (Staffing, food and supplies, other?)			
From what sources have funds been obtained? (Describe all, if more than one, and relate to relevant time period.)			
Are there any accountability requirements attached? To whom?			
What proportion of program operating costs consist of monies allocated from within the school system?			
What proportion of program operating costs consist of monies received from outside the school system? From whom are these monies received?			
Are there any accountability requirements attached to the funds received from outside the school system? Describe.			
If the program has run for several years or several funding periods, what changes in sources of funds and cost trends have occurred?			
What is the per participant cost of the program? What is the cost per family?			

EVALUATION

Have any provisions been made for periodic review/evaluation of the program within each site? At the school board level? Describe.			
What records do program staff keep on a weekly basis? On a per term basis?			
Is there a program team at each site that monitors the program? If so, how often do they meet?			
How are decisions made to modify the program?			

OUTSTANDING OBSERVATIONS

What are the most outstanding things about the program?			

Appendix O: Staff Evaluation Form

Staff Evaluation Form
School:
Session dates:

Program goals	
Average # participants per 10-week session	
Food expense per 10-week session	
Children's activities	
Parents' activities	
"What's working?"	
Issues/ challenges	
Parents' Feedback	

Appendix P: Data Collection timetable

School		Prior	April – June 2001	Sept – Dec 2001	Jan – March 2002	April – June 2002	Sept – Dec 2002	Jan – March 2003	April – June 2003	Sept – Dec 2003	Total
Each 3-4 month term (each CFF session)			**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	
D	Questionnaire 1st										**n/a**
	Questionnaire 2nd										**n/a**
	Questionnaire 3rd										**n/a**
	Observations		2	5		1		1			**9**
	Parent interviews							3			**3**
	Staff interviews								1		**1**
	Admin interviews								2		**2**
	Staff evaluations	Sept-Dec 1999 Jan-Mar 2000		yes	yes	yes					
E	Questionnaire 1st					6	3				**9**
	Questionnaire 2nd						4		1		**5**
	Questionnaire 3rd								3		**3**
	Observations				1	1	1		1		**4**
	Parent interviews					1	3	2			**6**
	Staff interviews		1						1		**2**
	Admin interviews								1		**1**
	Staff evaluations	Sept 2000 – June 2001	yes								
F	Questionnaire 1st					7	9		9		**25**
	Questionnaire 2nd						1		7		**8**
	Questionnaire 3rd										
	Observations			10		4	4		2		**20**
	Parent interviews						2		5		**7**
	Staff interviews		1					1	1		**3**
	Admin interviews								1		**1**

Appendix P: Data Collection Timetable (cont'd)

Group	Measure	Date	1	2	3	4	5	6	7	8	Total
H	Questionnaire 1st					9	5				**14**
	Questionnaire 2nd						4				**4**
	Questionnaire 3rd										
	Observations		1	3		1	1		1		**7**
	Parent interviews					3					**3**
	Staff interviews										
	Admin interviews										
	Staff evaluations	Apr-Jun 1998 Oct-Dec 1998 Jan-Mar 1999 Mar-June 1999	yes		yes						
I	Questionnaire 1st					5	8				**13**
	Questionnaire 2nd						1		4		**5**
	Questionnaire 3rd								1		**1**
	Observations					2	1		1		**4**
	Parent interviews						1		1		**2**
	Staff interviews								1		**1**
	Admin interviews								1		**1**
	Staff evaluations	Sept 1997 – June 1998 Sept – Dec 1998 Oct 1998 – June 1999	yes	yes	yes						
K	Questionnaire 1st					6	2		1		**9**
	Questionnaire 2nd						5		1		**6**
	Questionnaire 3rd								3		**3**
	Observations					1	1				
	Parent interviews					1		2			**3**
	Staff interviews								1		**1**
	Admin interviews					1			1		**2**
	Staff evaluations	Nov 1998 – June 1999				yes					

Appendix P: Data Collection Timetable (cont'd)

Group	Method									Total
L	Questionnaire 1st				10	1				**11**
	Questionnaire 2nd					4				**4**
	Questionnaire 3rd							2		**2**
	Observations		18	2	4	1		1		**26**
	Parent interviews				1	1	1			**3**
	Staff interviews						2	1		**3**
	Admin interviews							1	1	**2**
M	Questionnaire 1st				2	5				**7**
	Questionnaire 2nd					1				**1**
	Questionnaire 3rd									
	Observations				1	1		1		**3**
	Parent interviews						2			**2**
	Staff interviews							1		**1**
	Admin interviews							1		**1**
	Staff evaluations									
No school	Admin interviews	1						1		**2**
Total	Questionnaire 1st				**45**	**33**		**10**		**88**
	Questionnaire 2nd					**20**		**13**		**33**
	Questionnaire 3rd							**9**		**9**
	Observations	**3**	**36**	**3**	**15**	**10**	**1**	**7**		**75**
	Parent interviews				**6**	**7**	**10**	**6**		**29**
	Staff interviews	**3**					**3**	**8**		**14**
	Admin interviews	**2**						**10**	**1**	**13**

Appendix Q: Annotated Code List

HU: Cooking Fun for Families
File: [E:\CFF Atlas Files\CFF02-12-0901[2]2]

BF eating together - observations/interview examples/opinions about families eating
together either at the program or at home
BF food security - sections discussing food-related support as benefit (i.e., taking
prepared food or ingredients home, learning to budget/shop)
BF instrumental support - sections discussing support other than food-related (i.e.,
clothing exchange, ESL practice, childcare, babysitting networks)
BKKS cooking - sections discussing children learning cooking skills as benefits
BKKS food safety - sections discussing children learning food safety skills as benefits
BKKS nutrition/healthy eating - sections discussing children learning nutrition/healthy
eating skills as benefits
BKP-S community integration - sections discussing children integrating in
school/community as benefits
BKP-S emotional support - sections discussing children meeting new
friends/socializing/feeling good as benefits
BKP-S enjoyment - sections about children enjoying themselves in the program (playing
games, playing with each other, cooking/baking, eating)
BKP-S social skills - opportunities for or developing/enacting social skills with others
around (other kids, staff, parents)
BPKS cooking - sections where respondents think that parents benefit from program by
developing cooking skills
BPKS food safety - sections where respondents think that parents benefit from program
by developing food safety skills
BPKS nutrition/healthy eating - sections where respondents think that parents benefit
from program by developing nutrition/healthy eating skills
BPP-S community integration - sections where respondents think that parents benefit
from program by integrating in community (i.e, involved in other school programs, come
to school more often, networking at school/community, volunteering)
BPP-S emotional support - sections where respondents think that parents benefit from
program by meeting friends/socializing/doing things that make them feel good about
themselves, increased confidence in themselves
BPP-S enjoyment - enjoyment/having fun in CFF as a benefit to parents; program as
enjoyable, something to look forward to (some - hopefully minimal - overlap with PSP-S
enjoyment)
BPP-S social skills - learning to work as a team, in a group setting, organization, sharing
tasks
Expectations from CFF - mainly responses to the question: "what are your expectations
of the program?" as well as other more indirect instances I could catch discussing the
same; some overlap with "main focus of CFF" below

Language/communication - how people communicate (i.e., in what language do parents communicate with each other and with staff, ESL barriers, what staff use to communicate with non-English speaking participants)
main focus of CFF - what respondents think are the foci and goals of CFF
P Improvement - what needs to be improved in program; suggestions
PC family, children - conversations about family/children, not necessarily always in relation to CFF (sometimes as a description of the family)
PC food, nutrition, food safety - conversations about food/nutrition/food safety
PD culture - culture as a factor in: differences in recruitment, socializing between parents, parents and staff, understandings about food and cooking, etc.
PD food - mainly menu summaries
PD kids - description of kids and/or their activities
PD parents - description of parents and/or their activities
PD staff - description of staff and/or their activities
PI kids/kids – description of interactions between children
PI parents/kids – description of interactions between parents and children
PI parents/parents – description of interactions between parents
PI researchers - researchers with parents/kids/staff/other interactions
PI staff/kids – description of interactions between staff and children
PI staff/parents – description of interactions between staff and parents
PO accountability - mainly responses to question: "Who are you accountable to?"
PO funding - sections discussing funders, funding issues/strategies, Food Bank use
PO leadership - sections dealing with interview questions about (staff) leadership
PO program planning – sections describing program planning
PO recruitment/attendance - both codes about recruitment and names/numbers of people who attended the sessions; second coding only about recruitment
PO space - descriptions about setting of programs
PO staffing - staffing strategies/issues
PO support: administrative - emphasis on financial; overlap with "PO support: staff"
PO support: parents – description of organization of support for parents
PO support: staff - emphasis on emotional; overlap with "PO support: administrative"
PO training - training of staff issues; mainly limitations
PS challenges – challenges to program strategies
PS cooking - observations/specific instances where parents are learning about food/cooking, are participating in preparation
PS recipe - whether/how recipes are distributed, how parents read/translate/use them
PSFS behaviours - sections in observations or specific examples given in interviews where participants are enacting food safety behaviours; overlap with "PSFS skills" below because not clear about the difference between behaviours and skills in this context
PSFS education - sections in observations or specific examples given in interviews where participants are potentially learning about food safety
PSFS skills - see "PSFS behaviours" above

PSFSec budget, shop - combined in 2nd coding under "food security"; sections in observations or specific examples given in interviews where participants are potentially learning about budgeting skills, shopping inexpensively; some overlap with "PSFSec learning inexpensive"

PSFSec food home - combined in 2nd coding under "food security"; sections in observations or specific examples given in interviews where participants take prepared food or ingredients home

PSFSec learning inexpensive - combined in 2nd coding under "food security"

PSN behaviours - sections in observations or specific examples given in interviews where participants are enacting nutrition/healthy eating behaviours; much overlap with "PSN skills" below because not clear about the difference between behaviours and skills in this context

PSN education - sections in observations or specific examples given in interviews where participants are potentially learning about nutrition/healthy eating

PSN skills - see PSN behaviours above

PSP-S breaking down isolation - strategies such as allowing parents to come to the place on days other than when the program is held, encouraging parents to work together and get involved in things together, meet others, etc.

PSP-S enjoyment – psychosocial strategies involving fun atmosphere, having music, etc.

PSP-S self efficacy, confidence, emotional support – psychosocial strategies involving self-efficacy, self confidence and exchange of emotional support

Appendix R: List of Codes

Goals/Expectations:
      Expectations from CFF
      main focus of CFF/goals

Program:
      Description
            PD culture
            PD food
            PD kids
            PD parents
            PD staff
      Organization
            PO accountability
            PO funding
            PO leadership
            PO program planning
            PO recruitment/attendance
            PO space
            PO staffing
            PO support: administrative
            PO support: parents
            PO support: staff
            PO training
      Strategies
            Cooking and Recipes
                  PS cooking
                  PS recipe
            Food Safety
                  PSFS behaviours
                  PSFS education
                  PSFS skills
            Food Security
                  PSFSec budget, shop
                  PSFSec food home
                  PSFSec learning inexpensive
            Nutrition
                  PSN behaviours
                  PSN education
                  PSN skills

           Psycho-social
                PSP-S breaking down isolation
                PSP-S enjoyment
                PSP-S self efficacy, confidence, emotional support
           Interactions
                PI kids/kids
                PI parents/kids
                PI parents/parents
                PI researchers
                PI staff/kids
                PI staff/parents
           Conversations
                PC family, children
                PC food, nutrition, food safety
           Language/communication
                Language/communication

Benefits:
    Nutrition
        Family
            BF eating together
            BF food security
            BF instrumental support
        Parents
            BPKS cooking
            BPKS food safety
            BPKS nutrition/healthy eating
        Kids
            BKKS cooking
            BKKS food safety
            BKKS nutrition/healthy eating
    Psycho-social
        Parents
            BPP-S community integration
            BPP-S emotional support
            BPP-S enjoyment
            BPP-S social skills
        Kids
            BKP-S community integration
            BKP-S emotional support
            BKP-S enjoyment
            BKP-S social skills

Appendix R: List of Codes (cont'd)

Program Challenges and Improvements
      PS challenges
      P Improvement