A Mixed-Methods Case Study Evaluation of a Community-Based Food Literacy Program in the North End of Winnipeg: Community Tables

By

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ABSTRACT

A substantial number of community members access food in community-based organizations in the North End of Winnipeg. However, many staff and volunteers in these organizations do not have adequate nutrition knowledge and food skills, nor are there healthy food policies to guide food programs. Food Matters Manitoba developed a food and nutrition education program, Community Tables. The purpose of this study was to evaluate Community Tables for its effectiveness in increasing staff/volunteer basic nutrition knowledge and food skills, and facilitating the adoption of healthy food policies by participating organizations. Data collection included questionnaires to determine knowledge acquisition and participant satisfaction, and in-depth follow-up interviews to determine each participant's experience with developing/implementing a healthy food policy. Results suggest that the program was moderately successful in increasing participant food and nutrition knowledge; and while three organizations were able to implement policies to some degree, others faced challenges, which prevented full implementation.

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Table of Contents

List of Figures and Tables

CHAPTER ONE

Introduction

Research Problem Statement

There are twenty community-based organizations in Winnipeg's North End that serve food to over nine hundred community members every month (Bewza, 2011). These initiatives began due to the high rate of poverty and food insecurity[1] in the area (Malabar & Grant, 2010). Community-based organizations are non-profit organizations that work at the community-level and are intended to bring forth positive change to their surrounding community. However, building a healthy community cannot happen if food program staff and volunteers lack basic nutrition knowledge and food skills to serve healthier food (Bewza, 2011). To address this problem, Food Matters Manitoba[2] developed the program, Community Tables. Community Tables was developed to incorporate capacity building, to enhance traditional "fusion" food (traditional Aboriginal foods and contemporary market food) and culturally appropriate food access, and to increase food literacy[3]. Food Matters Manitoba partnered with the University of Manitoba (Dr. Joyce Slater, Department of Human Nutritional Sciences) to develop, implement, and evaluate the Community Tables program.

[1] Food security exists when "all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life" (World Health Organization, 2015).

[2] Food Matters Manitoba is a community-based organization that advocates and promotes healthy eating by partnering with northerners, newcomers, farmers and families, including within Winnipeg's North End (Food Matters Manitoba, 2014).

[3] Food literacy refers to "a collective of inter-related knowledge, skills, and behaviors required to plan, manage, select, prepare and eat foods to determine food intake, as well as the scaffolding that empowers individuals, households, communities and nations to protect diet quality" (Vidgen & Gallegos, 2014, p. vii).

Community Tables

A. Program Overview

Community Tables is part of a large health promotion and food security project, called Our Food Our Health Our Culture, which is implemented by Food Matters Manitoba and funded by the Public Health Agency of Canada. The Our Food Our Health Our Culture project is intended to create a supportive environment, where cultural foods and healthy foods are valued and accessible, within its three target sites: the North End of Winnipeg, Fox Lake Cree Nation, Manitoba and La Ronge, Saskatchewan.

In Phase I (2010-2012), the Winnipeg's North End community-based organizations identified "community agency food standards and associated training" as a priority intervention. In Phase II (2012-2016), Community Tables was piloted in November 2013 (Session 1), to determine which program components and evaluation tools were appropriate. Using the findings of this pilot, the program was fully launched in May 2014 (Session 2). This evaluation enabled Food Matters Manitoba to modify the program and evaluation process to ensure smooth and effective operation in the future.

B. Rationale for the Program

Winnipeg's North End has a high population of Aboriginal people, newcomers, and disadvantaged/vulnerable groups with low socioeconomic status, including children, youth, seniors/elders, and families (City of Winnipeg, 2014). Winnipeg's North End has high incidences of low income compared to the rest of Winnipeg, approximately $20,000 less per household annually compared to the rest of Winnipeg (City of Winnipeg, 2014; Winnipeg Regional Health Authority, 2004). This area has been referred to as a "food desert", meaning community members have limited access to retail food stores, and as a result often pay "high

costs for food of little nutritional value" at corner/convenience stores (Malabar & Grant, 2010). With low incomes, these populations have high rates of food insecurity and regularly access food that is often nutritionally deficient through community-based organizations.

C. Program Description

Staff and volunteers from twenty community-based organizations in Winnipeg's North End who provide supplemental food through snacks, meals and hampers to vulnerable groups were recruited to participate in the nutrition education program, Community Tables, to:

a) increase staff nutrition knowledge and food skills

b) develop feasible healthy food guidelines (policy) for their organizations (e.g. utilization of charitable food donations to maximize nutrition; nutritious menu planning).

Community Tables is an 8-module nutrition education program, offered in one half-day session per week, for five weeks. Three of these sessions consist of both theoretical and applied components (hands-on food experience). A trained nutritionist who is knowledgeable in adult education developed and facilitated the program. An ad-hoc committee of North End organization representatives selected the following program content:

- Basic Nutrition, Sugar (Week 1)
- Label Reading, Recipes (Week 2)
- Budgeting, Food Bank Food, Food Buying in Winnipeg (Week 3)
- Menu Planning, Basic Shelf Food List, Cooking without a Kitchen (Week 4)
- Healthy Food Guidelines (Policy) (Week 5)

Rationale for Program Evaluation

In planning any successful program, a mixed-methods evaluation approach that actively involves all parties either before and/or during the program's implementation is essential (Israel

et al., 2010; Israel et al., 1998). An evaluation of Community Tables was necessary to describe and assess what was intended (goals and objectives), what was unintended, what was actually implemented, and what outcomes and results were achieved (Patton, 2012). It was important that the content and flow of its program components was appropriate, so that the community members could perceive the program as effective. By following a Utilization-Focused Evaluation[4] approach, the results are more likely to be used by the program organizers in order to improve the program.

Relevance of Study

Community Tables is a novel community-based program that required an equally novel community-based, participatory evaluation strategy. This comprehensive evaluation report can help similar food and nutrition programs in their development, implementation and evaluations. Maximizing the impact of the program benefits the program participants, Winnipeg's North End community, and the program organizers, Food Matters Manitoba. It is anticipated that making these positive changes in organizations will positively impact dietary intake among Winnipeg's North End community members, thus improving food and nutrition insecurity in the community.

[4] Utilization-Focused Evaluation (UFE), developed by Michael Quinn Patton, is an approach based on the principle that an evaluation should be judged on its usefulness to its primary intended users and engages the primary intended users in every step of the evaluation process (Patton, 2012).

CHAPTER TWO

Literature Review

This literature review will focus on building capacity in community-based programs to improve food and nutrition security; the importance of serving healthier, and where possible, traditional Aboriginal foods; and evaluating these programs in a meaningful way for the community. It will begin with background information on the community where the Community Tables program and evaluation research occurred.

Socio-demographic Profile of Winnipeg, Manitoba

Winnipeg is the capital city of the province of Manitoba, Canada and is located in the southern region of the province. As of January 2014, the population of Manitoba was estimated to be 1,272,000 and the population of the Winnipeg Health Region is approximately 734,187 (Manitoba Bureau of Statistics, 2014). Winnipeg has the largest urban Aboriginal[5] population of all the major cities in Canada, which was 78,420 in 2011 (Aboriginal Affairs & Northern Development Canada, 2013). The off-reserve First Nations population in the Winnipeg Health Region was 24,674 (Manitoba Bureau of Statistics, 2014). A map of the Winnipeg Health Region geographical boundaries is found in Figure 1. The focus of this literature review will be on Winnipeg's North End area, in which the Community Tables program is implemented.

[5] The term "Aboriginal people" describes the three groups that comprise Canada's indigenous population: First Nations, Métis, and Inuit.

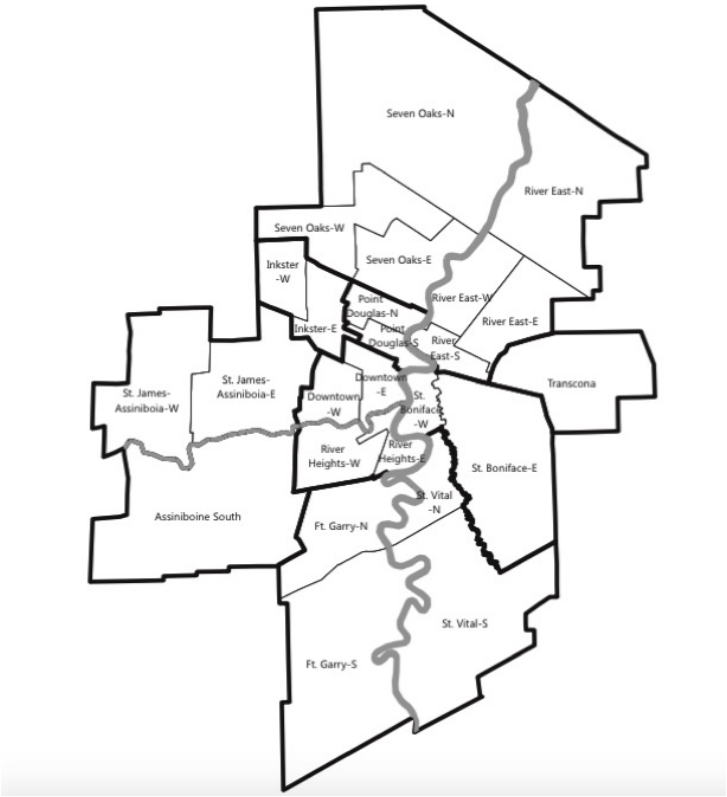


Figure 1. Map of Winnipeg Health Region with Community Areas and Neighborhood Clusters (Source: Fransoo et al., 2013)

Socio-demographic Profile of the North End of Winnipeg

Geographical Boundaries. Many organizations have differing boundaries of Winnipeg's North End (L. Rappaport, personal communication, September 15, 2014). Winnipeg's North End is generally bordered by the Red River on the east, the Canadian Pacific Railway mainline on the south, McPhillips Avenue on the west, and Carruthers Avenue on the north. It generally encompasses the following ten neighborhoods: Robertson, Inkster-Faraday, St. John's, Luxton, St. John's Park, Burrows Central, William Whyte, Dufferin (Dufferin Industrial), Lord Selkirk Park, and (North) Point Douglas (Figure 2). The City of Winnipeg is divided into twelve

Community Areas. The Community Area that represents Winnipeg's North End is Point Douglas. Throughout the literature review, Point Douglas data is used.

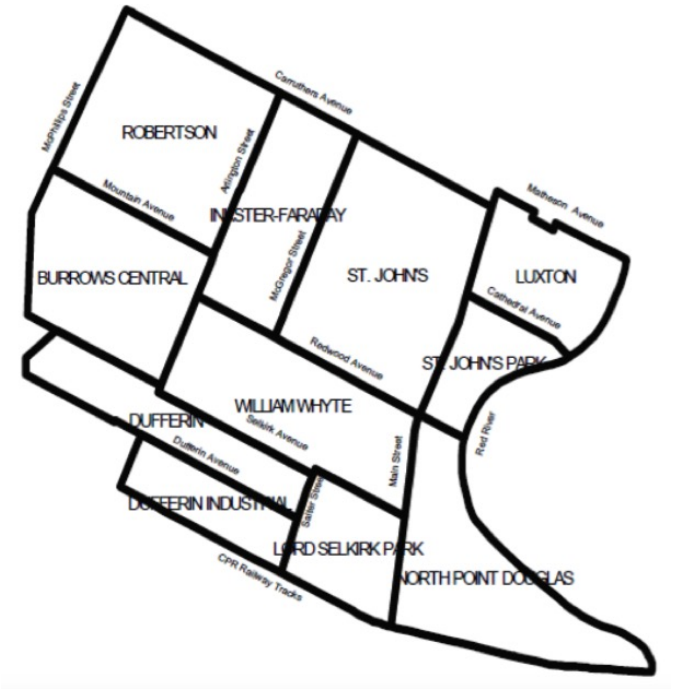


Figure 2. Winnipeg's North End Communities/Neighborhoods

(Source: North End Community Renewal Corporation, 2015)

Demographics. The 2006 Census reported that the population of the Point Douglas Community Area was 41,897 (Winnipeg Regional Health Authority, 2010). The Aboriginal population was 10,915, which constitutes approximately one third (29.0%) of the Community Area (City of Winnipeg, 2014). The Point Douglas Community Area also has a large number of immigrants compared to other Community Areas: 7,795 (City of Winnipeg, 2014). There are a slightly higher percentage of people under 24 years of age and significantly more lone-parent families, when compared to the rest of Winnipeg (Malabar & Grant, 2010). The Point Douglas

Community Area has a high proportion of children and youth aged 19 years and under (29.7%) and mid-range proportion of seniors aged 65 years and older (12.6%) (Winnipeg Regional Health Authority, 2004). The Point Douglas Community Area had the second highest population density of 4014.4 people per square kilometer in the city (Winnipeg Regional Health Authority, 2010).

Poverty and Unemployment. Income is the most influential health determinant (WRHA, 2004). With lower incomes, many community members of Winnipeg settle in the poorer areas of the city, such as Winnipeg's North End (Balakrishnan & Jurdi, 2013). Poverty is a significant issue in the Point Douglas Community Area. In 2001, average household annual income was $33,831, compared to the City of Winnipeg average household annual income of $53,752 (WRHA, 2004). The Point Douglas Community Area had the highest incidence of low income (41%) of all Community Areas in the Winnipeg Health Region (WRHA, 2004). This value was more than double that for the Winnipeg Health Region (20.0%), Manitoba (18.0%), and Canada (16.0%) (WRHA, 2004).

Many community members are unemployed and rely on income assistance or other government programs (Malabar & Grant, 2010). In 2006, the unemployment rate among both male and female Point Douglas community members aged 25 years and over was 7.2% compared to the 3.9% rate for the City of Winnipeg (City of Winnipeg, 2014). Government programs do not appear to be having a significant impact on closing this income gap between the Aboriginal population and non-Aboriginal population (Adelson, 2005).

Nutritional Status of the Population: Risk & Outcomes

It is difficult for low-income families to consume a diet as recommended by Canada's Food Guide (Howard & Edge, 2013). Consequently, a diet with less variety, fewer vegetables and fruits is consumed compared to those who are food secure (Howard & Edge, 2013). A diet of

poor nutritional quality has been linked to the development of chronic disease, including diabetes, heart disease, obesity, hypertension, and hyperlipidemia (Howard & Edge, 2013).

Diet

Vegetables & Fruit Consumption. Vegetables and fruit are an important source of vitamins, minerals and fiber. Vegetable and fruit consumption is often used as an indicator for general nutrition status (WRHA, 2010). Low vegetable and fruit consumption is an important modifiable risk factor for poor health (Kettner, 2010). In Canada's Food Guide, it is recommended that women, men and teens ages 14+, should consume at least 7 servings of vegetables and fruit daily (Health Canada, 2007). Children between the ages 2-13 should consume 4-6 servings daily (Health Canada, 2007).

Similar to Canadian vegetable and fruit consumption trends, Manitobans do not consume daily requirements (Statistics Canada, 2013; Kettner, 2010). Only 40.6% of Manitobans reported eating at least the recommended number of servings of vegetables and fruit daily (Statistics Canada, 2013). Vegetable and fruit consumption trends in Winnipeg are slightly lower than those of Manitoba. Only about one-third (34.4%) of Winnipeg respondents indicated that they consume at least five servings of vegetables and fruit per day (WRHA, 2010).

Results from the Canadian Community Health Survey Cycle 1.1 (2001) and Cycle 2.1 (2003) combined found that only 35.6% of Point Douglas residents aged 12 years and older consumed vegetables and fruit "at least five times per day" (WHRA, 2013). Only 25% of Grade 7-12 Point Douglas students reported consuming vegetables and fruit "two or less times a day" and 36% reported consuming vegetables and fruit "three to six times per day" (WRHA, 2012). This vegetable and fruit consumption data is limited in that it tracks the "number of times per day" it is consumed, rather than number of servings consumed. This makes it difficult to

determine if this population is meeting the recommended servings outlined by Canada's Food Guide.

Sodium Consumption. Health Canada (2012) has recommended that adults should not exceed the Tolerable Upper Intake Limit of 2,300 milligrams per day to avoid health risks such as obesity and high blood pressure. In 2004, at least 70% of all age groups in Canada are exceeding this Tolerable Upper Intake Limit (Health Canada, 2012). Of Canadian children aged one to three, 77% exceed the recommended Tolerable Upper Intake Limit and 93% of children aged four to eight did as well (Health Canada, 2012). Of Canadian adolescents aged nine to eighteen, 97% of boys exceed the Tolerable Upper Intake Limit and 82% of girls consume sodium above this limit (Health Canada, 2012). In Manitoba, more than 90% of men and 70% of women report exceeding the recommended amount of salt in their diet (Health Canada, 2012). Monteiro et al. (2013) identified ultra-processed products, which are "attractive, hyper-palatable, cheap, ready-to-consume food products that are characteristically energy-dense, fatty, sugary, and/or salty and generally obesogenic." In the early 2000s, ultra-processed products have risen to over half of all calories consumed in Canada and are displacing foods such as potatoes, legumes, milk, and fruits in Canada (Moubarac et al., 2013). These products are becoming dominant in the global food system, including food desert environments such as Winnipeg's North End.

Health Outcomes and Health Status

Diabetes Mellitus. Diabetes mellitus occurs when the body does not produce enough insulin, or when the insulin function is impaired (Canadian Diabetes Association, 2012). Diabetes may lead to a reduced quality of life as well as complications such as heart disease, stroke and kidney disease (Statistics Canada, 2013). In 2012, 6.5% (1.9 million) of Canadians aged 12 or older had diabetes that was diagnosed by a health professional (Statistics Canada,

2013). This was not a significant change from 2011, though it was an increase from 5.8% in 2007 (Statistics Canada, 2013). Local data is reported in terms of the number of people receiving treatment for diabetes (Figure 3). In Manitoba, the number of people receiving treatment for diabetes increased from 6.7% to 8.7%, from 1998-2001 to 2003-2006, respectively (WRHA, 2010). In Winnipeg, the number of people receiving treatment increased from 6.2% to 8.2%, from 1998-2001 to 2003-2006, respectively (WRHA, 2010). In the Point Douglas Community Area, the number of adults who received treatment for diabetes increased from 8.8% to 11.3%, from 1998-2001 to 2003-2006, respectively (WRHA, 2010). Data from 2003/04-2005/06 showed that diabetes prevalence in the "Point Douglas North" (~10%) and "Point Douglas South" (~14%) neighborhood clusters exceeded the Manitoba average (~9%) and both increases for each area were statistically significant (Fransoo et al., 2009).

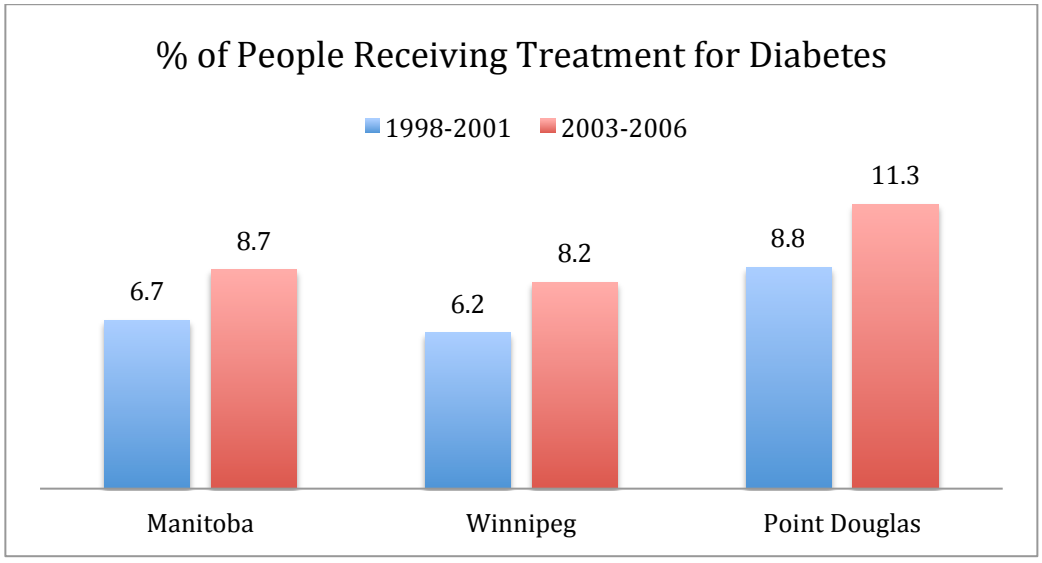


Figure 3. Comparison of Diabetes Treatment Rates

Source: Winnipeg Regional Health Authority, 2010

High Blood Pressure. In 2012, 17.4% (5.1 million) of Canadians aged 12 and older reported having high blood pressure (Statistics Canada, 2013). This was not a significant change

from 2011, though it is an increase from 16.4% in 2008 (Statistics Canada, 2013). In Manitoba, the population who received treatment for high blood pressure increased from 20.6% to 23.7%, from 2000-2001 to 2005-2006, respectively (WRHA, 2010). In Winnipeg, the population who received treatment for high blood pressure increased from 20.3% to 22.9%, from 2000-2001 to 2005-2006, respectively (WRHA, 2010). In the Point Douglas Community Area, the number of adults who received treatment for high blood pressure increased from 21.6% to 24.8%, in 2000-2001 and 2005-2006, respectively (WRHA, 2010). A comparison shows that Point Douglas rates exceed both Winnipeg and provincial rates (Figure 4).

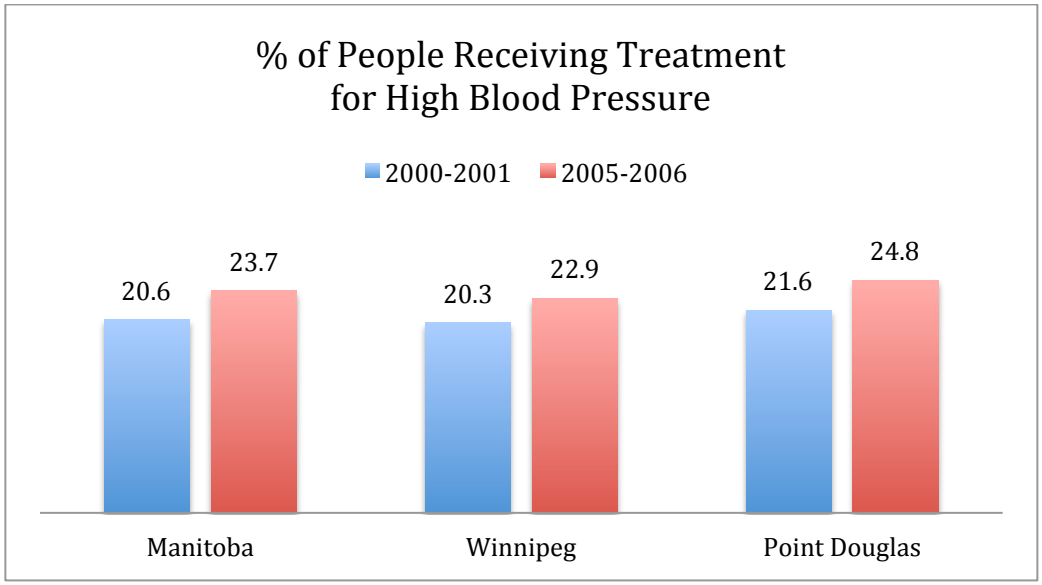


Figure 4. Comparison of High Blood Pressure treatment rates

Source: Winnipeg Regional Health Authority, 2010

Overweight & Obese Adults, Youth & Children. About one-quarter of Canadian adults are obese (Public Health Agency of Canada, 2011). In 2012, 18.4% of Canadians aged 18 and older reported height and weight that classified them as obese (Statistics Canada, 2013). In the same year, 41.3% of men and 26.9% of women reported height and weight that classified them as overweight, which have not significantly changed since 2003 (Statistics Canada, 2013).

In the 2004 Canadian Community Health Survey, it was found that 31% of Manitoba youth and children aged two to seventeen were overweight or obese (Yu et al., 2010). Overweight and obesity in Manitoba youth is positively correlated with low levels of daily vegetable and fruit consumption and regular physical activity (Yu et al., 2010). In Manitoban males aged 12 to 17, food insecurity increased the likeliness of overweight and obesity (Yu et al., 2010). In Manitoba, the proportion of residents categorized as "obese" in Winnipeg (18.4%) was close to the provincial rate (20.8%) (WRHA, 2010).

In Point Douglas, 39.4% of adults are overweight and 22.0% of adults are obese (WRHA, 2010). The Point Douglas Community Area has many below average health outcomes, including cardiovascular disease, cancer, and diabetes (WRHA, 2004).

The Winnipeg North End Food Environment

In October 2008, the North End Food Security Network (NEFSN) was launched in response to food insecurity in Winnipeg. Lead consultants Malabar and Grant (2010) reported several significant findings in the North End Food Assessment Report, most notably the charitable model that exists around food and the poverty that affects health and food security. A survey conducted among forty community members found that the majority of respondents (62.5%) sacrificed groceries to pay rent, among other bills (Malabar & Grant, 2010). In the past 2 months, 50% of respondents had used food banks and 44% corner stores; 81% agreed that the fresh fruits and vegetables are expensive in the North End; 88% of respondents agreed that meat and protein were expensive in the North End; 68% of respondents agreed that it is difficult to grocery shop in the North End; and 44% indicated that some foods are difficult to get in the North End (Malabar & Grant, 2010).

The food environment in Winnipeg's North End has been described as a "food desert" (Malabar & Grant, 2010). A food desert is generally defined as an impoverished area lacking in grocery stores that sell healthy food at affordable prices (American Nutrition Association, 2015). In 2010, the North End had sixty-two corner/convenience stores and only three large chain grocery stores (Malabar & Grant, 2010). However, two of the grocery stores sell food notably higher than the prices found in the rest of the city (Malabar & Grant, 2010). There are a higher percentage of people in the North End who rely on public transportation or walking as their main means of transportation compared to other Community Areas in Winnipeg (Malabar & Grant, 2010). Because of the reliance on public transportation, many residents cannot go to grocery stores outside of the area and rely heavily on the corner/convenience stores for food, which have few (and more expensive) nutritious foods.

Malabar and Grant (2010) published an inventory of existing food security initiatives in Winnipeg's North End. Approximately twenty community-based organizations had charitable programs in which food is prepared and served as snacks, breakfast, lunch, and/or supper to community members of all ages. This is a significant number of organizations that provide food to children, families, adults, and/or seniors on a regular basis. Without any guidelines surrounding food, food that is more convenient to prepare (and incidentally less nutritious) is served. Furthermore, food program staff and volunteers reported not having the time or energy to do health and nutrition programming, which results in less nutritious food being prepared and served to community members (Bewza, 2011). Almost all North End community-based organizations also offer short-term relief for hunger, primarily through food bank and/or emergency food depots (Malabar & Grant, 2010). The high number of charitable programs in this area further emphasizes the need for capacity building to overcome food insecurity.

Food Security

Food security exists when "all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life" (World Health Organization, 2015). Conversely, food insecurity is defined as limited or uncertain accessibility or availability of nutritionally adequate and safe foods (Tarasuk, 2001; Carter et al., 2013). Household food security is influenced by a "household's ability to pay for food, physical access to adequate food resources, health requirements for nutritious food, and preferences for culturally appropriate food for an active and healthy lifestyle" (Howard & Edge, 2013). Food insecurity is not typically examined in terms of the underlying poverty-related problem, which contributes to increased food bank usage (Tarasuk, 2001). Other key risk factors in household food insecurity include: the costs of food and non-food essentials; geographic isolation; lack of transportation; and food literacy (the skills, knowledge, and behavior of how to choose and prepare nutritious foods) (Howard & Edge, 2013; Skinner et al., 2013). The populations that are at risk of being affected by one or more of these risk factors include those groups who are highly represented in Winnipeg's North End – Aboriginal peoples, lone-parent families, women and children, immigrants, and the elderly (Howard & Edge, 2013; Malabar & Grant, 2010). Food insecurity results in increased social and health costs at both the local and national level (Howard & Edge, 2013).

Food Insecurity in Canada

The *Household Food Security Survey Module* in the 2012 Canadian Community Health Survey found that 1.7 million Canadian households, or slightly more than 12.6%, experienced some level of food insecurity (Tarasuk, Mitchell & Dachner, 2013). This number slightly increased from 2011 and amounts to nearly one in eight households and 4 million individuals in

Canada, including 1.15 million children (Tarasuk, Mitchell & Dachner, 2013). In 2012, one of five households who were food insecure was severely food insecure (Tarasuk, Mitchell & Dachner, 2013). Lone-parent households had the highest incidence of food insecurity for all living arrangements (Statistics Canada, 2013). The findings from the Canadian Community Health Survey are limited as certain populations were excluded from data collection.

Food Insecurity in Manitoba

In the 2011-2012 Canadian Community Health Survey, the percentage of households with food insecurity in Manitoba (7.9%) was slightly less than the national average (8.3%) (Statistics Canada, 2013). The prevalence of total (marginal, moderate and severe) food insecurity was found to be 12.4% in Manitoba and 12.3% in Canada (Tarasuk, Mitchell & Dachner, 2013). Including marginal food insecurity is important because this level of uncertainty over access to food makes one more vulnerable than those who have no level of uncertainty (Tarasuk, Mitchell & Dachner, 2013). Furthermore, the proportion of children who lived in food insecure households was 18.9% in Manitoba (Tarasuk, Mitchell & Dachner, 2013).

Food Bank Usage

One measure of food insecurity is self-reported food bank usage data; this data is collected by Food Banks Canada. Food banks are "extra-governmental community organizations that collect donated foodstuffs and redistribute them to the needy, working largely with volunteer labor and donated equipment and facilities" (Tarasuk, 2001). Increasing food bank usage in Canada illustrates either a higher need, or greater awareness of food banks as a resource (Howard & Edge, 2013). The latest *Food Banks Canada Hunger Count Report 2014* found that 841,191 Canadians used a food bank in March 2014 (Food Banks Canada, 2014). This number increased by 1% compared to the same period in 2013, and is 25% higher than in 2008 (Food Banks

Canada, 2014). An increase in food bank users is likely related to the number of food-insecure households (Howard & Edge, 2013).

Of all food bank users, 48% received social assistance (Food Bank Canada, 2014). One in seven individuals who received food bank assistance self-identified as First Nations, Métis, or Inuit (up from 11% in 2012 to 14% in 2014) (Food Banks Canada, 2014). Twelve percent of food bank users are immigrants or refugees, which has increased to 20% in cities with populations greater than 100,000 (Food Banks Canada, 2014). The total number of Manitobans assisted by food banks in the month of March 2014 was 61,691, 44.3% of which were children, which is up 2.4% from the previous year and up 52.5% since 2008 (Food Banks Canada, 2014). Winnipeg Harvest is a food distribution and training centre that distributes food to more than 60,000 people each month through 384 agencies, including schools, daycares, soup kitchens, drop-in centres, nutritional meal and snack programs and senior programs (Winnipeg Harvest, 2013). The high reliance on food donations by community-based organizations further emphasizes the need to serve healthy foods through these initiatives.

Characterizing the Aboriginal Population

Aboriginal status is a social determinant of health (Mikkonen & Raphael, 2010). Given that Winnipeg, in particular the North End, has the highest urban Aboriginal population in Canada, the food security issues and consequent health status among this segment of the population merits further attention. It is important to note that the histories and present-day experiences of urban/rural First Nations (status, non-status, on-reserve, off-reserve), Inuit and Métis people need to be recognized as distinct and unique (National Collaborating Centre for Aboriginal Health, 2013).

Population Statistics

In the 2011 *National Household Survey*, 1,400,685 people self-identified as Aboriginal, representing 4.3% of Canada's total population (Aboriginal Affairs & Northern Development Canada, 2011). In recent years, the Aboriginal population growth rate has been exceeding the non-Aboriginal population growth rate (Balakrishnan & Jurdi, 2013). First Nations are the largest of the three groups, making up nearly 60% of the Aboriginal population living in Canada (Statistics Canada, 2010).

In the Winnipeg Health Region, 8.5% of residents self-identified as Aboriginal (WRHA, 2004). As of 2006, Point Douglas had the highest proportion of Aboriginal people (29%) compared to other Community Areas (WRHA, 2010). The Winnipeg Aboriginal people population is projected to almost double from about 80 000 to about 150 000 people by 2036 (WRHA, 2010).

Urbanization

According to the 2011 Census, the off-reserve Aboriginal population growth is surpassing any other demographic in Canada (AANDC, 2013). In 2011, 56% of Aboriginal people lived in urban areas, which is an increase from 50% in 2006 and 49% in 1996 (AANDC, 2013). The majority (75%) of First Nations are living off-reserve in urban areas (NCCAH, 2013). In 2011, Winnipeg had the largest Aboriginal population (78,420) in Canada (AANDC, 2013). The strong presence of Aboriginal people in urban areas will continue to increase (Balakrishnan & Jurdi, 2013).

The Benefits of Traditional Aboriginal Foods

Aboriginal people procure food through two overlapping food systems: "the harvesting, sharing and consumption of traditional foods and the purchasing and consumption of

market/commercial/store-bought foods" (Kuhnlein & Receveur, 1996). Traditional Aboriginal foods "originate from local plant or animal resources through gathering or harvesting, and which possess cultural meaning as a traditional food" (Willows, 2005). Some examples include deer, bison, rabbit, saskatoon berries and dandelion greens (Food Matters Manitoba, 2014). Studies have found that traditional foods are nutritionally superior compared to market/commercial/store-bought foods available in stores today (Elliot & Jayatilaka, 2011; Willows, 2011). In a 2010 study conducted in nine Manitoba First Nations communities, it was found that the nutritional quality of food intake of community members was improved when traditional food was eaten (Chan et al., 2012). The nutritional benefits of these foods include: less calories and saturated fat, and more iron, zinc, Vitamin A, and calcium (Centre for Indigenous Peoples' Nutrition and Environment, 2015). Besides these nutritional benefits, traditional food provides many significant holistic health benefits, such as improving community health and strengthening cultural identity (Willows, 2011; Elliot & Jayatilaka, 2011; Centre for Indigenous Peoples' Nutrition and Environment, 2015). Market foods are accessed in most settings that sell or serve food. For example, Aboriginal people access these foods at grocery stores, restaurants, and community-based organizations.

The 'Nutrition Transition'

Prior to colonization, Aboriginal peoples had strong health knowledge systems (NCCAH, 2013). Colonization played a critical role in the "nutrition transition" – the transition from an exclusive traditional diet (and associated procurement activities) to a diet of primarily market foods. The declining consumption of traditional foods over time has contributed to a significant decline in Aboriginal health that is exacerbated by many factors such as poverty and food insecurity (Kuhnlein & Receveur, 1996; Elliot & Jayatilaka, 2011; Skinner, 2013; Willows,

2005; NCCAH, 2013). Today, obtaining traditional foods through hunting or fishing is still threatened by a number of factors such as the high associated costs, the loss of traditional knowledge in the family (not having a skilled hunter/fisher in the family), the loss of traditional land, weakened cultural identity, increased urbanization, lifestyle adaptations, government restrictions and regulations on hunting and fishing, as well as contamination and species decline due to pollution and climate change (Elliot & Jayatilaka, 2011; Howard & Edge, 2013; Willows, 2011).

Aboriginal Health Status

In 2011, age-standardized rates show the prevalence of diabetes was: 17.2% for on-reserve First Nations, 10.3% for off-reserve First Nations, and 7.3% among Métis (Public Health Agency of Canada, 2011). These are remarkably high compared to the non-Aboriginal population diabetes prevalence – 5.0% (Public Health Agency of Canada, 2011). In 2007, off-reserve Aboriginal populations self-reported data have shown that obesity rates are higher compared to non-Aboriginal people (24.8% vs. 16.6%, respectively) (Public Health Agency of Canada, 2009). The off-reserve Aboriginal population has unique circumstances that affect their health and need to be examined further (Willows et al., 2011).

Food Insecurity in the Aboriginal Population

A major problem the Aboriginal population faces as a result of socio-cultural, political and environmental barriers is food insecurity. The burden of food insecurity is dramatically greater on the Aboriginal population than on the non-Aboriginal population (Skinner, 2013; Power, 2008; Howard & Edge, 2013). Aboriginal adults in food insecure households are more likely to have "poor general health, high stress, less life satisfaction, and a very weak sense of community belonging" (Willows et al., 2011).

Food Insecurity Rates. Aboriginal status increases the likelihood of food insecurity; 27% of Aboriginal households in Canada are food-insecure (Tarasuk, Mitchell & Dachner, 2013). This rate is more than three times higher than the non-Aboriginal population rate (Willows et al., 2008). Reflecting a similar trend, about one in five (20.9%) Aboriginal households living off-reserve are food insecure (Howard & Edge, 2013). In Canada, 13.6% of the 841,191 food bank users identified as Aboriginal (Food Banks Canada, 2014). Data on food bank users who identified as First Nations, Métis, or Inuit was unavailable in urban areas in Manitoba (Food Banks Canada, 2014).

The distinct food security issues that the Aboriginal population faces is not well understood (Power, 2008; Skinner, 2013). Furthermore, the current understanding of these issues that has been developed does not consider Aboriginal-specific contexts (Power, 2008). For the urban population whose diet is primarily market food-based, food insecurity issues may be defined and measured in ways similar to the non-Aboriginal population, which is not always appropriate (Power, 2008).

Barriers to Overcoming Food Insecurity in an Urban Context

The urban setting, particularly the food environment, does not support strong cultural identity (Senese & Wilson, 2013). Many barriers are faced in terms of accessibility and availability of traditional foods. In rural and northern communities, it is already known that it is difficult to obtain healthy market foods (Willows, 2005). However, the health of Aboriginal people moving from a reserve or rural community to an urban centre declines as they experience difficulties (Adelson, 2005). These difficulties include "linguistic and cultural barriers to healthcare, a lack of Aboriginal healthcare professionals and limited access to dietitians and nutrition services for pregnant and breastfeeding women" (Macaulay, 2009). However,

considering traditional food specifically, government regulation can pose as an additional barrier in that it drastically limits the amount of traditional meats available for public consumption. The *Natural Resources Transfer Agreement,* which forms part of the *Constitution Act, 1930,* provides First Nations *Fishing, Hunting, and Gathering Rights and Responsibilities* to "sell, trade, barter, or give away fish, meat, or any part of a wild animal with other First Nations individuals" (Government of Manitoba, 2015). Wild animals (namely bison, elk, and deer), which are legally referred to as game production animals under *The Wildlife Act*, are permitted for sale to the public if they are farmed[6] (Government of Manitoba, 1996). There are stores in Winnipeg, including in the North End, that sell some farmed game meats year-round (eg: deer and bison) (Food Matters, 2014). All other meats, such as moose and caribou, are not government-regulated and cannot be purchased in stores, for food safety reasons. Further examination of the consumption patterns of traditional foods in an urban setting would be beneficial in terms of understanding food security in this context (Elliot & Jayatilaka, 2011).

The Promising Role of Traditional Aboriginal Foods in an Urban Context

The revitalization of traditional Aboriginal foods has not been well supported by the federal government and has consequently resulted in many Aboriginal people consuming a diet based heavily on market foods (Suschnigg, 2012). Despite the challenges, Aboriginal people still want to eat traditional foods (Elliot & Jayatilaka, 2011). The 2008/10 Manitoba First Nations Longitudinal Regional Health Survey determined that the consumption of land-based animals increased for First Nations adults living on-reserve and has remained the same for youth since the 2002/03 Regional Health Survey (First Nations Information Governance Centre, 2011).

[6] Farmed meat is produced using government-approved processes in a government-approved facility.

Though these numbers reflect on-reserve Aboriginal populations, this does not mean that urban Aboriginal populations do not want to consume these foods as the urbanization rate is steadily increasing. The North End Food Assessment Report survey also found that in the past 12 months a significant portion of community members who were surveyed, had eaten traditional and land-based foods (Malabar & Grant, 2010).

Despite the combination of the high Aboriginal presence and high rates of food insecurity in urban areas, the current research does not reflect the clear need for more knowledge in this area (Elliot & Jayatilaka, 2011). In the research that has been done, authors like Elliot and Jayatilaka (2011) have noted the inappropriateness of using standard food security definitions and measures in an Aboriginal context (Elliot & Jayatilaka, 2011). Similarly, Skinner (2013) observed, "current conceptualizations of food security lack the context, food practices, and perspectives of Aboriginal people". A thorough examination of food insecurity experienced by Aboriginal people in Canada has yet to be undertaken (Skinner, 2013).

Community-Level Response to Food Insecurity

Food insecurity has been recognized as an issue at the community level and strategies were developed in an attempt to address it. However, progress is limited by the underlying problem in the community – poverty (Tarasuk, 2001). By alleviating poverty, the burden of food insecurity at the household level would be significantly reduced (Howard & Edge, 2013). This is a difficult problem to overcome. The typical community-level response is the development of participatory, community-based programs designed to enhance individuals' knowledge and skills in food selection, shopping and preparation (food literacy) and to improve their access to food (Tarasuk, 2001). However, these community-based food security initiatives receive minimal

financial support, resulting in higher numbers of charitable responses (eg: food banks, soup kitchens) instead of capacity building responses (Tarasuk, 2001).

There are a number of concrete ways to build capacity in the area of nutrition in order to address the food insecurity at the community level. One important way of doing this would be to share community-based program frameworks and evaluation findings with each other. This would include sharing knowledge based on both community-generated and academic-generated experiences (Food Secure Canada, 2011). Conducting partnership-based research (that involves the community) in the process further builds community food security (Slater, 2007). A newer approach to building capacity for nutrition, which has been confirmed as effective in influencing eating behaviors in a variety of environments, will now be discussed.

Food Environment

The effect policy imposed on food environments has on promoting healthier eating behaviors has been receiving more attention in the past decade (Story et al., 2008). Food environments are defined as the "collective physical, economic, policy and sociocultural surroundings, opportunities and conditions that influence people's food and beverage choices and nutritional status" (Swinburn et al., 2013). Most food environments are not conducive to a healthy diet due to the overwhelmingly higher availability and easier access to processed, packaged foods in a majority of settings, including convenience stores and fast foods in restaurants (Swinburn et al, 2011). More recently, studies have focused on neighborhood environmental influences on diet, as opposed to the more heavily studied home, worksite or school environments (Ball et al., 2006).

Story et al. (2008) have demonstrated that, in addition to individual-level factors (eg: skills and behaviors), there are three important environmental contexts.

- The social environment involves interactions with family, friends, and community members who may impact food choices through social norms, as one example (Story et al., 2008).
- The physical environment includes settings where people eat or procure food such as at home or in the community. In addition, Story et al. (2008) identified seven common eating settings: homes, work-sites, schools, after-school and summer school programs, child care, neighborhoods and communities, restaurants and fast food outlets, supermarkets and convenience and corner stores. The physical settings within the community influence which foods are available to eat, and present either barriers that hinder or opportunities that facilitates healthy eating (Story et al., 2008).

The physical environment is of particular interest, as it pertains to community-based organizations. The community is the level where many community-based organizations and health organizations have the capacity to intervene. Knowledge is not sufficient to change people's food habits in the long-term (Mancino & Kinsey, 2008). Therefore, policies that support healthy eating are an important way of altering the food environment at the community level.

- Finally, the macro-level environment plays a more distal and indirect role but has a substantial effect on what people eat. The macro-level factors operate at a larger scope and include "food marketing, social norms, food production and distribution systems, agriculture policies, and economic price structures" (Story et al., 2008).

Story et al. (2008) found that all three levels of influence interact, both directly and indirectly, to influence food choices.

What is a food policy?

Evidence has confirmed that policy on physical environments has a greater effect on changing diets (Swinburn et al., 2011; Story et al., 2008). Merriam-Webster (2015) defines

policy as a "definite course or method of action (selected from among alternatives) and in light of given conditions to guide and determine present and future decisions." Food policies aim to enforce and maintain change at multiple levels. Policy interventions at the environmental level "tend to be more sustainable, affect the whole population, become systemic and reverse some of the environmental drivers compared with health education and promotion programmes" (Swinburn et al., 2011). At the local (or organizational) level, a food policy goal would be primarily to "prevent diet-related ill-health" (Lang, Barling, Caraher, 2009). Such local food policies include individual, family, and community group efforts to enforce change (Englberger et al., 2011).

Swinburn et al. (2011) developed a framework that illustrates that environmental interventions, even with greater political difficulty, have a greater effect on a population than behaviour (through health promotion programs) and physiology (through drugs and/or surgery) interventions. These interventions include targeting environmental drivers to the food supply and marketing environments, which promote high-energy intake (Swinburn et al., 2011). However, with any change, usually comes some form of resistance. Swinburn et al. (2011) affirms there is likely to be public reluctance to changing environments to which they have been accustomed.

Community-based initiatives must go beyond providing health education programs. Given that most Winnipeg's North End community-based organizations have food programs, which serve food to community members, it is important that the Community Tables program be effective at educating food program staff and volunteers how to develop and implement healthy food policies, which are a set of nutrition standards for providing healthier food and beverages.

Examples of Healthy Food Policies

The following two examples are local efforts to change specific food environments through policy: the Manitoba School Nutrition Policy and Making the Move to Healthy Food Choices. The extent of the effects of these policies have yet to be determined.

Manitoba School Nutrition Policy. One of the most established food and nutrition policies in Manitoba is the Manitoba School Nutrition Policy. In response to increasing concern about poor nutrition in Manitoban children, the provincial government launched the Healthy Kids, Health Futures All-Party Task Force in 2004 (Government of Manitoba, 2009). In 2005, the Task Force developed one strategy to increase access to nutritious foods in schools by requiring all schools to have a written school food and nutrition policy. Presently, it is mandatory for all schools in Manitoba to develop a school nutrition policy.

Making the Move to Healthy Food Choices. In Manitoba, it was identified that there is little selection of healthy food choices for meals and snacks at recreation facilities, where many families spend a great amount of time. In 2008, a toolkit was developed by the *Healthy Food Choices for Community Recreation Facilities Committee* for recreation facilities to offer nutritious food choices (Meadows et al., 2008). Part of the toolkit included practical information on how to serve and market nutritious food and a nutrition policy development guide with real examples of healthy food policies.

For policies at the local level to be successful, there needs to be awareness and training (Englberger et al., 2011). Collaboration among community and the community organizations increases the probability of success of these initiatives (Englberger et al., 2011). The primary goal should be to make appropriate changes in neighborhood environments that support healthy eating (Story et al., 2008).

Program Evaluation

What is program evaluation and why is it important?

To evaluate something, such as a program, process or policy, means to determine its "merits, worth, value, or significance" (Patton, 2012). An evaluation of a program involves answering questions such as: "How effective is the program?" "To what extent has the program been implemented as expected?" or "What goals, outcomes, and results were achieved by the program?" (Patton, 2012). Household food security programs are criticized for the "anecdotal evidence of success" that is most often presented (Howard & Edge, 2013). Additionally, little research has been published regarding successful community nutrition programs which implement environmental policy on food, which demonstrates the need for appropriate evaluation measures (Story et al., 2008). Suitable evaluative methods are important in order to "improve the focus of household food security initiatives and provide important information concerning the most effective aspects of the program" (Howard & Edge, 2013). Both qualitative and quantitative data should be collected and examined in evaluations (Howard & Edge, 2013).

Gaps in the Literature

While other food environments have been studied such as schools, worksites, health care facilities and homes, literature is lacking in strategies to improve community-based organization or neighborhood food environments, where many community members access food on a regular basis. There are few existing programs that aim to encourage policies, such as healthy food policies, in community-based organizations as its target outcome. Programs such as Community Tables are important to encourage healthy eating in vulnerable populations, as well as change the food environment in community-based organizations that offer food programs. This thesis project demonstrated the feasibility and impacts of implementing environmental policy on

nutrition and eating habits at the community level. This research also exemplifies the benefits of engaging in community-based participatory research, while adopting a utilization-focused framework. By doing so, this significantly increases the likelihood of a community-based nutrition program achieving its targeted outcomes and an evaluation producing meaningful results that will be used by the primary intended user to make program improvements. Well-executed evaluations can provide the evidence that the food security programs are worth investing in and ensure that they continue to be invested in (Howard & Edge, 2013).

Research Aim

This study employed an evaluation case study methodology to determine whether Community Tables increased the capacity of Winnipeg's North End community-based organizations to serve healthier food.

Research Objectives

- Determine whether participating organizations were able to develop and implement healthy food policies, as a result of Community Tables.
- To identify the factors that facilitated the development and implementation of a healthy food policy by community-based organizations.
- To identify the barriers experienced in the development and implementation of a healthy food policy by community-based organizations.
- To determine whether participants increased their food literacy (attitudes, skills, and knowledge about food) as a result of the program.
- To identify the factors that positively facilitated the implementation of the program.
- To identify the challenges faced in the implementation of the program.

CHAPTER THREE

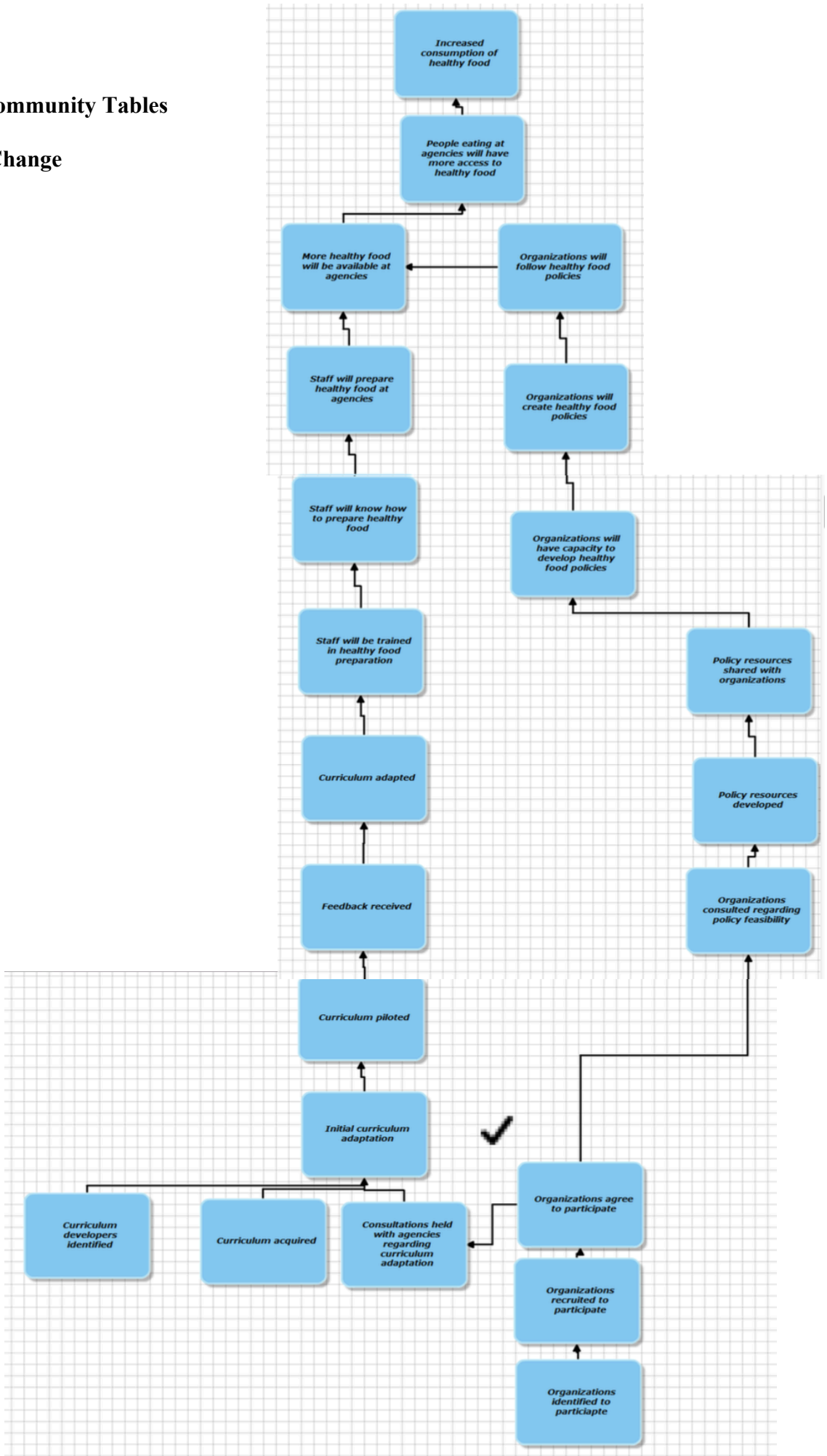
Methodology

Evaluation Design for Community Tables

Community Tables was evaluated for its effectiveness in helping community-based organizations increase food and nutrition capacity in food program staff and volunteers and adopting healthy food policies, using a mixed methods approach. The methods were developed collaboratively through meetings with the community organization, Food Matters Manitoba, over the course of the evaluation. Food Matters Manitoba developed a "theory of change" that guided the planning, decision-making and evaluation processes (The Center for Theory of Change, Inc., 2013) (Figure 5). A theory of change is a "graphic representation of the change process, depicting a set of building blocks or preconditions theorized to achieve the desired change" (The Centre for Theory of Change, Inc., 2013).

Figure 5. Community Tables

Theory of Change



Community-Based Participatory Research

Community-based participatory research is a "partnership approach to research that equitably involves community members and academic researchers in all aspects of the process, enabling all partners to contribute their expertise and share responsibility and ownership" (Israel et al., 2010). This approach can facilitate capacity building and policy change (Israel et al., 2010). Successful initiatives are characterized by effective partnerships with community-based non-profit organizations (Story et al., 2008). Working with the community is beneficial given the community partner's knowledge of local contexts and this active involvement in the evaluation enhances the relevance and increases the usefulness of the results. Collaboration is fundamental to the implementation and evaluation of Community Tables; Food Matters Manitoba and the University of Manitoba researchers equitably share control of the research agenda through active and reciprocal involvement in the research design, implementation and dissemination (Centre for Community Based Research, n.d.). Co-involvement in all phases of research is important so that all involved partners, both the academic research body and the community, will benefit.

Case Study Evaluation

A case study evaluation determines how an initiative (program), through examination of its processes, is connected to its outcomes (Yin, 2014). The use of a logic model can assume a key role in designing the needed case study evaluation (Figure 6). A logic model helps determine the process components of an initiative that lead to an output, followed by a desired outcome (Yin, 2014). A logic model was developed in order to theorize "how the actions might produce the immediate outcome of interest" (Yin, 2014). Developing a logic model benefits from the complex, nonlinear dynamics that a Utilization-Focused Evaluation allows. Figure 7 illustrates the planning of the logic model.

Figure 6. Program Logic Model

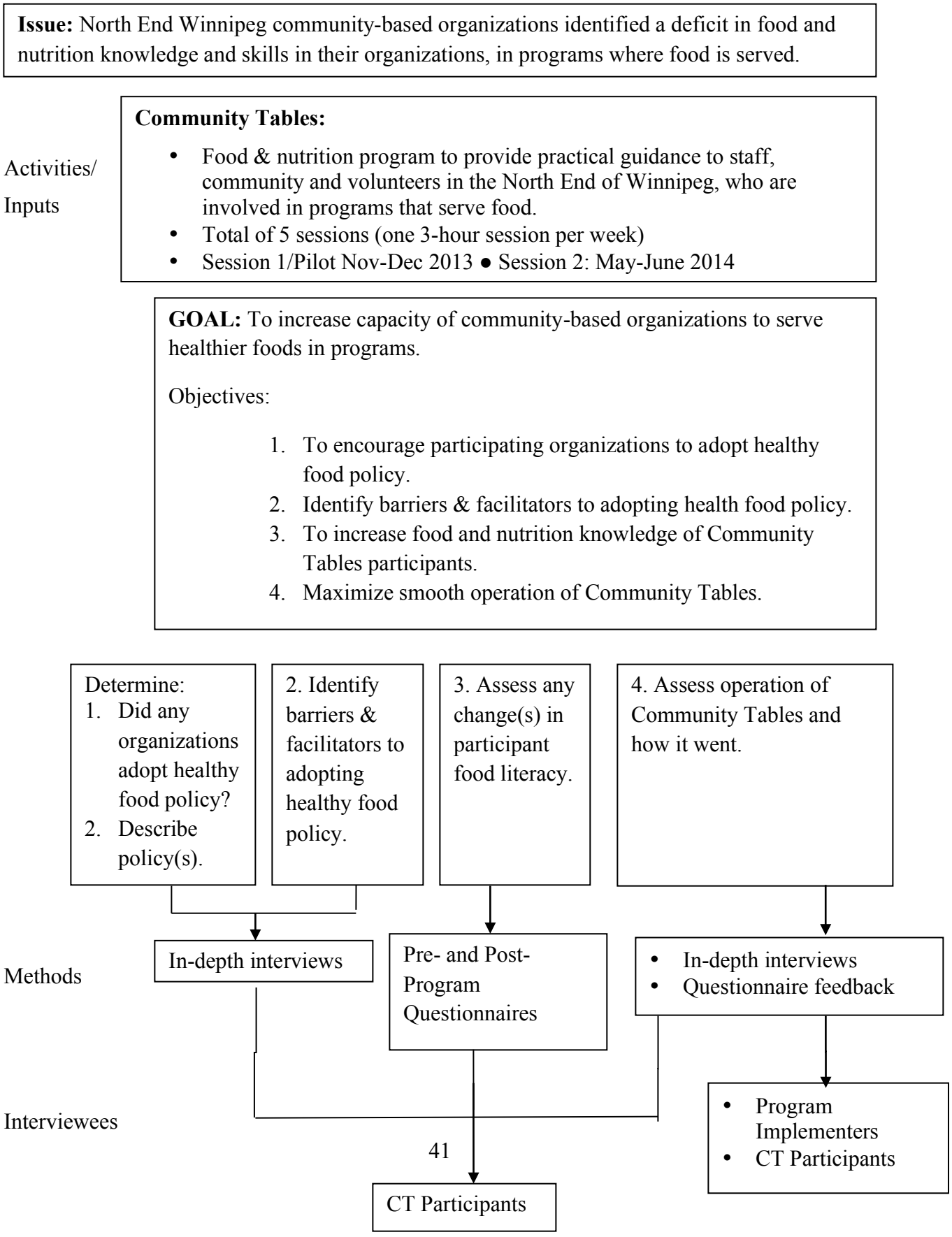
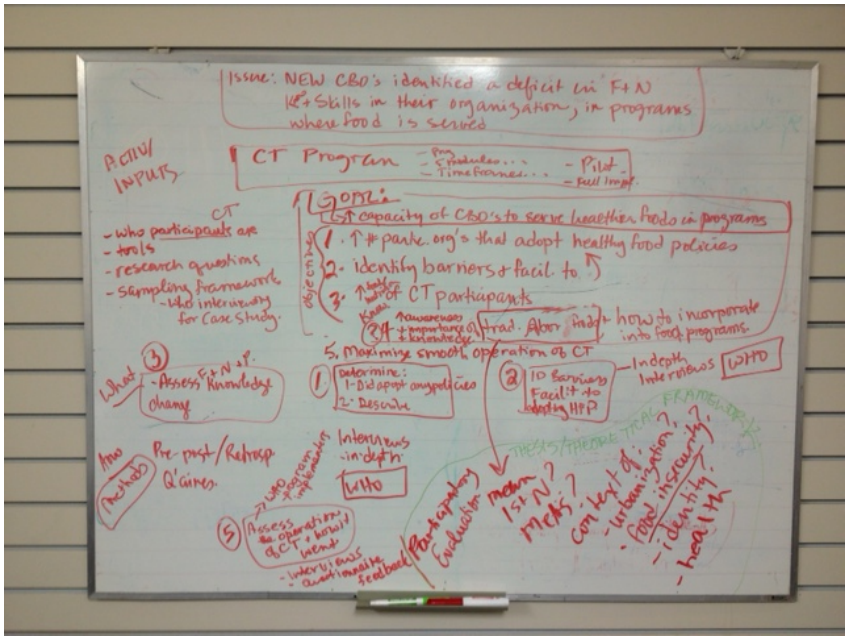


Figure 7. Program Evaluation Logic Model Planning



Utilization-Focused Evaluation

Utilization-Focused Evaluation is highly "personal and situational", in that it hones a working relationship between the *evaluators* and the *primary intended users* (Patton, 2012). In this study, the evaluators are the University of Manitoba partners and the primary intended user is the organization, Food Matters Manitoba. This approach is similar to the community-based participatory research approach because it follows the same basic principle – active involvement of the community partner, Food Matters Manitoba. Utilization-Focused Evaluation is flexible and appropriate because it allows primary intended users to select the "most appropriate content, model, methods, theory, and uses for their particular situation" (Patton, 2012). A Utilization-Focused Evaluation can include any evaluative purpose (including formative), any kind of data (including mixed-method), any kind of design, and any kind of focus (processes, outcomes, etc.) (Patton, 2012, pp. 6). For the Community Tables program, the evaluators and primary intended

users (Community Tables Program Director, Program Coordinator, and Facilitator) were equally involved in developing the Theory of Change, Logic Model, program content, research questions, and evaluation methods and tools. All partners met regularly to develop and refine these program components, as well as interpret the findings as they were presented. This approach fosters a community-based participatory approach, which is the foundation of this study.

Research Questions

The following research questions were developed:

1. Were participating organizations able to develop and implement healthy food policies?
2. What factors facilitated the development and implementation of a healthy food policy?
3. What factors were barriers to the development and implementation of a healthy food policy?
4. Did participants increase their food literacy (attitudes, skills, and knowledge about food)?
5. What factors positively facilitated the implementation of Community Tables?
6. What challenges were faced in the implementation of Community Tables?

Study Design

Pilot Program. Before full implementation (Session 2) of the Community Tables program, a pilot (Session 1) was launched in November 2013. The evaluation tools consisted of:

- *Organizational Profile*, which was administered before the program began. It was completed by a program manager or the person with the most responsibility for food service/food programs in the organization, to learn more about the organizations participating and the food programs they offer;

- *Pre-Program Questionnaire*, which was administered at the beginning of Session 1 to determine information about the organization's food programs and participants' knowledge and attitudes towards food use in their organization;
- *Pre-Questionnaire*, which was administered at the beginning of each of the five days to determine baseline nutrition knowledge and what participants wanted to learn prior to each module;
- *Post-Questionnaire*, which was administered at the end of each of the five days to determine nutrition knowledge gain (if applicable) and what participants felt they actually learned;
- *Post-Program Questionnaire*, was administered at the last session to gain feedback on the logistics of the program.

A pilot was essential before full program implementation because it allowed necessary changes to the program content, program delivery, and evaluation techniques based on participant and facilitator feedback. The tools were pilot-tested with the target population, North End community-based organization food program staff and volunteers. Obtaining this preliminary information helped the evaluators and primary intended users determine how Community Tables was working, so that it could be tailored to better meet the needs of Winnipeg's North End community-based organizations. Following the pilot, a meeting was held with the evaluation team to discuss the necessary changes for the evaluation methods and tools.

The process of developing and refining the methodological tools was done collaboratively between the evaluators and the primary intended users. Following the pilot, the evaluators and primary intended users met to discuss several changes that needed to be implemented.

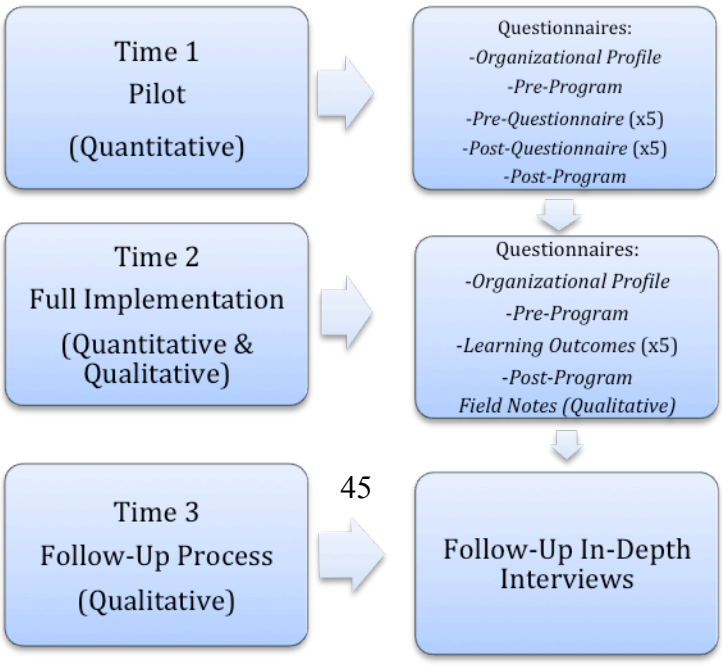
These changes included:

- rearranging the order of the modules for a more logical flow;
- adding a Traditional Aboriginal Foods component;
- changing the knowledge-based evaluation questions in the Pre- and Post-Questionnaires to be more attitudinal-type questions (measuring confidence);
- changing content to be more user-friendly and reflect what participants expressed that they want to learn;
- condensing questionnaires for participants to fill out to be more effective and time efficient;
- creating more resources to accompany and enhance the module content.

Method Design

This study followed a *sequential mixed-methods design*, which involved an initial quantitative phase followed by a qualitative phase. Data collection occurred at three time points (Figure 8). The first time point was the pilot phase (Session 1), in which quantitative methods were developed and then refined. The second time point was the full implementation (Session 2) of the program, in which both quantitative (questionnaires) and qualitative (field notes) data was collected. The third time point was the follow-up interview process (qualitative).

Figure 8. Methods Design



Evaluation Tools

The following tools were developed for the evaluation:

1. *Organizational Profile* (N=28 questions): Following five participant demographic questions, twenty-three questions collected basic information on the food program(s) including: participants' perceptions of healthy food use and the perceived plausibility of the adoption of a healthy food policy in their organization (Appendix A)

2. *Pre-Program Questionnaire* (5 questions): Baseline data was collected at the beginning of Module 1 to determine participants' confidence in the area of food literacy (basic nutrition, food planning and preparation). (Appendix B)

3. *Learning Outcome Questionnaires* (3 questions): This tool was administered at the end of each day to determine participants' level of learning and the potential for application of knowledge gained at the organization, as a result of module training. This questionnaire also asked questions about the participants' personal opinions related to what was useful in the curriculum and what should be changed. (Appendix C)

4. *Post-Program Questionnaire* (10 questions): This tool was administered at the end of the last day. The Likert-scale questions used in the Pre-Program Questionnaire were included to measure any changes in confidence in the area of food literacy. Additional questions were included regarding participants' overall experience with the program. (Appendix D)

The evaluation tools were administered according to an Evaluation Framework that was developed by the evaluation team. (Appendix E)

Study Participants

Participants were any staff or volunteers from Winnipeg's North End community-based organizations that have a food-related program (food bank, snack and/or meal program, other emergency food, food classes, etc). Nineteen participants from nine community-based organizations were included in this study. For two organizations, more than one staff member/volunteer participated in the program and evaluations. From Session 2, nine participants (from seven organizations) completed the questionnaires and six participants (from five organizations) participated in a one-on-one interview. From Session 1 (Pilot), three participants (from three organizations) participated in a one-on-one interview (**Table 1**).

Table 1. Participants in Community Tables Program and Evaluation

	Session 1 (Pilot) Program Enrollment (Nov-Dec 2013)	**Session 1 - Follow-Up Interview**	**Session 2 (Full Implementation) Program Enrollment** (May-June 2014)	**Session 2 - Follow-Up Interview**	**Total**
# of Participants	9	3	9	6	**19**[7]
# of Organizations[8]	5	3	7	5	**9**[8]

[7] Two of these participants included a Food Program Coordinator and Director from two different organizations, who did not participate in Community Tables, at the time of interview.

[8] Organizations may be repeat participants, resulting in the same organization being represented in multiple sessions.

Recruitment

Recruitment for the Community Tables program was done by the Program Coordinator through posters in the North End community, North End email list-serves, North End Food Security Network e-mail list, Food Matters Manitoba and North End Food Security Network social media, Food Matters Manitoba website, and community network meetings. Recruitment for follow-up interviews was conducted through a purposive sampling strategy as the researcher contacted participants who consented to an interview.

Quantitative Evaluation Approach

Data Collection. The quantitative component of this research assessed any self-reported changes in nutrition knowledge and food skills gained by participants after participating in the Community Tables program. Two questionnaires that were administered collected interval data ("which is continuous, with a logical order, standardized differences between values, and no natural zero") in Likert scale questions (The Pell Institute and Pathways to College Network, 2015). All questionnaires (*Pre-Program Questionnaire*, *Learning Outcomes Questionnaires*, and *Post-Program Questionnaire*) were self-administered except one. The Community Tables Coordinator administered the *Organizational Profile Questionnaire* with either the prospective participant or Director of the organization via telephone.

Data Analysis. First, the data was tabulated in a frequency distribution chart for each variable. Descriptive statistics (means, counts) were used to describe the data set from the questionnaires. A matched pair t-test assessed the statistical difference between the two pre-program and post-program response groups. The t-test was appropriate given that the Community Tables program had two matched groups to compare (pre vs. post Likert scale scores) (Moore, McCabe & Craig, 2012, pp. 416). A t-test was also appropriate for a small

number of participants as it works best with fewer data points for each group. (Moore, McCabe & Craig, 2012, pp. 418).

Qualitative Evaluation Approach

Data Collection. The qualitative component assessed participants' experiences with implementing policy or program measures to their food programs, if any, as a result of the Community Tables training. In-depth interviews were implemented, at either 3-4 months (Session 2) or 9-10 months (Session 1) post-program, utilizing a pre-determined evaluation matrix of guiding questions and sub-questions. (Appendix F) Six participants from Session 2 and three participants from Session 1, plus the program developer, program implementer and the program administrator were interviewed. It was determined by Food Matters Manitoba that sufficient time from the end of the Community Tables program to the time being interviewed was necessary to allow participating organizations to plan and to fully develop and implement the healthy food policies. Interviews were approximately twenty minutes, on average. In addition, the evaluator took field notes throughout the Community Tables training. The field notes revolved around the participants' experiences with the evaluation tools and their experiences with the program. Those who participated in the in-depth follow-up interview were compensated with a $25 gift card.

Data Analysis. Interviews were recorded and transcribed verbatim by the researcher. After transcription, the interview transcripts and field notes were coded to derive themes. Coding was reviewed by a senior researcher. All codes were printed. Codes from three interviews were visually sorted by hand to derive preliminary themes. Further analysis involved sorting the remaining codes into either the preliminary themes developed or by creating new themes. The

final themes and codes were entered into an Excel spreadsheet. Data interpretation involved regular meetings with the primary intended users, Food Matters Manitoba.

Inclusion Criteria

Inclusion criteria for the interview were participants having: completed more than three of the five days during the Community Tables training program and/or still being involved in the organization (employed or volunteering). Initially, the intended data was to be collected from those who completed Session 2. However, due to a low number of participants who could be interviewed from this session, participants from Session 1 (Pilot) were invited to participate in a follow-up interview to enrich the data.

Confidentiality

Participants' confidentiality and privacy were maintained by the use of numbers to code responses, perceptions, opinions and ideas obtained from the interviews and questionnaires. None of the data collected were identified by name or other personal information. Some quotes were used in the final report submitted to Food Matters Manitoba, but these remained anonymous. All of the recorded data and consent forms were kept in a locked cabinet in a locked room at the Human Ecology Building at the University of Manitoba. Data was accessible only to the researcher (Kerry Spence), the program director of Food Matters Manitoba and the researcher's advisor (Joyce Slater). The transcripts, audio files, and consent forms will be destroyed within 5 years.

Knowledge Translation

A final report of the Community Table evaluation findings was submitted to Food Matters Manitoba on March 23, 2015. This will be used for program improvements and submitted in a report to the funder, The Public Health Agency of Canada. An Executive

Summary of the program evaluation findings was prepared and sent to all participants, who wished to receive a report. The evaluation research findings were presented to the HNSC 7200: Food & Nutrition Seminar class, as part of degree requirements.

Ethics

The Joint Human Research Ethics Board at the University of Manitoba approved this study in May 2014 (Appendix G). The Join Human Research Ethics Board also approved an amendment request to include participants from Session 1 in the interview process in October 2014 (Appendix H).

CHAPTER FOUR

Results

The participating community-based organizations varied in terms of their clientele and their food programs. Data on these organizations and food programs was collected via the *Organizational Profile* prior to the program. Participating organizations served primarily Aboriginal people, including children, families, adults and seniors. Food programs at these organizations served breakfast, lunch, supper and/or snacks. A tabulated snapshot of each participating organization's food program is found in Table 2. A complete descriptive analysis of each organization, compiled from the twenty-eight question *Organizational Profile* is found in Table 3. Participants were able to select more than one option for each question.

Table 2. Snapshot of Food Programs of Participating Organizations (N=9)

Organization (N=9)/Session Attended	No. of Participants (N=17)/ Interviewed	Primarily Serves	Food Programs	Clientele per Week	Regular Food Budget
#1 (Session 2)	1 1	• Adults • Aboriginal people • Newcomers	• Breakfast • Snacks	0-50	No
#2 (Session 2)	1 0	• Children/Youth • Families • Aboriginal people • Newcomers	• Supper	0-50	No
#3 (Session 2)	2 2	• Children/Youth • Aboriginal people • Newcomers	• Supper • Snacks	201-300 (250)	Yes
#4 (Session 2)	1 0	• Women only • Adults • Aboriginal people	*none, staff only (but will be in the future)*	*0-50 (not food program related)*	Yes
#5 (Session 2)	1 1	• Children/Youth • Aboriginal people • Newcomers	• Breakfast • Lunch • Supper • Snacks	0-50	Yes

Organization (N=9)/Session Attended	No. of Participants (N=17)/ Interviewed	Primarily Serves	Food Programs	Clientele per Week	Regular Food Budget
#6	1 (1) (Session 1) 2 (2)* (Session 2)	• Seniors • Aboriginal people • Newcomers	• Lunch (Saturdays) • Snacks	51-100	Yes
#7	2 (0) (Session 1) 2 (2)* (Session 2)	• Children/Youth • Seniors • Adults • Families • Aboriginal people • Newcomers	• Lunch • Snacks • (Breakfast)	• 51-100 • (101-150)	Yes
#8	1 1	• Aboriginal people • Families • Children/Youth • Seniors • Adults	• Snacks • Staff Meetings	0-50	No
#9	1 1	• Adults • Aboriginal people • Families • Children/Youth • Seniors	• Breakfast • Lunch • Snacks	51-100	Yes

* At these organizations, a food program director and organization director, who did not participate in the Community Tables program at the time, were also interviewed, in addition to the participant.

Table 3. Descriptive Analysis of Participating Organizations (Complete Organizational Profile findings)

Questions (1-28)	N (%) Total number of organizations = 9
1. Where most participants come from:	7 (78) North End; 1 (11) Downtown; 1 (11) Other parts of the city; 2 (22) Not Sure
2. Who is primarily served by the organization:	6 (67) Children/Youth; 5 (56) Adults; 4 (44) Seniors; 4 (44) Families; 9 (100) Aboriginal people; 5 (56) Newcomers
3. Main programs/services offered:	1 (11) Primary Care 4 (44) Cultural Programs 3 (33) Cooking Classes 2 (22) Health & Nutrition 7 (78) Life Skills Classes (counseling, job assistance, learning, housing, emergency, parenting) 5 (56) Families/Children's programs 3 (33) Community outreach/events 1 (11) Food bank Program 3 (33) Recreation/Fitness/Crafts 3 (33) Gardening 2 (22) Seniors 1 (11) Other (Catering CO-OP)
4. Meal/Snack programs:	8 (89) have; 1 (11) don't *(continued on next page)*

Questions (1-28)	N (%) Total number of organizations = 9
5. Meal/Snack programs offered:	3 (33) Breakfast; 4 (44) Lunch; 7 (78) Snacks; 3 (33) Supper; 2 (22) Board Meetings/Staff
6. Have food skills programs/activities:	9 (100)
7. Food skills programs/activities offered:	5 (56) cooking class with adults; 4 (44) cooking class with children; 3 (33) other (food handlers/practical skills/food bank/other position); 5 (56) gardening; 1 (11) child/baby nutrition classes
8. # of participants attend programming/week:	5 (56) 0-50; 3 (33) 51-100; 1 (11) 201-300;
9. # of organizations that have staff/volunteers working in food programming:	9 (100)
10. # of organizations with *Full-Time Staff, Part-Time Staff, Casual Staff, and Other (Full-Time Summer Students)* working in food programming:	Full-Time: 3 (33) Part-Time: 3 (33) Casual/Occasional: 0 (0) Other (Summer Students): 1 (11) Did not specify: 2 (22)
11. # of organizations with *volunteers* working in food programming:	0 hours/wk: 1 (11) 1-5 hours/wk: 1 (11) 6-10 hours/wk: 3 (33) 20+ hours/wk: 2 (22) Occasional/On-Demand: 1 (11) Did not specify: 1 (11) *(continued on next page)*

Questions (1-28)	N (%) Total number of organizations = 9
12. Kitchen/adequate food preparation area:	8 (89) yes; 1 (11) no
13. Regular food budget/# of organizations with budget increments:	6 (67) yes - $250/month: 1 - $500/month: 2 - $1200+/week: 2 3 (33) no
14. Main sources of food for programs:	8 (89) major grocery stores; 3 (33) neighborhood stores; 3 (33) food donations made directly to organization; 4 (44) Winnipeg Harvest; 2 (22) Winnipeg FoodShare Co-Op;
15. Control over food received from food bank: (*five organizations answered this question)*	2 (22) yes; 1 (11) not sure; 2 (22) did not answer
16. Food items not used in organization:	6 (67) Specified foods not used/avoided -salty foods, pop, junk food, whole grains, lentils, peanut butter, fast food, highly processed foods, meat/animal products) 3 (33) No restrictions
17. Regularly make menu plans (each week):	6 (67) said yes 3 (33) did not respond
18. How organizations determine make meal plans:	• Feedback • Cooking comfort • Budget • Alternate light snack & meal • Health • Time of the month (hours open) • Kitchen staff (review together) *(continued on next page)*

Questions (1-28)	N (%) Total number of organizations = 9
19. Think healthy food too expensive for organization:	6 (67) no; 3 (33) yes
20. Enough staff time to prepare healthy food:	6 (67) yes (2 organizations indicated this was due to volunteers); 3 (33) no
21. Places near organization where can buy healthy foods:	7 (78) yes; 2 (22) no
22. Have equipment and space to make healthy foods:	8 (89) yes; 1 (11) no
23. Organization perceives staff to have adequate knowledge about healthy food:	7 (78) yes; 1 (11) not sure; 1 (11) no
24. Organization perceives staff to have adequate knowledge about nutrition:	6 (67) yes; 2 (22) not sure; 1 (11) no
25. Organization perceives staff to have adequate knowledge about food preparation:	6 (67) yes; 3 (33) no
26. # of organizations that currently have healthy food policy (prior to attending program):	7 (78) no HFP; 2 (22) have HFP
27. # of organizations interested in developing healthy food policy:	7 (78) yes; 1 (11) not sure; 1 (11) no response
28. Reasons participants gave for registering for program:	• reinforcing what she knows about societal eating habits; • concerned about food illnesses; • learning experience because he/she didn't go to school; • to learn more healthy eating, meal planning with a small budget that are healthy, new staff; • to learn; • to get more nutritional food preparation for clients, residents who live on EIA on fixed set income

The remainder of this section will report each of the six evaluation questions, organized by each research tool – the questionnaires or interviews. Questionnaire data contributed to answering Evaluation Questions #4-6. Themes emerged from the interview data, which contributed to answering Evaluation Questions #1-6.

Evaluation Question #1. Were participating organizations able to develop and implement healthy food policies?

Participants from seven out of nine organizations (Organizations #1-7) who completed Community Tables were interviewed post-program. (Table 4) Follow-up interviews were not conducted with three organizations' participants (Organizations #8-10)[9].

Of the nine participants interviewed, three participants (Organizations #1-3) stated that they developed a healthy food policy as a result of the program. At these organizations, changes that were implemented included eliminating the serving of sugary beverages such as pop, replacing soda with water and serving healthier snacks to community members. The remaining six participants (Organizations #4-7) did not develop a healthy food policy but stated that they were interested in developing one. Nonetheless, Organizations #4-7 also referred to changes that they were either in the process of making or already made, prior to attending Community Tables. These changes included serving more vegetables and fruits, limiting or eliminating sugary beverages, and incorporating all food groups from Canada's Food Guide into every meal.

[9] These participants were unable to be interviewed due to lack of time and not meeting inclusion criteria for an interview.

Table 4. Organizations that implemented a healthy food policy as a result of Community Tables

Organization (N=10)	Developed & Implemented Healthy Food Policy	Changes
Organization #1	Yes	- offer alternatives to white sugar (for coffee/tea) - always have water as an option - always have fresh fruit as an option - no soda/pop, chips, candy, bars, chocolates, cookies, or sweets
Organization #2	Yes	- implement more healthy snacks in workshops
Organization #3	Yes	- no pop/sodas/juice - serve only water - read labels of food purchased - avoid high sodium foods - created "Cooking Without a Kitchen" workshop
Organization #4	*Interested (had a healthy food policy rule in place)*	- has "no pop/soda" in the Centre rule - *Follow-Up Support Needed:* want more sample Healthy Food Policies
Organization #5	*Interested*	- serve more vegetables and fruits - make more wholesome, homemade meals - limit sweets (eg juices) - put water out to increase consumption - *Follow-Up Support Needed:* need help getting rest of staff interested/on board
Organization #6	*Interested*	- no more slurpees, pop, chips, hot dogs - serve only fresh fruit - less fatty/greasy food served - *Follow-Up Support Needed:* want Food Matter Manitoba's help and to 'come behind them as an expert' so organization can be taken seriously by community
Organization #7	*Interested (had a healthy food policy rule in place)*	- have to incorporate all food groups from Canada's Food Guide into every meal) - *Follow-Up Support Needed:* want to incorporate more cultural foods to meet the needs of the community members

Evaluation Question #2. What factors facilitated the development and implementation of a healthy food policy in participating organizations?

Participants identified six factors that facilitated the development and implementation of a healthy food policy in their follow-up interviews. These included: the importance of community, the commitment of participating organizations, the promotion/advertisement of healthy food policies, the available resources from the Community Tables program and the organization, the regular review of healthy food policy and the benefits that a healthy food policy offers to organizations. Facilitators were categorized as either internal (within the participant's direct control/influence) or external (outside of the participant's direct control/influence). Three facilitators had several sub-themes, which will be briefly described.

Facilitator #1: Importance of Community

There was evident unity, cooperation, and passion among various levels (community members, front-line worker, leadership, neighborhood organizations) of all participating organizations, which is crucial to building a healthy community. Building a healthy community or building healthy processes within organizations was perceived to benefit community members and foster the development of healthy food policies. Several groups of key people involved in the policy development and implementation processes were identified.

a. **Community Members (External).** Participants stated that acceptance of healthy food from the community members is important in order for the policy to become entrenched. Organizations have the capacity to reach out to community members to discuss the importance of any changes they make to their food programs. This community involvement was viewed as necessary to promote healthy eating. When healthy food was served, participants noticed some community members enjoying it.

One participant mentioned the importance of getting activists in the area involved, who can champion healthy eating in the community.

"*Yeah, I told them (co-workers) all about what we did (at Community Tables).*"

"'*cause people know..stuff. But people know other things too that you can share - information about food*." (Program Organizer)

b. **Staff & Volunteers (Front-Line Workers) (Internal).** Providing the basic nutrition knowledge and food skills to the entire program/organization staff was considered necessary to provide a greater understanding of the need for healthy food policy, and the knowledge of how to implement it. This would increase their support in the implementation of the policy. Some staff also stated that they want to promote healthy eating with family, friends and peers, which will increase acceptance of policies in organizations. One participant stated, "*the other staff, I'll have to teach them like, show them, use up, like leftovers, cause they're always sitting there, and it's no good when after I come in a weekend.*"

c. **Leadership (Board of Directors) (Internal).** One participant emphasized the importance of seeking board approval of a healthy food policy before it is developed, as the board guides the direction of the organization.

d. **Other Community-Based Organizations in Winnipeg's North End (External).** Engaging other community groups/organizations in developing and implementing a healthy food policy was considered important for community 'pan-agency' events. Sharing ideas with other organizations' staff and volunteers in the neighborhood increases interest and support for the healthy food policy. Reciprocity is also evident in the community, in terms of sharing both resources and ideas, in terms of food. This further fosters relationships and builds

connections in the community. Such relationships align organizations together in achieving the same goal – a healthy community.

Facilitator #2: Commitment of Organization

The following sub-themes were identified in the interviews that demonstrate the participants' commitment to serving the community members the best way they can.

a. **Resourcefulness of Organization (Internal).** Despite the many barriers and obstacles organizations face, the organizations' staff/volunteers typically worked hard to overcome and deal with them. They adapted to organizational changes (which can occur often, such as funding cutbacks) and did the best job with what they had. Creativity was important when serving food to a group of people, when resistance would otherwise be met. For example, participants would serve cut-up fruits and vegetables, and pitchers of water for community members, which encouraged consumption of these foods and beverages. Organization staff and volunteers have knowledge of their community's food preferences, and the local contexts and resources. As a result of Community Tables, some organizations offered (or were planning to offer) food workshops. One participant intended to apply for Winnipeg Harvest food donations. Some participants planned to apply for grants to upgrade their current kitchen and equipment, to build their capacity and offer nutrition workshops to more participants. One participant utilized several resources in developing a healthy food policy, such as utilizing the Internet and talking to different people who could help. Another participant stated that she would request the assistance of other staff members (doctors/nurses) in developing a healthy food policy. These examples demonstrate the initiatives being taken to build capacity within their organization to meet the needs of community members.

"*I always find (vegetables) in the fridge, so I try and incorporate them in a soup or stew*."

"*I try and we try to do the best with what we have."*

"*but sometimes, I share (food) with next door (other community-based organization)*"

"*I put them (vegetables) in the freezer, wash them, and then make a soup with it."*

"*our fruit just sat before, now we do..fruit salads or cut up fruit."*

"*they won't eat oranges (unless they're cut up) so I just cut them up in the morning."*

"*I just add veggies."*

b. **Attitude to Change (Internal).** Despite the challenges, participants had a positive outlook on the process of change, with respect to developing and implementing a policy. They desired change and were optimistic of their organization's capacity to change. They believed that change has to start with their staff/volunteer position and had realistic expectations. They were open and willing to receive help from other organization such as Food Matters Manitoba. They acknowledged, rather than ignored, the food norms in the community, which can pose as a challenge.

"*I'm sure there's going to be (change), they'll (community members) following healthy eating."*

c. **Attempts to Serve Healthy Food (Internal).** Participants gave many examples of how they were attempting to serve healthy food to the community members. Some examples included: offer community members options when it comes to serving food, serve familiar food, be consistent, avoid junk food, introduce new foods, educate participants about healthy food, consider community context when selecting meals/snacks, and make compromises when it comes to serving cultural foods. For example, one participant stated that the Aboriginal community enjoyed consuming their cultural food, bannock. Despite

the participant recognizing that this food was not particularly healthy and the fact that a healthier version of it was difficult to attain, bannock was still being served to meet the needs of the community.

"*We try and limit sweets, like juices. They have too much juices."*

"*We try to get them to drink water too, put water on (the table)."*

d. **Existing Knowledge About Food (Internal).** Prior to attending Community Tables, each participant stated that they had some experience with preparing/serving food. A few organizations already had some "rules" that were similar to a healthy food policy, such as not allowing soda in the organization. One food program coordinator who was interviewed, had previous experience of developing and implementing a healthy food initiative at a nearby school.

Facilitator #3: Promotion/Advertisement of Healthy Food Policy (Internal)

Participants who developed or were in the process of developing a healthy food policy pointed out the need for promoting or advertising the healthy food policy at the organization level, primarily to: the community members, the food program staff/volunteers, the organization staff/volunteers, and other Winnipeg's North End community-based organizations. This was viewed as a way to prevent people from forgetting about the policy and ensuring healthy food stayed on the agenda. Participants wanted to promote via their organization's website or posting the policy in their kitchen/organization.

"*it makes it a lot easier when you're trying to explain something to people*";

"*by advertising, teaching, and keep bringing it up every time, every group we have, so people know about it*."

Facilitator #4: Resources (External)

All participants reported that both Community Tables resources and the available organizational resources helped facilitate the process of developing and implementing a healthy food policy. The Community Tables participants liked the resources and visual aids provided during the program training. In particular, participants stated that they wanted more examples of healthy food policies, as some did not know where exactly to begin. Participants also wanted posters to display in their organizations because they serve as a visual reminder of the importance of healthy food for both the attending community members and staff/volunteers.

Within the organization, only one participant noted having internal support staff (eg: doctors and nurses) as a resource, who could contribute their knowledge to the development of a healthy food policy.

Outside the organization, free nutrition workshops available to the community organizations were valued because they educate staff/volunteers of the importance of serving healthier food to community members. Other external resources identified by participants included: Good Food Box, Winnipeg Harvest, funding & grants, Food Matters Manitoba, FACT (Families & Communities Together) Coalition, Community Registered Dietitians, Heart & Stroke Foundation, and the North End Food Security Network.

Facilitator #5: Regular Review of Healthy Food Policy (Internal)

One participant stated that reviewing the healthy food policy regularly would be beneficial and help improve the policy over time to ensure its relevance as attending community members and staff/volunteers change. This participant stated that the healthy food policy would be reviewed either annually or bi-annually, with the Board of Directors, at his/her organization.

Facilitator #6: Policy Opportunities (Internal)

a. **Participants and funders viewed policy positively.** Despite the fact that policy was a new concept, policy was viewed as a tool that can help participants achieve their organization's objectives/mission/vision. A few participants were beginning to re-develop and re-organize their policies at their organization (i.e.: reviewing and revising policies and procedures manual). Participants had a generally positive, respectful, and accepting attitude of policy. Many were health conscious and cared about the type of food they serve to community members, and the role they play in the community members' health. They believed healthy food is important and didn't want to contribute to the nutrition-related problems in their community. One participant stated that funders received the newly developed healthy food policy in her organization positively and highlighted this as a benefit of having one.

> "*I think they're (healthy food guidelines) are very relevant and very useful…I think that it's very relevant to have something to be able to help our residents, because that's what we're supposed to be doing*."

b. **Policy makes implementing changes in food programs easier.** Having a healthy food policy gave staff and volunteers in organizations the "authority" to enforce the rules, which they would otherwise have difficulty doing. When food program staff asserted that it is their "policy to serve only healthy food", community members generally accepted it.

> "*if you give your volunteers the information, to arm them so that they know what to say, and they sound authoritative, everybody else (community members) just sort of falls in line*."

Participants reported that they have observed other organizational staff attempting to follow healthy eating principles outlined in their policy. They believed it was important to "practice what they preach." This compliance ensures success of the implementation of this policy.

Evaluation Question #3. What factors were barriers to the development and implementation of a healthy food policy?

In the follow-up interviews, participants identified four barriers: food norms in the community; the process of change; limited resources; and policy implications. The barriers were categorized as being either internal (within the participant's control/influence) or external (outside of the participant's control/influence).

Barrier #1: Food Norms in the Community (External)

One of the challenges that all participants experienced in implementing a healthy food policy was serving foods that are not commonly consumed by community members who frequent the organizations. The "new food" that some participants attempted to serve at their organizations was met with resistance. Junk food and less healthy food are largely consumed and breaking this norm was very difficult. Several participants stated that the community members often expressed dislike and/or discomfort of trying new, healthy foods and requested their preference for less healthy foods.

> "*cause our kids don't like vegetables, some kids*";
>
> "*but sometimes, they love their French Fries and hamburgers*";
>
> "*and this year, still, juice would come up (wanted by community members*)";
>
> "*because I find that it's so easy for them to get it (unhealthy food), but so hard to get fresh fruit and vegetables*";
>
> "*so we try really hard to get them to eat..35% of them this will be their only meal of the day*";
>
> "*the odd youth will drink milk but it's mostly juice*."

The participants further discussed three sub-themes, related to the food norms.

a. **Dietary Ailments.** Serving unhealthy food was viewed as contributing to the state of diet-related health problems in the community. Many participants pointed out that risk factors,

such as poor diet, (for conditions such as diabetes, high blood pressure and cholesterol rates) are high in the Aboriginal community in Winnipeg's North End.

b. **Dietary Needs.** Though not considered unhealthy, participants from two organizations stated that they have to meet the dietary needs of community members. They noted having to work around allergies, and vegetarians' and vegans' dietary needs.

c. **Culturally Appropriate Foods.** Culturally appropriate foods presented some challenges. Few participants discussed the difficulty of attaining cultural foods to serve to Aboriginal community members (e.g. finding healthier versions of bannock). Cultural foods were new foods to some Aboriginal community members and were difficult to access, prepare and serve.

Barrier #2: The Process of Change (External)

Participants stated that change is a difficult process. It was acknowledged that change takes time to be fully implemented and embraced by those affected, as many community members and staff/volunteers did not like change. Some food program staff, organization staff, and community members perceived changing the way food is served in their organization as difficult or intimidating. Change was also perceived to be especially difficult for the older generation (community members/staff/volunteers) to accept. Another consideration is that some staff/volunteers at organizations may experience "change fatigue" because they have had to regularly adapt to other changes (eg: new community members attending the programs), on top of implementing a healthy food policy. On top of implementing changes, maintaining the changes required a lot of work and overcoming resistance that was met by fellow staff and/or community members. One participant stated, "*but it's hard to change, a person like…their way of eating's got to be done gradually*."

Barrier #3: Limited Resources (Internal/External)

Most participants described the limitations of their food programs. Five limitations included: staff/volunteers, food sources, kitchen/equipment, cost of healthy/local/cultural food, and funding.

a. **Staff/Volunteers (Front-Line Workers) (Internal).** Some participants stated that they did not have enough staff to prepare meals, particularly healthy meals (which requires more time and preparation) at their organizations. One participant pointed out that some staff were young and were not as eager to take the initiative or brainstorm new (healthy food) ideas. Some staff do not have adequate nutrition knowledge. There may or may not be enough time for staff to prepare healthy meals, to attend nutrition workshops, or to develop a healthy food policy on their own. Nutrition workshops, if available, can also be expensive or be available at times that do not suit staff schedules.

b. **Source of Food (External).** Some organizations do not have a food budget and heavily rely on food banks for their programs. Food banks do not necessarily provide healthy foods and organizations take what they can get. Some organizations also do not qualify to be a food bank depot.

c. **Kitchen/Equipment (Internal).** Some organizations have no commercial kitchen or no kitchen equipment/appliances, which makes it difficult to serve healthy food (which requires preparation space).

d. **Cost of Healthy/Local/Cultural Food (External).** Participants said it can be difficult to purchase healthy food or local food because of the higher cost associated with it. One participant said that one of the food budget requirements at her organization is that the food must be purchased within Winnipeg's North End, which tends to cost more. It is also

difficult to attain cultural foods in terms of availability, cost, knowledge of how to prepare/incorporate into meals, and acceptance by the community members.

e. **Funding (External):** The challenge was the high cost of healthy and local food, which the organization's budget may not account/allow for.

> "*we had a FACT grant at the centre, every single day the City of Winnipeg would make a snack, but we lost that grant*";
>
> "*because this organization is funded by (organization name), like we've had our cutbacks, yeah on our budget*";
>
> "*I think budget is probably our biggest obstacle";*
>
> *"but the dollar doesn't stretch very far when you go shopping today*";
>
> "*we technically would need much more people doing the kitchen work than we have and that's just managing the time between two of us*";
>
> "*people in..some of these agency..there is a lot of turn-over*".

Barrier #4: Policy Implications (Internal)

Four implications of developing and implementing a new policy emerged.

a. **Staff Compliance to Policy.** In addition to community members, it was difficult to get organization staff to support healthy eating in organizations, even if food program staff supported it. Some staff enjoyed healthy food when it was served, but at times brought in unhealthy food for their personal consumption. This was perceived as possibly sending the wrong messages to attending community members. Some staff also expressed a lack of interest of having a healthy food policy in the organization, even though not directly.

> "*(it's) bit difficult to try to get the staff to follow it, cause I will be trying to advertise healthy eating and all the staff…will be coming in eating pizza. So it's a little bit tough, it's a work in progress*";
>
> "*Nobody said very much, it's still sitting there (healthy food policy workbook), I showed them, "oh", that's all.*"

b. **Lack of Experience With and Understanding of Policy.** Policy development and implementation were both perceived to be difficult and intimidating, as most participants had no prior experience in doing either. Combined with this lack of experience, there was some misunderstanding as to what a healthy food policy was.

> "*I have no idea how to make a healthy food policy, I would have no clue of where to even start*"

c. **Lack of Experience with Healthy Foods.** In addition to limited experience related to policy, some organization staff/volunteers had limited experience with preparing and/or serving healthy foods. It was intimidating for some to develop and implement a policy about healthy food, especially if planning and preparing healthy meals and snacks was an entirely new experience as well.

Evaluation Question #4. Did participants increase their food literacy?

Community Tables had a positive impact on participant nutrition knowledge and food skills. In the *Learning Outcomes Questionnaire*, 100% of the participants at Sessions 1-3 reported that they did learn something new, in response to the Yes/No question "Did you learn something new?" In Session 4, 71% of participants reported that they learned something new, with 29% reporting that they did not learn anything new. In Session 5, 80% of participants reported that they learned something new, with 20% of participants reporting no response.

Participants identified areas with which they learned in the *Learning Outcomes Questionnaires*, which were categorized into 11 themes. (**Table 5**) The most common responses were basic nutrition, reading food labels, and healthy eating on a budget.

Table 5. Participant descriptions (including frequency) of what they learned[10]

Responses Categorized	Session 1 (N=9)	Session 2 (N=9)	Session 3 (N=8)	Session 4 (N=6)*	Session 5 (N=5)	Quotes
1 Basic Nutrition (eg: Sugar, Sodium)	19	1		1	1	*"how sugar medically affects one"*
2 Reading Food Labels		16				*"nutrient content claims"*
3 Recipes		4	2	2		*"how to puree soups"*
4 Healthy Eating on a Budget			11			*"numerous ways to strategize when buying foods"*
5 Food Bank Foods			5			*"how to make food bank foods nutritious"*
6 Menu Planning				4	1	*"how to menu cycle"*
7 Basic Shelf Food List				3		*"what to buy in bulk and have on hand at all times"*
8 Cooking Without a Kitchen				1		*"easy tasty dishes for prep kitchen"*
9 Healthy Food Policy					3	*"learnt (sic) ideas of policies I can use"*
10 Cultural Foods/New Foods	1		1			*"Cooking using turnips! That's a first"* *"Halal foods"*
11 Resources	2		3		2	*"Aboriginal traditional food guide stores in Winnipeg"*
12 How to Teach Nutrition	1				1	*"basic nutrition advice which can be conveyed in simple language"*
13 Other: Entrepreneurship/ Group Dynamics/ Reflection on Current Practices		1			2	*"interaction with others"*

[10] Question was open-ended, resulting in multiple responses for each participant

* In Session 4, there were 7 participants, but 1 participant did not answer this question

In the *Learning Outcomes Questionnaire*, all participants at Sessions 1-4 reported that they learned something that they believe they will be able to apply to their organization. In Session 5, 80% of participants reported that they learned something new, with 20% of participants reporting no response.

Participants identified thirteen concepts that they learned, which they believed they would be able to apply to their organization. (**Table 6**) The most common responses participants reported were menu planning and reading food labels.

Table 6. Participant descriptions (including frequency) of what they learned that they would apply in their organization[11]

Responses Categorized	Session 1 (N=9)	Session 2 (N=10)	Session 3 (N=8)	Session 4 (N=7)	Session 5 (N=5)	Quotes
1 Basic Nutrition	3					*"the food guide teaching visuals"*
2 Reading Food Labels		4	1			*"when we are shopping, watch the labels"*
3 Recipes		2	2	1		*"I can use the recipes we cooked today to serve for a meal"*
4 Healthy Eating on a Budget			3	3		*"I will be able to buy more food on my very little budget"*
5 Food Bank Foods			1			*"I did not know much about organizational food banks. Coming from non-profit organization. This info will be useful as we are running on low budget"*
6 Menu Planning	7		1	5		*"the menu planning sheet will be very helpful to plan kids camp meals and snacks"*
7 Healthy Food Policy					2	*"my workplace have very limited amount of policies around food. It was helpful to learn how to incorporate and create policy within agency"*
8 Incorporating New Foods				1	1	*"will use whole grains and diff veggies, fruits, lentils"*
9 How to Teach Nutrition	1	3	1			*"to show kids how to plan eating from all*

[11] Participant responses were open-ended, which may have resulted in multiple responses for each participant

				food groups"; *"the youth I work with be taught how to prepare and cook a healthy pita using different herbs and veggies";* *"I can teach this to our clientele"*
10 Review		1		*"all the information I knew from the past and it's already applied in my organization"*
11 "Everything"			1	*"I will be able to implement everything and learn in time"*
12 Resources	1			*"I did not know much about organizational food banks. Coming from non-profit organization, this info will be useful as we are running on low budget"*
13 Visual Aids	1			*"the hands on peel sticker, the tangible (Canada Food Guide visuals)"*

In the *Post-Program Questionnaire*, participants identified four concepts that they learned from Community Tables that they already applied to their organization by the time the questionnaire was administered. The most common response was menu planning. (**Table 7**)

Table 7. Participant responses (including frequency) to Question 10: *Have you used anything you learned so far?*

Responses Categorized	Session 5 (N=5)[12]	Quotes
1 Resources	1	*"I have posted the sheets that describe the amount of sugar in the drinks on my kitchen doors."*
2 Knowledge Sharing	1	*"I have been sharing my knowledge with my coworker and together we have a list of healthier snack choices!"*
3 Menu Planning	3	*"Menu planning on a budget"*
4 Food Bank Foods (making food more nutritious)	1	*"Healthy meals from food bank foods"*

Nine participants completed the *Pre-Program Questionnaire*. However, only five participants completed the post-test. The following t-test results reflect five paired means in both pre-test and post-test. Results showed a significant increase in self-reported participant confidence with respect to nutrition knowledge. (**Table 8**) While participant confidence did not increase significantly for the other categories, there was a noticeable upward trend.

Table 8. Participant Food & Nutrition Self-Efficacy Likert-Scale Rating

Question	PRE-TEST (Pre-Program Questionnaire) (N) Mean		POST-TEST (Post-Program Questionnaire) (N) Mean
1. I am confident with my nutrition knowledge	(5) 4.20	(9) 3.67	(5) 5[13]
2. I am confident with my cooking skills	(5) 4.40	(9) 3.78	(5) 5
3. I am confident with planning snacks and meals at my organization	(5) 4.60	(9) 3.89	(5) 4.8
4. I am confident the meals and snacks I plan are healthy	(5) 4.20	(9) 3.84	(5) 4.6

[12] Only 4 out of 5 participants that were present answered this question

[13] P-value <0.05 Paired T-Test

Data from follow-up interviews indicated that participants learned knowledge and skills. In terms of knowledge gained, participants identified the basic nutrition principles they learned such as sugar and other sources of food. Three participants stated,

"*I definitely took the..about how much sugar is in juice and stuff like that*";

"*We also discussed other sources of food like hunting, berry picking…*"; and

"*the sugar unit..amazed most of my board*."

The skills participants reported that they learned were how to menu plan and cook new meals such as soups.

> "*I learned new recipes… how to make soups…how to do a basic kitchen..how to cook without utensils*"; and
>
> "*menu planning ..was also a very important one I took out of there..was helpful towards children's program*."

Evaluation Question #5. What factors positively facilitated the implementation of Community Tables?

In the *Learning Outcomes Questionnaires*, participants reported what they liked about each of the five sessions. Their responses were broken down into 14 categories. (**Table 9**) The majority of participants reported that they liked the hands-on and interactive components, including learning activities and cooking.

Table 9. Participant responses (including frequency) to Question 3a: What did you like about today's session?[14]

Responses Categorized	Session 1 (N=9)	Session 2 (N=9)	Session 3 (N=8)	Session 4 (N=7)	Session 5 (N=5)	Quotes
1 Recipes			2	3		*"new recipes"*
2 Healthy Eating on a Budget			1			*"learning ways of saving money on the food budget"*
3 Basic Shelf Food List				1		*"it was good to write out what our dry food supplies were at our centre and consider what I would like to have on hand on a regular basis"*
4 Healthy Food Policy					2	*"doing vision and goals for healthy food planning-for our organizations"*
5 Hands-On (Interactive)	7	7	4			*"I always enjoy the meal prep"; "I like cooking the meals, they are great examples"*
6 Visual Aids	6		1			*"very interactive and visual aids were used, which made the workshop interesting"*
7 Positive Group Dynamics	2	2	1	1		*"I love hands on experience, team work"; "The comaradrie (sic) with the women I met"; "Working with other women and cooking and talking with instructor"*
8 Knowledge Gained			2		1	*"I love the knowledge of this workshop.Megwetch."*
9 Personal Application of Knowledge			1			*"My parents go to food banks so I have a lot to tell them"*
10 Resources			1			*"resource info"*

[14] Question was open-ended, which may have resulted in multiple responses for each participant

11 Review of Knowledge Already Known				1		*"it was a great reminder of what I learned in university"*
12 "Everything"		1	2	1	1	*"everything"*
13 Facilitation Techniques	2					*"liked hands on, visuals, and verbal explanations"*
14 Other: Speaking Own Language		1				*"the comaradrie (sic) with the women I met, also speaking my language, and have good healthy food"*

Post-program, 100% of participants reported that the material covered in the program was what they expected; 100% of participants liked the location the program was held at; 80% of participants felt the length of each session was suitable; and 100% of participants reported that the information learned will be useful to their organization.

Post-program, participants reported the most useful concepts they learned from the program that they hope to use in their organization. (Table 10) Participant responses were broken into 9 categories. The most common responses were learning how to teach nutrition and how to prepare and cook healthy meals.

Table 10. Participant responses (including frequency) to Question 5: *Overall, what did you find most useful from attending Community Tables that you hope to use in your organization?*[15]

Responses Categorized	Session 5 (N=5)	Quotes
1 Menu Planning	1	*"Checklists that give you ideas to consider when planning snacks and menus"*
2 Resources	1	*"Checklists that give you ideas to consider when planning snacks and menus"*
3 Healthy Food Policy	1	*"I found the last session the most useful, session about creating policies"*
5 How to Teach Nutrition	2	*"Many ideas! I plan on using these ideas to teach youth how to make nutritional choices and basic cooking like we did";* *"Simple ways to teach nutrition"*
6 Hands-On (Cooking)	2	*"how to cook and use grains"*
7 Basic Nutrition	1	*"also use less salt, sugar and fats"*
8 Cooking Without a Kitchen	1	*"Cooking without a Kitchen series"*
9 Food Bank Foods	1	*"healthy meals with food bank products"*

In the participant follow-up interviews, some participants reported that the plain language use throughout the program was beneficial.

Participants also reported other impacts the program had, aside from developing and implementing healthy food policies. Participants learned new, creative ways to serve healthy food, by sharing ideas with each other. Many participants wanted to expand their programming to include more holistic components around food including cultural and social aspects of food, and food security. One participant wanted more involvement of people in the community from "soil to table" at her organization. Some participants were inspired by Community Tables to create food workshops to offer to community members.

> "*so for instance, our kids, this was our first summer, that our kids, never had juice.. Not once*";

[15] Question was open-ended resulting in multiple responses for each participant

"*we had made a note that we weren't serving any pop,…or any type of juice. So we said only water for everyone*";

"*we also made it a commitment to read labels most of the time*";

"*as we go forward, we'll probably look at more food security*."

Not only did the program have impacts on the food programs of participating organizations, some participants reflected on their own eating habits and made small personal changes in their lives. For example, three participants stated,

"*I had so much fun learning that cause I am one to drink a lot of pop and stuff. It kind of made me stop a little bit, I don't drink as much now*";

"*I've even stopped bringing goody goodies like sweet goodies (to work*)";

"as much as I like sushi, we don't do that hardly at all anymore"

The program organizers identified four positive aspects related to the program in their in-depth interviews.

1. **The Community Tables program provided many benefits, beyond the participating organizations**. These included: personal benefits, networking and building connections among the community, and it provided the opportunity to share ideas and share experiences related to food so participants can learn from each other. The program organizers stated,

   "but I…still think no matter where they're involved, they still get something out of it. Whether it's personal changes...personal experience and skills...or affecting their organization";

   "I think…what is really great about it is a chance for people who are working in a similar neighbourhood and a similar field...to get together and talk about food and the challenges that they face and offer experiences and support to others, so they're really learning from each other a lot";

   "having internal or intra- or interorganizational support with one another around foods is an intended outcome";

   "what works is...getting them to talk about their own experience and share their own stories of their agency";

"another thing that has been useful..is enabling participants to talk with each other...in the facilitation process, and recognizing that there's a lot of knowledge and skills already, represented in the group of participants in the class"; and

"I have heard some…very positive feedback…particularly around some of the connections in the community ..(that) developed amongst participants."

2. **There was an evident interest and need in Winnipeg's North End community to take Community Tables**. The program organizers heard from various sources that participants valued the Community Tables program. The program organizers stated,

"when we have advertised it, we've heard amazing responses. People are really excited about it…Program participants saying really positive things about it";

"people aren't getting the best access to healthy food on a regular basis at home, so providing that through our organizations (in the North End) is needed. So it's really important";

"people were engaged and talking for the most part";

"a lot of people in the inner city…that cook for different agencies…don't have a real strong background in nutrition and they don't have a real strong understanding of what is healthy food";

"people are being really receptive to it…I talk to them on an individual basis...they're really excited to be able to learn about healthy foods cause they're struggling with that"; *"we have strong community interests"*; and

"we've seen some interest from other neighborhoods and other places about implementing a program like this"

3. **The hands-on cooking and interactive components were beneficial**.

"I think...the hands-on cooking is always a real hit...people like being in the kitchen...for a lot of people doing some of these recipes or doing different aspects of cooking is really new";

"the sugar activities are really popular";

"that's always been kind of in the back of my mind, to make a place that's really comfortable and easy for them to say what it is they need to say"; and

"The participants really liked it...they liked, being able to see a visual and being participatory in the activity (re: Canada Food Guide activity.)"

4. **Participants learned valuable skills and knowledge that is beneficial to their food programs at their organizations**.

"it's definitely teaching people cooking skills, nutrition knowledge, culturally appropriate foods";

"just from talking to participants, a lot of them saying this is the first time they've actually understood what nutrition was about"; and

"people are getting a lot of information out of it. I feel like they're getting a lot of information out of it."

Evaluation Question #6. What challenges were faced in the implementation of Community Tables?

Participants reported few negative aspects of the program. Only three responses emerged: the length of one session was too long; the length of time divided between the theoretical component and cooking component in one session was unequal/disliked; and the facilitator failed to inform the class of the cooking component during one session.

In terms of program content, some participants were confused and did not fully grasp what a healthy food policy was. For example, some participants thought it referred to their menu plan. In addition, tools were needed to help participants create a healthy food policy. Participants also discussed some areas for improvement for the program content, which included: diabetes; traditional Aboriginal foods; and providing more healthy meal ideas.

"*I'd love to see more stuff about diabetes for adults and children*";

"*I actually wish you would have been able, had the time to go into traditional Aboriginal foods a bit more*"

Program organizers identified seven challenges they experienced, related to the program.

1. **Recruiting target participants/organizations was difficult.** It was a challenge to recruit and retain participants who do not have healthy food as a priority in their meal planning.

   "so we've had people complete it but I think it's the organizations that are already putting healthy food as a priority for their organization that will be able to send staff."

2. **It was difficult to maintain regular attendance.** Some participants registered and did not attend the workshop. Some registered and attended only a few sessions.

   "*We definitely had some people register who didn't show up at all*";

   "*We might be able to reach more organizations if we only offer a one-time three-hour workshop on a variety of things*"

3. **The Healthy Food Policy section was difficult to teach.** Participants wanted additional resources to be created in a user-friendly format, in order to enhance comprehension of this concept. The section also needed to address the challenges participants may experience in development and implementation of such policy.

   "*just the way we talk about it (policy), it's kind of a big scary thing to a lot of people*";

   "*so I think that policy piece has been hard...in terms of communicating it and then also in terms of organizations implementing that piece*";

   "*we thought the idea of healthy food policy would be more exciting than maybe it was received*";

   "*I don't think we've seen any...organization changes that we expected. But again that's probably a slow process. And we're re-examining how to do that*";

   "*just this whole policy development, people weren't really sure about it*"; and

   "*talking about how we articulate...the idea of policies or guidelines which can seem kind of foreign to people*."

4. **Follow-up support post-program is important to help participants and their organizations create and implement policies.** Maintaining changes over time (that organizations implement) was also an issue experienced by participants in their organizations that needed to be addressed.

   "…so we're hoping to be able to support them more one-on-one now (post-program) to be able to do that (develop and implement healthy food policies";

   "people in…some of these agency...there is a lot of turn-over"; and

   "see if people are taking their learnings and implementing them in their organizations, see if they even if they are implementing them, does that implementation stick over time? Do they get really excited for three weeks they don't have sugary drinks but then they come back?"

5. **Adapting content of Community Tables program to participants' wants and needs was challenging.** It was difficult to tailor a program to each participant's particular preferences.

   "*and so I think there's a mix of people that are participating";*

   "there's sometimes a challenge of making sure that people get the most of it that they can because sometimes maybe things are too hard and sometimes maybe things are too easy";

   "sometimes we spend too much time on talking about one thing that's maybe not that important, when people are interested in talking about";

   "some people were more interested in being able to talk about and learn about traditional foods. While maybe some other people were interested in basic nutrition knowledge";

   "We might be able to reach more organizations if we only offer a one-time three-hour workshop on a variety of things…and then kinda being able to offer them and tailor it to organizations so if one organization wants all their staff worrying about basic nutrition and cooking with food bank foods we can combine those two little workshops together and be able to facilitate it to them."

6. **The length of program (5 weeks) posed a major time commitment for participants, whose organizations already have limited resources.** It was difficult to teach participants everything in a small time frame. The time of year and time of day the program was operated was also viewed as a possible deterrent for participants signing up for the program or attending regularly.

   "*trying to...squish in a lot of information...in a short period of time...can be hard";*

   "if we weren't able to appeal to the people who can commit to that time or can make that time slot";

   "I think it's been a little challenging for people because it requires such a big time commitment";

   "sometimes it seems rushed in class, cause people start having a good discussion then we have to stop it to...do the cooking portion…I wish it could be just a tiny bit longer."

7. **There was a need to incorporate more cultural foods (traditional Aboriginal and Halal foods) content into the program.** Challenges identified included access, availability, providing relevant recipes, teaching appropriate cooking methods, and creating dishes that would be liked and accepted by community members.

   "one of the big challenges in this program is…you can talk about traditional foods, but then at the same time, can people actually serve them?";

   "but how do you really provide some strong education around those traditional foods..but also make sure that it's something that's open and accessible as well"; and

   "(with) traditional foods, trying to figure out how to put more into that..cause there's a lot of people asking about it. And there's so much regulations about traditional foods. So I guess even just talking about it I think is helpful for people to understand why traditional foods are more difficult to put into agencies."

CHAPTER FIVE

Discussion

The Community Tables program was moderately successful in achieving many of its intended outcomes. Though healthy food policy was a difficult concept to understand and implement for most organizations, three organizations reported that they were able to do so. Many participants reported positive changes made to food programs, as well as to their personal lives, which were attributed to the nutrition knowledge and food skills gained at Community Tables. Both positive aspects and areas for improvement of the program were identified. The following section will discuss these findings in relation to the present literature, as well as the research implications, limitations and recommendations.

Development and Implementation of Healthy Food Policies

Results suggested that healthy food policies were developed and implemented to varying degrees at three organizations. The remaining organizations faced significant challenges, yet still expressed an interest in developing healthy food policies. These results signify progress for a new program. This demonstrated the desire for change in the North End, despite the limited resources each organization had. Prior to taking Community Tables, two organizations already had "rules" in place regarding their food programs (eg: no soda), which means they were already beginning to take steps towards a healthy food policy.

This program demonstrated the potential that policy has to successfully govern food and increase consumption of healthy foods in the North End community. In order to transform this potential, a greater understanding of each participant's experience with developing and implementing the healthy food policy was needed. It was found that participants were either struggling or persevering with the process, or both. Overcoming the barriers and focusing on the

facilitators would ensure the successful implementation of healthy food policies in these organizations. This is consistent with community-based social marketing, in which "promoters identify the activity to be promoted and the barriers to this activity, and then design a strategy to overcome these barriers" (McKenzie-Mohr, 2000). This process is more likely to lead to sustainable behavior.

Facilitators in the Development and Implementation of Healthy Food Policies

Six factors facilitated the development and implementation process: importance of community, commitment of organizations, promotion/advertisement of healthy food policy, resources, regular review of healthy food policy, and policy opportunities.

1. Importance of Community

The most important facilitator, which operates at a macro-level, was the sense of community both within and among the participating organizations. Many community members in the North End feel like part of an "organizational community" in the community-based organizations. Garnering community member support for healthy food policy and instilling pride in their organizational community will increase success of the implementation of these policies (Stephens, 2006).

The leadership in community-based organizations "set the tone" and have the capacity to make changes associated with implementing the policy either easier or more difficult (Groves, 2006). In addition, front-line workers, namely the staff and volunteers who work in the food programs at the organizations, contribute to the sense of community and also have a role on shaping the formulation of policy, rather than just holding responsibility for implementation of it (Haycock-Stuart & Kean, 2013). Therefore, it is important to engage and work with the leadership and staff as much as possible when implementing change such as healthy food policy.

Organizations in the North End are very supportive of one another in terms of sharing resources. By sharing resources and forming partnerships, this "unites the organizations in a cooperative community and ensures the most consistent support to community members who come to these organizations" (Stephens, 2006).

2. Commitment of Organization

Cooperation at each level (eg: staff/volunteers working together) is important for the other levels to be able to work together and be aligned in reaching the same goal – to increase healthy eating in the community. Collectively undertaking a healthy food policy can contribute to increased "community cohesion", which can positively influence food choices (Wrieden et al., 2007). There were several key traits that participating organizations demonstrated that they were committed to when developing and implementing a healthy food policy.

The majority of organizations had limited resources, knowledge, and skills (regarding both policy and healthy eating), yet participants were resourceful and optimistic in attempting to serve healthy food. They were continually seeking new ways to build capacity within their organizations such as applying for food donations or accessing health professionals on staff (eg: doctors and nurses) for assistance in developing a healthy food policy. While they were realistic of what change might look like for their organization, they still believed that the change(s) brought by a healthy food policy was necessary. Funders and other supporting organizations such as regional health authorities can build on this resourcefulness to support community-based organizations making changes to healthier food programs.

Many participants reported examples of healthy foods that they began serving, as a result of attending the program. This indicates genuine commitment to the goals of the Community Tables program. These sincere attempts to serve healthy food also demonstrate to others in the

community organization that healthy food has a place within it, building "buy-in" for these changes.

Participants possessed previous experience and knowledge about food, which is expected considering Community Tables targeted food program staff/volunteers. Prior knowledge and experience, whether it be from work experience, volunteer experience, formal education or professional development, is instrumental to implementing a healthy food policy (Gardner, 2003).

3. Promotion/Advertisement of Healthy Food Policy

Some participants emphasized the importance of promoting or advertising the healthy food policy within their organization, as well as to the surrounding community. This is a crucial component to adopt as it demonstrates to others the commitment the organization has to serving healthy food and enforcing the policy. Advertising has the possibility of influencing other organizations to adopt a healthy food policy as well.

4. Resources

The resources available to participants played a key role in healthy food policy development and implementation including those provided by the Community Tables program and the organization. Participants were able to access resources outside the organization, such as food donations and the North End Food Security Network but also wanted ideas for developing their own healthy food policy, to make the process easier. The more resources that organizations (with limited resources) have access to, means a more supportive process with healthy food policy. Inter-organizational collaboration could lead to sharing of critical resources and the facilitation of knowledge transfer, which would prove beneficial to the policy process (Hardy, Phillips, & Lawrence, 2003).

5. Regular Review/Evaluation of Healthy Food Policy

The importance of a regular evaluation of a healthy food policy was identified. An evaluation would determine the effectiveness of the policy and what outcomes and results were achieved (Patton, 2012). Participatory evaluation can have a positive impact on the organization's internal group processes and strengthen their involvement and commitment to the organization (Papineau & Kiely, 1996). Another unexpected benefit of this process is that it can serve as a model for outside organizations, thereby strengthening more healthy food policies (Papineau & Kiely, 1996).

6. Policy Opportunities

Because policy can be an intimidating concept and only a few organizations developed and/or implemented a healthy food policy, it was unexpected that participants would view policy as positively as they did. Participants were beginning to see the potential that having such a policy would have on the food environment. This could possibly be attributed to the researcher influenced the participants' responses or the program is doing a good job with teaching policy to participants. However, the latter appears to be truer given the participants' detailed perceptions of what policy can offer the organizations. This includes healthy food policy being received positively by funders and policy makes implementing changes in food programs easier.

Barriers in the Development and Implementation of Healthy Food Policies

It is evident that more difficulty than ease was experienced in developing and implementing healthy food policies, as only three out of nine organizations succeeded in some form of implementation. However, only four barriers were identified.

1. Food Norms in the Community (Resistance)

All participants understood the need for healthy food policy in their organization – community members in Winnipeg's North End are not eating enough healthy foods (WRHA, 2013). It was expected that participants noted the difficulty of serving foods to community members, to which they may not be accustomed. For example, there is low fruit and vegetable consumption; however this is also the case with the rest of the Canadian population (Statistics Canada, 2013). There is evidence that habit is one of the most powerful predictors of eating behaviour (van't Riet et al., 2011). This means that altering the situation in which the habits occur may be the most effective way to establish healthy eating habits (van't Riet et al., 2011). More specifically, changing physical food-related environments (through policy), helps people to change existing eating habits over time (Neal et al., 2006). It is important to note that changing the food habits of North End community members is not an intended direct output of this program, rather it is an intended outcome of the parent program, Our Food Our Health Our Culture. Therefore, focus should be placed on changing food habits within the organizations, and not necessarily the broader scope of changing the food habits of community members.

2. The Process of Change

Participants acknowledged that adopting a healthy food policy would mean changing their usual food practices. Change was anticipated to be difficult, especially for older staff who are used to preparing certain foods. However, participants were acknowledging that change is necessary and this optimism bodes well for healthy food policy implementation. Any change requires energy, commitment, and an understanding of its importance, and if done properly, should be appropriately rewarded (Best, 2012). As long as these are fulfilled, then change will less likely be a hindrance, and rather be a positive thing. Furthermore, leadership will need to

accept that change processes often need time, as new roles and responsibilities pertaining to policy implementation will evolve gradually (Haycock-Stuart & Kean, 2013). By accepting that change processes take time, less tension will be created amongst leadership and front-line workers during the policy process.

3. Limited Resources

Participants described many limitations to their food programs. One of the main limitations is the minimal funding that community-based organizations receive and those in Winnipeg's North End are no exception. Their food budgets are expected to accommodate a high number of community members who access these organizations for food on a daily and monthly basis (Bewza, 2011).

Other limitations included not have enough staff and volunteers (front-line workers) to prepare healthy meals. Therefore, this equates to less time to devote to the healthy food policy process. In addition, the staff/volunteers who work in these food programs have minimal nutrition knowledge and food skills (Bewza, 2011). These organizations also experience a high turnover rate, which makes it difficult to consistently have trained staff/volunteers to serve healthier foods (L. Rappaport, personal communication).

Participants at organizations who use donated food had difficulty with healthy food policy. Of Winnipeg's North End community-based organizations that serve food, 80% receive donations from a food bank, grocery stores and/or meat suppliers (Bewza, 2011). For many of these agencies, food donations are their only source of food and the quality is often poor/inconsistent (Teron & Tarasuk, 1999). This reliance relinquishes most control of the types of food. This is compounded by the difficulty in purchasing healthy food in the North End because of its perceived high cost (Bewza, 2011).

The lack of community organizational resources (such as human resources, educational resources or knowledge/skills), can lead to frustration and not fulfilling the policy agenda (Haycock-Stuart & Kean, 2013). Therefore, there is a responsibility in policy making to ensure that the resources are available to both leadership and front-line workers to enable them to meet the policy agendas (Haycock-Stuart & Kean, 2013).

4. Policy Implications

Participants experienced difficulties directly related to the policy process (both in the development and implementation). All participants were interested in adopting a healthy food policy at their organizations, and their leadership supported each participant to attend Community Tables. However, this desire for change did not necessarily transcend to the rest of the organization. Other staff members who did not take Community Tables resisted the changes, by either expressing dislike of them or continuing to bring in unhealthy food for personal consumption. This lack of compliance with the healthy food policy hinders the process and efforts should be made to get all staff "on board". It was a somewhat unexpected barrier that some organization staff did not want to comply with the healthy food policy, as the organizations were seeking to create change in their food programs, resulting in the development of the Community Tables program (Bewza, 2011). However, leadership (and not necessarily front-line workers) could have driven this desire for change.

It is especially difficult for participants to develop (and implement) a policy if they don't fully understand it. Most participants did not understand policy, prior to taking Community Tables. Even after taking the program, many were intimidated by the concept and did not understand what it entails. Therefore, it is crucial that the Community Tables program introduces and teaches policy to participants in a non-intimidating and clear way. Though the program did a

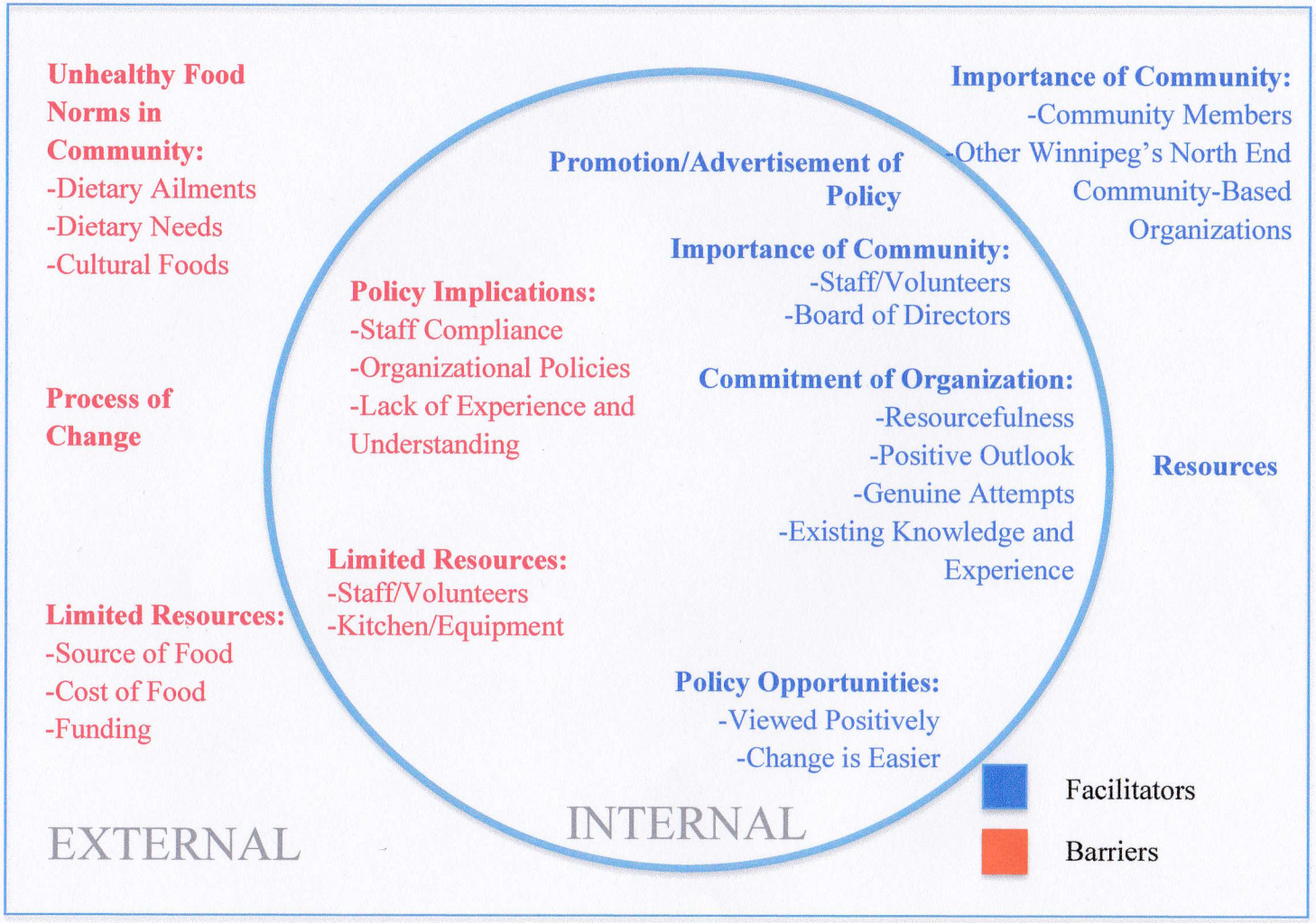
good job, further improvements are needed. Lack of understanding of the policy process by community partners can be a barrier as it is a complex process. However, once it is fully understood, this can empower community-based organizations to create a bigger impact with policy (Dukeshire & Thurlow, 2002).

Even though a few participants had a good understanding of policy, they still struggled with developing a healthy food policy, due to limited experience with healthy foods. This inexperience is expected, as this is the reason the Community Tables program was developed, and the theoretical and applied food/nutrition (food literacy) component of Community Tables should be maintained, as this is a basis for future policy development.

A Conceptual Model for Barriers and Facilitators for Healthy Food Policy

The barriers and facilitators were categorized by the researcher as either external or internal to the organization, signifying the perceived degree of control/influence each participant/organization had of each factor. The conceptual model depicts that the majority of facilitators were internal and the majority of barriers were external (Figure 9). This can allow the focus to be on the internal barriers and facilitators, as well as determining the ways that external barriers and facilitators could be influenced. For example, although organizations cannot directly control the unhealthy food norms in the community, by implementing and maintaining a healthy food policy for a long period of time, this could create a "ripple effect." This means that the policy may expose community members to healthy food habits that could eventually be adopted in the home.

Figure 9. A Visual Representation of Participating Organizations' Degree of Control/Influence



Participant Gains in Food Literacy

Community Tables participants gained basic nutrition knowledge and/or food skills. Literature suggests that nutrition knowledge may play a "small but pivotal role" in the adoption of healthier food habits or a healthy food policy, which is the aim of Community Tables (Worsley, 2002). Reading food labels was one area of knowledge gain. It has been noted that difficulty in reading food labels is common among older adults, adolescents, infrequent label users, and those with less education (Campos et al., 2011). Providing the nutrition knowledge of reading food labels is therefore important, and has shown to have positive results in low-income and other vulnerable populations (Campos et al., 2011).

Participants also increased their level of confidence in terms of selecting and preparing healthy foods. An increase in participant confidence with selecting and preparing food is a success. In a community-based food skill intervention, increased confidence was found to correlate with increased enthusiasm and 'adventurousness' around food preparation and trying new foods (Wrieden et al., 2007). These are positive qualities to have in terms of food programming, as healthy food policies mean new experiences for many front-line workers involved in food preparation.

Program Operation (Content & Facilitation)

Both participants and program organizers reported that the program's content and facilitation techniques were received positively, and few improvements were identified. The main strength reported was the hands-on and interactive components. Community Tables is centred on providing both theoretical and applied knowledge, which is considered to be an optimal approach (Worsley, 2002). Future programming should continue to incorporate these.

One unintended outcome of the program was that some participants also made small dietary changes in their own lives. The program was structured in a way that would allow these other outcomes to happen and should continue to in future developments. The implementing organization, Food Matters Manitoba, is already modifying the program based on results.

Limitations

The major limitation was the small sample size. Initially, data collection was intended for Session 2 (full implementation). However, due to the lack of follow-up with these participants, the researcher had to expand the participant pool to Session 1 (Pilot). This was important in order to enrich the data and gain feedback from diverse organizations in Winnipeg's North End. Had more participants been interviewed, more barriers and facilitators in the development and implementation of the healthy food policies in organizations may have emerged.

Related to the small sample size, the final session had a low attendance. This resulted in less *Post-Program Questionnaires* confidence scores being matched with the *Pre-Program Questionnaires* confidence scores. Had more participants completed both *Pre-* and *Post-Program Questionnaires*, results may have achieved statistical significance in the t-test for more questions. This is likely because the participants, who did not complete the *Post-Program Questionnaires*, reported lower scores of confidence in the *Pre-Program Questionnaires*.

The third limitation was the lack of follow-up. Follow-up was limited to a single interview per participant. Due to the limited scope of this research project, follow-up did not include visiting participating organizations. Therefore, the extent that healthy food policies were developed could not be validated.

Program Recommendations

1. Develop a bottom-up approach to the development and implementation of policy

Policy development and implementation in community-based organizations tends to follow a "top-down" approach, where senior administrators are making decisions without front-line staff involvement. This increases resistance in frontline workers rather than commitment (Haycock-Stuart & Kean, 2013). Successful policy implementation is impaired if front-line workers are not consulted in regards to proposed changes, and given the opportunity to question them (Hunter, 2008). Even though some front-line workers may feel that the "ideal" policy is being developed, without broader consultation, the policy will not be as successful unless it is "owned" (Haycock-Stuart & Kean, 2013). Therefore, adopting a "bottom-up" approach, which provides more flexibility and involvement of front-line workers who implement the policy, is important (Crinson, 2009). Though participants never discussed the importance of front-line worker involvement in the policy development and implementation process, the "bottom-up" approach is still beneficial in that it allows front-line workers to "explore and negotiate with leadership in the organization of the deployment of resources and educational development to prepare for the implementation of policy and changes in the organization" (Haycock-Stuart & Kean, 2013).

More direct engagement of leadership (Board of Directors and/or Directors) is also key to policy implementation in order to bring about significant organizational change (Haycock-Stuart & Kean, 2013). They have the authority and power to allocate (financial, human, etc.) resources to ensure that the policy is implemented smoothly.

2. Implement Regular Policy Training Sessions

Due to the high turnover rate of staff in these community-based organizations, there needs to be some form of ongoing training. The frequency and duration of these sessions will be dependent on each organization's needs. As one participant stated, new staff are hired in his/her organization "approximately two times per year". Part of this training should include training food program staff and volunteers how to enforce the healthy food policy within their organizations. Regular enforcement of the policy is necessary as some staff may eventually forget about the healthy food policy. One method of enforcing the policy is by the promotion and advertisement of it. This can be done in a number of ways, which must suit the organization. Other scenarios where enforcement will be necessary are when any person within the organization resists the healthy food policy. Staff and volunteers will need to be equipped with the knowledge and skills of how to deal with this resistance.

3. Continually Seek New Ways to Increase Organizational Capacity

For a healthy food policy implementation to be successful, each organization will need to expand capacity around food programming, be it improving staff/volunteer nutrition knowledge and/or food skills, or related kitchen equipment/space. The front-line workers and leadership will both need to be open-minded and willing to do more to build their capacity. It will need to begin with one committed person (within the food program) to the policy.

4. Ensure Policy is Evaluated Regularly Following Utilization-Focused Evaluation Approach

Regular review of the healthy food policy will help improve the policy as time goes on, to ensure its relevance, as attending community members and staff in the organization change. It is important to include all stakeholders (front-line workers and leadership) in the evaluation of the policy. This process will empower them and also value their input.

5. Begin with Small Changes

Resistance to change will need to be anticipated and prepared for. Small, incremental changes to the food programs will be necessary. Examples of a small change could be to replace white bread with brown bread or limit the serving of juice to special events. By implementing small changes, this offsets/lightens the burden of change.

6. Provide the Entire Organization with the Appropriate Support Regarding Policy/Changes

It is important for the Community Tables program to include more follow-up support (and resources) in policy formulation and implementation. The specific types of support that would benefit community-based organizations are: further capacity-building opportunities (eg: nutrition/food literacy workshops) for those who prepare/serve foods; assistance in developing programs to engage and teach community members (especially children/youth) healthy eating; physical resources to promote healthy eating (eg: posters, recipes); healthy food policy orientations for other staff and leadership; ongoing support from Food Matters Manitoba, in the form of regular visits; public health staff visits, such as Community Dietitians; mentor visits (eg: star athletes) to visit and encourage youth to live a healthy lifestyle.

7. Strengthen Cultural Foods Component

One of the many challenges program planners experienced was incorporating the appropriate amount of cultural food content that would build participant capacity to serve these foods. Therefore, it would be important to:

- include more "fusion"[16] food recipes
- develop novel ways to teach participants about cultural foods (eg: interactive games)

[16] Fusion food: traditional Aboriginal foods and contemporary market food combined into one dish.

Theoretical Implications

The theoretical basis of the Community Tables program is that implementing a policy to govern food ("healthy food policy") would be an effective intervention to promote and increase healthy food consumption in Winnipeg's North End community-based organizations. It was hypothesized that the outcome of this program would be that by changing the eating behavior within the community-based organizations that this change would eventually translate into community members' homes. The Community Tables program goal is for all twenty community-based organizations with food programs in Winnipeg's North End to implement healthy food policies. This is a process that will take a great deal of time, investment, and commitment on behalf of both the organizational community (community members, front-line workers and leadership) and the implementing organization, Food Matters Manitoba. This process takes longer and is more difficult in an environment where there is a high turnover rate. It is better to attempt to serve healthy food, even with limited resources, than serving unhealthy food (the way it is now). Therefore, if appropriate resources and supports are available and provided to both community-based organizations and Food Matters Manitoba, then the payoff will be greater than the investment.

Conclusion

Using healthy food policy to build capacity and create environments to serve healthier food has been gaining traction at the community level in school and recreation facility settings in Manitoba. Community Tables is an innovative community-based program that has significant potential to contribute to this movement. However, little is known about policy in community-based organizations in vulnerable urban settings where significant numbers of community members access food programs, such as in Winnipeg's North End.

The Community Tables program taught important food literacy skills to staff and volunteers at the participating community-based organizations as well as demonstrated to participants of serving healthy food to community members through the development and implementation of healthy food policy. This study conducted a participatory, case study Utilization-Focused Evaluation to determine the effectiveness and impact of Community Tables, a food and nutrition capacity building program, in Winnipeg's North End. This study demonstrated the utility and feasibility for evaluating other community-based nutrition education programs using this approach. The Utilization-Focused Evaluation approach was successful because:

- each partner (University of Manitoba and Food Matters Manitoba) was able to contribute knowledge and local contexts to the evaluation, which enhanced the process
- the process allowed Food Matters Manitoba to select the most appropriate content, model, methods, theory, and uses for their particular situation, thereby increasing the usefulness of the results (Patton, 2012)
- the process led to results that was ultimately used by Food Matters Manitoba to improve the program

This evaluation examined each participant's experience with healthy food policy at his/her respective organization; determined the effectiveness of the program in increasing participant food literacy; and determined the ways the program content and facilitation were working and could be improved.

This is one of the first participatory research studies using the Utilization-Focused Evaluation approach in a vulnerable urban community to evaluate a food and nutrition program. By providing meaningful and useful results through a collaborative process, the primary intended user, Food Matters Manitoba will implement the recommendations. With program improvements, including tailored supports in terms of policy, Community Tables has the

potential to reach all twenty community-based organizations with food programs in Winnipeg's North End to adopt healthy food policies. Despite the challenges identified, Community Tables is a promising program that can significantly increase the number of healthier foods being served in these organizations. This will hopefully lead to improved food security, nutrition, and ultimately the health and well-being of community members. During the program planning process, uncovering barriers to behavior change, conducting pilots and evaluating community implementations increases the likelihood for sustainable behaviors, as a result of the program (McKenzie-Mohr, 2000).

Recommendations for Future Research

Further examinations of healthy food policy development and implementation process at the community level are needed. As a follow-up to this study, researchers could work closely with these community-based organizations to determine the specific types of supports that are needed in order to overcome the barriers to ensure the successful implementation of a healthy food policy. The results of these studies would inform those looking to successfully implement policy at the community level. Other community-based food programs could also use the Utilization-Focused Evaluation approach, along with the specific methods used in this study, to assess program impact and outcomes.

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Appendices

APPENDIX A

Community Tables Organizational Profile

Date:_____

Interviewer: _____

Purpose: This organizational profile will help us learn more about the organizations participating in the Community Tables program, and the food programs those organizations offer. This information will help us better understand how the Community Tables program is working, so we can tailor the program to meet the needs of North End organizations.

What will be done with the information provided: The information will be used for the purposes of the Community Tables evaluation as well as determining findings and deriving lessons learned that will be shared with partners and those interested in learning more about our program.

Your organization will only be identified as having participated in the Community Tables program in reports to the funder; other than that, the information you provide here will not be associated with your individual organization, but will be grouped with responses from other organizations.

Who should answer the questions on the form? A program manager, or the person with the most responsibility for food service/programs in the organization.

1. Organization Name:

_____

2. Organizational Contact:

Name:_____

Position: _____

Organization Address:

_____

_____

Postal Code:_____

Email address: _____

Phone number: _____

3. Where do most of your participants come from?

□ North End
□ Downtown
□ Other parts of the city
□ Not sure

4. Who do you primarily serve (select all that apply):

□ Children/youth □ Adults □ Seniors □ Families
□ Aboriginal people □ Newcomers
□ Other _____

5. Please briefly describe the main programs and services your organization offers:

_____

_____

_____

_____

_____

_____

6. Do you have meal or snack programs? □ No □ Yes. If yes, which ones?

□ Breakfast programs
□ Lunch programs
□ Supper programs
□ Snacks offered as part of other programs (E.g. after-school recreation program)
□ Staff meetings
□ Other_____

7. Do you offer food skills programs or activities? □ No □ Yes. If yes, which ones?
□ Cooking classes for adults
□ Cooking classes for children/youth
□ Child/baby nutrition classes
□ Meals on special occasions (holidays)
□ Gardening programs
□ Other _____

8. Approximately how many participants do you serve per week in your food-related programs?

□ 0-50
□ 51-100
□ 101-150
□ 151-200
□ 201-300
□ 301-400
□ 401+

9. How many hours per week does your organization have staff working on food-related programming? (daily snack preparation, health programs, cooking classes, food bank, etc.)

_____ hours

10. How many hours per week does your organization have volunteers working on food-related programming? (daily snack preparation, health programs, cooking classes, food bank, etc.)

_____ hours

11. Do you have a kitchen or adequate food preparation area?

□ Yes
□ No

12. Do you have a regular food budget?

□ No □ Yes. If yes, approximately how much? _____

13. What are the main sources of food for your programs?

__ Purchase food from major grocery stores
__ Purchase food from neighbourhood stores
__ Winnipeg Harvest
__ Winnipeg Foodshare Co-op
__ Food donations made directly to your organization
__ Other _____

14. Are there any food items that you will not use in your organization? If yes, list. If yes, why?

_____

_____

15. Do you regularly make menu plans each week for your programs?

□ Yes

□ No

□ Not sure

16. How do you determine what you include in the meal plans at your organization?

□ Yes

□ No

□ Not sure

17. Do you think healthy food is too expensive for your organization?

□ Yes

□ No

□ Not sure

18. Do you think your organization has enough staff-time to prepare healthy food?

□ Yes

□ No

□ Not sure

19. Do you feel there are places near your organization where you can buy healthy food?

□ Yes

□ No

□ Not sure

20. Do you have the equipment and space to make healthy foods?

□ Yes

□ No

□ Not sure

21. Do you feel you or your staff have adequate knowledge about healthy food?

□ Yes

□ No

□ Not sure

22. Do you feel you or your staff have adequate knowledge about nutrition?

□ Yes

□ No

□ Not sure

23. Do you feel you or your staff have adequate knowledge about food preparation?

□ Yes
□ No
□ Not sure

24. Do you have control over what food you get from the food bank?

□ Yes
□ No
□ Not sure

25. Do you currently have a set of guidelines (or food policy) for what foods are brought into the organization, where foods are purchased, what foods are served?

□ No
□ Not sure
□ Yes

Explain:
_____
_____

26. Why are you registering for this program?

_____

_____

27. Would your organization be interested in developing a set of guidelines (or healthy food policy) for what foods are brought into the organization, where foods are purchased, what foods are served?

□ Yes
□ No
□ Not sure

28. We would like to ask you a few more questions right after, and about 2 months after the Community Tables Training. Can we contact you? □ Yes □ No

APPENDIX B

COMMUNITY TABLES PRE-PROGRAM QUESTIONNAIRE

Thank you for taking the Community Tables Nutrition Training Program. Please tell us what you think by filling out this form. It takes approximately 5-10 minutes to complete. This is not a test! Your answers and opinions are very important – they tell us what is working with the program, what can be improved, and will help us make this a better program for future participants.

Your answers will be anonymous and will be kept confidential and shared with other participants in the class. To make your answers anonymous, you will put a randomly drawn ID number on your questionnaire instead of your name. You will use this same number for the Post-Questionnaire (Total) so that we know which questionnaires go together. We will keep your number in an envelope that only you will open, so you don't have to remember it. PLEASE WRITE YOUR NUMBER INSIDE YOUR MANUAL SO YOU CAN USE THE SAME NUMBER FOR EACH QUESTIONNAIRE.

Meegwetch! If you have any questions, please feel free to ask your instructor.

ID Number: _____

Today's Date: _____

Please rate your confidence with each of the following statements, on a scale of 1 to 5, where 1 means "Not confident at all" and 5 means "Very Confident." (Circle only **ONE** answer.)

1. I am confident with my nutrition knowledge.	Not confident at all 1	2	Somewhat confident 3	4	Very confident 5
2. I am confident with my cooking skills.	Not confident at all 1	2	Somewhat confident 3	4	Very confident 5
3. I am confident with planning snacks and meals at my organization.	Not confident at all 1	2	Somewhat confident 3	4	Very confident 5

4. I am confident the meals and snacks I plan are healthy.	Not confident at all 1	2	Somewhat confident 3	4	Very confident 5

5. What do you want to learn from the Community Tables workshop series?

_____

_____

_____

Thank you!

APPENDIX C

Thank you for coming to today's Community Tables Lessons!

ID Number: _____ Date: _____

1. Did you learn anything new today? Yes / No

   If yes, please tell us up to 3 things you learned.

   a) _____
   _____

   b) _____
   _____

   c) _____
   _____

2. Do you think you will be able to apply anything you learned today in your organization? Yes / No

   Please explain:

   _____

   _____

   _____

3. What did you like about today's session? What didn't you like? Any suggestions?

APPENDIX D

COMMUNITY TABLES POST-PROGRAM QUESTIONNAIRE

Thank you for taking the Community Tables Nutrition Training Program. Please tell us what you think by filling out this form. It takes approximately 5-10 minutes to complete. This is not a test! Your answers and opinions are very important – they tell us what is working with the program, what can be improved, and will help us make this a better program for future participants.

Your answers will be anonymous and will be kept confidential and shared with other participants in the class. To make your answers anonymous, you will put a randomly drawn ID number on your questionnaire instead of your name. You will use this same number for the Post-Questionnaire (Total) so that we know which questionnaires go together. We will keep your number in an envelope that only you will open, so you don't have to remember it. PLEASE WRITE YOUR NUMBER INSIDE YOUR MANUAL SO YOU CAN USE THE SAME NUMBER FOR EACH QUESTIONNAIRE.

Meegwetch! If you have any questions, please feel free to ask your instructor.

ID Number: _____

Today's Date: _____

Please rate your confidence with each of the following statements, on a scale of 1 to 5, where 1 means "Not confident at all" and 5 means "Very Confident." (Circle only **ONE** answer.)

1. I am confident with my nutrition knowledge.	Not confident at all 1	2	Somewhat confident 3	4	Very confident 5
2. I am confident with my cooking skills.	Not confident at all 1	2	Somewhat confident 3	4	Very confident 5
3. I am confident with planning snacks and meals at my organization.	Not confident at all 1	2	Somewhat confident 3	4	Very confident 5

4. I am confident the meals and snacks I plan are healthy.	Not confident at all 1	2	Somewhat confident 3	4	Very confident 5

5. Overall, what did you find most useful from attending Community Tables that you hope to use in your organization?

   _____

   _____

   _____

6. Was the material covered in the 8 modules in this training what you expected?

Yes	No	If no, why not? _____ _____

7. Do you like the location for Community Tables?

Yes	No	If no, why not? _____ _____

8. Do you think the length of each session was suitable?

Yes	No	If no, why not? _____ _____

9. Will the information you learned in Community Tables be useful to your organization?

Yes	No	If no, why not? _____ _____

10. Have you used anything you learned at Community Tables so far? Please describe.

_____

_____

Thank you!

APPENDIX E: Evaluation Framework

<table>
<tr><th>Pre-</th><th>Session 1</th><th>Session 2</th><th>Session 3</th><th>Session 4</th><th>Session 5</th><th>Post-</th></tr>
<tr><td rowspan="2">1.Organizational Profiles

-demographics</td><td>3. Learning Outcome Questionnaire</td><td>4. Learning Outcome Questionnaire</td><td>5. Learning Outcome Questionnaire</td><td>6. Learning Outcome Questionnaire</td><td>7. Learning Outcome Questionnaire</td><td rowspan="3">9. Follow-up Interviews (2 months+ post-program)</td></tr>
<tr><td colspan="5"><u>Learning Outcome Questionnaires (3-7):</u>
-did participants learn anything new?
-if/how participants may use information from module in their organization
-what did participants like/didn't like? Suggestions?</td></tr>
<tr><td>2. Pre-Program Questionnaire

- attitudinal-type questions
- what participants want to learn</td><td colspan="4"></td><td>8. Post-Program Questionnaire

-attitudinal-based questions</td></tr>
</table>

Appendix F: Interview Questions

Community Tables Participants (9 questions)

1. Now that you have completed Community Tables, is your organization thinking about making any changes in your organization?
2. What changes was your organization able to make in your organization?/ Are there other changes your organization plan to put in place?
3. What would help your organization make these changes?/ What supports do you think would be helpful in making these changes?
4. What (specifically from Community Tables and in general) helped your organization make these changes? (from the program? Anything else?)
5. What might prevent your organization from making these changes?/ Were there any barriers?
6. What's going to help your organization sustain this (change) in the future?
7. Did you share your healthy food guidelines with your co-workers? Anyone else?
8. Do you still think your organization's healthy food guidelines are relevant/useful? Would you make any changes to your healthy food guidelines?
9. How is your organization using the healthy food guidelines in your organization?

Program Organizers (11 questions)

1. Please describe your experience with the program.
2. What were some of the positive experiences you've had with the program?
3. What were some of the less positive experiences you've had with the program?
4. Why do you think this program is needed?
5. How is the structure and logic of the program appropriate?
6. Was there anything that happened was unintended?
7. What activities/delivery methods worked or didn't work? What are the strengths and weaknesses?
8. Considering any of the following (before/during/after the Community Tables program), what were the participants' reactions?
9. What were some of the challenges you've experienced?
10. Do you think the program achieved its intended objectives?
11. Do you have any recommendations to improve the program?

APPENDIX G: Ethics Approval Certificate

UNIVERSITY OF MANITOBA | Research Ethics and Compliance
Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Fax +204-269-7173

APPROVAL CERTIFICATE

May 1, 2014

TO: **Kerry Spence** (Advisor J. Slater)
Principal Investigator

FROM: **Susan Frohlick, Chair** [redacted]
Joint-Faculty Research Ethics Board (JFREB)

Re: **Protocol #J2014:057**
"A Mixed-Methods Case Study Evaluation of a Community-based Food Literacy Program: "Community Tables"

Please be advised that your above-referenced protocol has received human ethics approval by the **Joint-Faculty Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). **This approval is valid for one year only**.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, please mail/e-mail/fax (261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM Project Number: http://umanitoba.ca/research/ors/mrt-faq.html#pr0)**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

APPENDIX H: Ethics Amendment Approval

UNIVERSITY of MANITOBA | Research Ethics and Compliance
Office of the Vice-President (Research and International)

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AMENDMENT APPROVAL

October 20, 2014

TO: **Kerry Spence**
Principal Investigator

FROM: **Susan Frohlick, Chair**
Joint-Faculty Research Ethics Board (JFREB)

Re: **Protocol #J2014:057**
"A Mixed-Methods Case Study Evaluation of a Community-based Food Literacy Program: "Community Tables"

This will acknowledge your request, dated September 30, 2014, requesting amendment to your above-noted protocol.

Approval is given for this amendment. Any further changes to the protocol must be reported to the Human Ethics Secretariat in advance of implementation.

APPENDIX I: Copyright Permission Approval

From: Martin Landy <martin@necrc.org>
Subject: FW: Copyright permission request (for image of North End of Winnipeg boundaries map)
Date: May 26, 2015 at 10:47:58 AM CDT
To: <umspen83@myumanitoba.ca>

Dear Kerry:

As per our conversation of today, North End Community Renewal Corporation grants you permission to use the requested map of the 11 communities that comprised the NECRC Catchment area, for use in your thesis as stated below.

Please advise me if you need anything else.

ML

Martin Landy Communications and Event Coordinator
North End Community Renewal Corporation
509 Selkirk Avenue Winnipeg, MB R2W 2M6
(phone): 204.927.2349 (mobile): 204.688.8705

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Website: www.necrc.org
Website: www.themerch.ca

APPENDIX J: Copyright Permission Approval

From: Martin Landy <martin@necrc.org>
Subject: Copyright permission request for map image
Date: May 12, 2015 at 5:14 PM CDT
To: <umspen83@myumanitoba.ca>

Hi Kerry,

I hereby grant you permission to reproduce the map from our report (Figure 1.3.6), for which MCHP holds copyright.

Let me know if I need to do anything else. We appreciate your careful attention to the correct citation information.

Cheers

Randy

Randall Fransoo, PhD;
Senior Research Scientist and Associate Director of Research, Manitoba Centre for Health Policy;
Assistant Professor, Community Health Sciences, College of Medicine, Faculty of Health Sciences, University of Manitoba;
(204) 789-3543;
Randy_fransoo@cpe.umanitoba.ca;